

Northampton General Hospital NHS Trust

# Northampton General Hospital

## Quality Report

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

## Ratings

### Overall rating for this hospital

Good



Critical care

Good



Maternity and gynaecology

Good



Services for children and young people

Good



Outpatients and diagnostic imaging

Good



# Summary of findings

## Letter from the Chief Inspector of Hospitals

Northampton General Hospital (NGH) is an 800-bedded acute hospital. There are approximately 713 general and acute beds with 60 maternity beds, and 16 critical care beds. The trust employs 4,875 staff, including 531 doctors, 1,487 nursing staff and 2,857 other staff.

We carried out this inspection as part of our routine focused inspection programme. We completed a short notice focused inspection on the 25 to 27 July 2017 and an unannounced inspection on 9 August 2017.

We determined the extent of this focused inspection following a review of information gathered and the findings from our previous inspection. This included an analysis of the trust's performance and information from stakeholders. The hospital was previously inspected under our comprehensive methodology in January 2014, when the overall rating was requires improvement.

We found the trust has taken significant action to meet the concerns raised from the January 2014 inspection, particularly in establishing an inclusive and supportive staff culture with a clear focus on patient safety.

We rated the four core services we inspected (critical care, maternity and gynaecology, children and young people and outpatients and diagnostic imaging) as good overall. Combining these core service ratings with the ratings for the other four services we last inspected in February 2017, the overall rating for the hospital was good. All five key questions were rated as good (safe, effective, caring, responsive and well-led).

We found that:

- Staff were friendly, professional, compassionate and helpful to patients in all interactions that we observed.
- Patients told us that the staff had been caring towards them and all spoke positively about the staff in all areas inspected.
- We observed care being delivered by nurses, play specialists, medical, therapy, and auxiliary staff that interacted with children and young people in a very positive and caring manner.
- There was a positive culture towards reporting incidents and learning from these to improve patient safety in all areas inspected.
- There were effective systems in place to ensure that standards of cleanliness and hygiene were maintained.
- The design, maintenance, and use of facilities, premises, and equipment generally met all patients' needs.
- Improvements had been made in some areas in the outpatient environment, which included the expansion of the chemotherapy suite and new equipment in the diagnostic imaging department.
- Medicines were generally stored and handled in line with the hospital's medicines management policy.
- There were generally effective processes in place to ensure that adults and children in vulnerable circumstances were safeguarded from abuse. Staff in all areas were aware of the processes to identify and respond to patient risk and there were systems in place to monitor and manage risks to patient safety.
- Medical, nurse and midwife staffing levels met patients' needs at the time of the inspection.
- Patients' outcomes were being measured and were generally in line with national average. Action plans were in place to drive improvements.
- There was clear evidence and data upon which to base decisions and look for improvements and innovation. The unit participated in the Intensive Care National Audit and Research Centre (ICNARC) audit and performed better or as expected in six out of eight indicators.
- The critical care outreach team provided 24 hour cover seven days a week and assisted with the monitoring and treatment planning of deteriorating patients throughout the hospital, ensuring risks were responded to appropriately.

# Summary of findings

- Patients and their relatives were supported during their stay within critical care services and staff provided opportunities to discuss care and treatment. This was delivered in a way that promoted dignity and confidentiality at all times.
- The maternity and gynaecology service completed the national maternity safety thermometer and monitored safety performance through clinical dashboards.
- The children and young people's service performed well in a number of national audits including the National Neonatal Audit (2015) and the Epilepsy 12 audit (2014). Gosset ward was working towards achieving Bliss accreditation.
- Policies were based on national guidance produced by National Institute for Health and Care Excellence (NICE) and the royal colleges.
- Pain of individual patients was assessed and managed appropriately.
- There were systems and processes in place to ensure that staff had the necessary qualifications, skills, knowledge and competencies to do their jobs.
- Effective multidisciplinary working was clearly evident throughout the departments and services.
- There were appropriate processes and systems in place to ensure that information needed to deliver care and treatment was available to relevant staff in a timely manner.
- Patient's consent was obtained in line with trust policy and statutory requirements.
- Services had been planned to take into account the needs of different people, for example, on the grounds of age, disability, gender or religion.
- Care and treatment was only cancelled or delayed when absolutely necessary.
- Access to services was generally effective and timely.
- Appointments were prioritised according to referral requests from GPs with urgent requests and cancer referrals booked within two weeks. The imaging department prioritised reporting higher risk examinations not seen by other clinicians.
- The hospital consistently met the referral to treatment standards over time.
- Waiting times for diagnostic procedures were better than England average.
- The service managed complaints swiftly, openly and constructive as part of a co-ordinated patient feedback system.
- The hospital staff worked with a variety of stakeholders and commissioners to plan delivery of care and treatment. There was a focus in providing integrated pathways of care, particularly for patients with multiple or complex needs.
- The leadership teams were cohesive and inclusive and were focused on delivering safe, high quality care and treatment for all patients.
- Staff felt there was a high level of staff engagement, which was positive and led to high levels of staff satisfaction.
- Staff believed in the leadership of the hospital and were proud of the organisation and its culture.
- Services had a clear vision, strategy, and objectives based on improving quality and safety in line with the overall trust vision.
- Leadership in services was well established and there was a clear focus on improvements and patient safety.
- Structured meetings were held throughout services to review all aspects of quality, risks and performance and high risks were escalated and monitored effectively.
- Effective governance arrangements were in place. There were structured meetings to review all aspects of performance, quality and risks and high risks were escalated through the services.
- Service risk registers reflected the risks within the service and there was evidence of ownership, mitigations having been implemented and ongoing monitoring.
- Innovation throughout staff teams was encouraged.

However, we also found:

- The critical care service was aware of the shortfall in band 8a specialist pharmacist support and was providing cover with a band 7 pharmacist. A business case had been put forward, which if successful, would ensure standards were being met.

# Summary of findings

- Medicines were not always stored safely behind locked doors or in restricted areas in critical care. We raised this with the trust and this was rectified immediately by the trust.
- There was effective working relationships and commitment to critical care between members of the multidisciplinary team. However, the trust was not meeting the national core standards for employment of allied professionals within critical care services.
- The critical care unit did not comply with the Department of Health's Health Building Note 04-02 critical care unit's standards; however, this had been risk assessed and was under review. Refurbishment plans were in place to address this.
- Not all medical staff in critical care had completed the required mandatory training.
- Hospital wide bed capacity affected the ability of the service to discharge patients to wards at the most appropriate time. Over eight hour delayed discharges were higher than the national average, however, action had been taken and improvement observed for patients waiting 24 to 48 hours.
- Single sex accommodation in critical care was not always maintained due to hospital wide bed pressures. Action was taken to protect patient's dignity at all times.
- Not all doctors, nurse and midwives had had annual refresher training for safeguarding adults at level two in the maternity and gynaecology service. Action plans were in place to address this.
- The maternity service had had higher than expected caesarean rates and perinatal mortality rates over time. Whilst actions and mitigating actions had been taken, these had not always improved outcomes. The service continued to monitor and assess these potential risks to patients.
- There were not always effective systems in place regarding the storage and handling of medicines in the children's outpatient department. The trust took immediate action to address this once we raised it as an urgent concern.
- Children or young people on Paddington ward could access the corridor to the delivery suite. This was a risk particularly for patients who may be at risk of self-harm or suicide. The trust took immediate action to address this once we raised it as an urgent concern.
- The pathway for patients who needed to cross the road between buildings had not been reassessed to ensure opportunities to prevent or minimise further harm were not missed. The trust took immediate action to address this once we raised it as an urgent concern.
- The child abduction policy was in draft and awareness was lacking in some areas of the service. The trust took immediate action to address this once we raised it as an urgent concern.
- Paediatric wards did not have the appropriate facilities to care for the increasing number of patients with mental health issues who could be at risk of self-harm or suicide.
- We found concerns about the fire exit in the fracture clinic. This had been addressed by the unannounced inspection and we found the service had also reviewed all fire exits throughout the service.
- Not all staff were compliant with infection prevention and control measures in the blood taking unit. We raised this with the service, and immediate actions were taken to review infection control precautions to mitigate risk. This had been addressed by the unannounced inspection.
- Not all staff had had the required frequency of mandatory training, including safeguarding.
- The controlled drugs cupboard in the pain relief clinic contained a variety of non-controlled drugs. This was not in line with medicines storage guidelines. We raised this with the service and this had been rectified by the time of our unannounced inspection.
- We observed poor infection control practices in both the blood-taking unit and the pain relief clinic. We raised this with the service and this had been rectified by the time of our unannounced inspection.
- Some staff in the diagnostic imaging department had limited understanding of the ionizing radiation (medical exposure) regulations (IR(ME)R) regulations themselves and five members of staff we spoke to were unable to locate where the employers' procedures were kept. We raised this with the service and senior staff took immediate action to address this.

We saw several areas of outstanding practice including:

# Summary of findings

- The trust had a duty of candour sticker that would be placed into the patient's notes when the duty of candour had been applied. This included, for example, staff name, date, name of person/patient receiving information, account of incident, details of incident and if an apology was offered.
- Two members of the critical care team had been nominated for the 'Best Possible Care' Awards. Patients and those close to them, as well as work colleagues, voted for staff members who had gone above and beyond to exceed expectations and had made a real difference to patient care.
- The 'Chit Chat' group was set up by the maternity service in 2016 to facilitate antenatal education, parenting advice and peer support for women with additional needs, including learning disabilities or anxiety. Staff said these meetings were two weekly and very well attended. This group meeting initiative had been nominated for two national awards and had won one at the time of the inspection.
- The maternity service reviewed and evaluated the provision of multi-disciplinary training when the service was chosen as one of the 10 pilot sites for enhancing patient safety. As part of the pilot, the service chose to concentrate on the fetal monitoring and team working and skills drills sections with the outcome that the service was able to deliver these training programmes completely internally (including Practical Obstetrics Multi-professional Training (PROMPT)).
- Gosset ward was working towards achieving Bliss accreditation. This means the ward had undertaken exceptional work through the involvement of parents to encourage bonding with these very special babies which has helped to build the evidence for Bliss accreditation.
- Staff had developed an assessment tool to improve the monitoring and assessment of baby's skin on Gosset ward. The ward was working with neonatal services from across the world (Canada and Turkey) to further develop the tool.
- The recruitment of 1.7 WTE advanced neonatal nurse practitioners (ANNP) onto the medical neonatal rota was helping to address recruitment issues in relation to junior doctors.
- The superintendent sonographer was very passionate about their service and had developed an excellent team which provided image quality assurance and peer review. They were able to detect team members' weaknesses and pair them with other sonographers to help them develop. The ultrasound department conducted many audits and fed these back to ultrasound community in England.

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

The trust should:

- Review pharmacy provision to meet the needs of the critical care service and be in line with national guidance.
- Continue to review and monitor over eight hour delayed discharges in critical care and report incidents and mixed sex breaches using the electronic reporting system.
- Monitor staff mandatory training to ensure compliance with the trust's target including annual refresher training for safeguarding adults at level two and safeguarding children level two and three.
- Continue to monitor caesarean rates and perinatal mortality rates in the maternity and gynaecology service.
- Review multidisciplinary support to critical care services to ensure national best practice is following, in relation to therapy support.
- To monitor allergy testing ampules ensuring use within their recommended expiry dates.
- The trust should consider improving the facilities for parents to stay overnight on paediatric wards.
- Continue to monitor and review the impact of patients admitted to paediatric wards with mental health issues.
- Continue to monitor and review the effect on children's services due to the limited availability of psychologist support, particularly for children with long term conditions.
- Continue to monitor controlled drugs are effectively stored in outpatient areas.
- Continue to monitor fire exits are accessible at all times.

**Professor Edward Baker**

Chief Inspector of Hospitals

# Summary of findings

## Our judgements about each of the main services

### Service

### Critical care

### Rating

Good



### Why have we given this rating?

We rated this service as good because:

- There was a strong culture of reporting, investigating and learning from incidents. Learning was shared throughout the team.
- Adequate medical and nursing staff was provided to meet the recommended staff to patient ratio, as defined in the core standards for intensive care units.
- There were effective systems in place to protect patients from avoidable harm and improve compliance with standards on a continuous basis. The principles of the duty of candour were well understood by all staff.
- There was clear evidence and data upon which to base decisions and look for improvements and innovation. The unit participated in the Intensive Care National Audit and Research Centre (ICNARC) audit and performed better or as expected in six out of eight indicators.
- The critical care outreach team provided 24 hour cover seven days a week cover and assisted with the monitoring and treatment planning of deteriorating patients throughout the hospital, ensuring risks were responded to appropriately.
- Staff were very caring and kind and provided emotional support for patients and relatives, for example, through the use of patient diaries.
- Leadership was well established and there was a clear focus on improvements and patient safety.
- Structured meetings were held throughout the directorate to review all aspects of quality, risks and performance and high risks were escalated and monitored effectively.
- Effective governance arrangements were in place. There were structured meetings to review all aspects of performance, quality and risks and high risks were escalated through the directorate. Innovation throughout the staff team was encouraged.

However:

# Summary of findings

- The pharmacy team were aware of the shortfall in band 8a specialist pharmacist support and were providing cover with a band 7 pharmacist. A business case had been put forward, which if successful, would ensure standards were being met.
- Medicines were not always stored safely behind locked doors or in restricted areas. We raised this with the trust and this was rectified immediately by the trust.
- The unit did not comply with the Department of Health's Health Building Note 04-02 critical care unit's standards; however, this had been risk assessed and was under review. Refurbishment plans were in place to address this.
- Not all medical staff had completed the required mandatory training.
- Hospital wide bed capacity affected the ability of the service to discharge patients to wards at the most appropriate time. Over eight hour delayed discharges were higher than the national average, however, action had been taken and improvement observed for patients waiting 24 to 48 hours.

## Maternity and gynaecology

Good



We rated this service as good because:

- The service completed the national maternity safety thermometer and monitored safety performance through clinical dashboards.
- The design, maintenance and use of facilities and premises met all patients' needs. There were systems and processes in place to ensure that the maintenance and use of equipment kept patients safe.
- Medicines were stored and handled in line with the hospital's medicines management policy. Individual care records were written in a way that kept patients safe.
- Effective systems were in place to assess risks to patients and to recognise deterioration, including the use of early warning score assessments.
- Medical, midwife and nurse staffing levels, skill mix and caseloads were planned and reviewed so that patients received safe care and treatment at all times, in line with relevant tools and guidance.
- Policies were based on national guidance produced by National Institute for Health and Care Excellence (NICE) and the royal colleges.

# Summary of findings

- Patients' outcomes were being measured and were generally in line with national average. Action plans were in place to drive improvements.
- The service leadership team was cohesive and inclusive and was focused on delivering safe, high quality care and treatment for all patients.
- The trust had a clear and effective vision for maternity and gynaecology services to deliver high quality person-centred care, which staff were committed to.
- The focus on safe patient care was clearly evident in all areas and from all staff.
- There were effective and clear governance systems in place to escalate issues and risks to the service leaders and to the trust board.
- The service risk register reflected the risks within the service and there was evidence of ownership, mitigations being implemented and ongoing monitoring.
- Staff believed in the leadership of the service and were proud of the organisation and its culture.

## However:

- Not all doctors, nurse and midwives had received annual refresher training for safeguarding adults at level two. Action plans were in place to address this.
- The service had had higher than expected caesarean rates and perinatal mortality rates over time. Whilst actions and mitigating actions had been taken, these had not always improved outcomes. The service continued to monitor and assess these potential risks to patients.

## Services for children and young people

Good



### We rated this service as good because:

- There was a well-embedded culture of incident reporting and staff said they received feedback and learning from incidents.
- Safety thermometer data from the last 12 months reported 100% of "harm free" care in the child health directorate.
- There were clear arrangements in place to safeguard children and young people from abuse, which reflected relevant legislation and local requirements. The majority of staff had undertaken the required level of safeguarding training.



# Summary of findings

- The service performed well in a number of national audits including the National Neonatal Audit (2015) and the epilepsy 12 audit (2014). Gosset ward was working towards achieving Bliss accreditation.
- Staff had the clinical skills, knowledge, and experience they needed to carry out their roles effectively. Mandatory training and appraisal levels were above trust targets.
- Actual nurse staffing levels met planned rotas during our inspection and patient's needs were met. Medical staffing was appropriate and there was an effective level of cover to meet patients' needs.
- Feedback from children and parents was consistently positive and parents told they were treated with dignity and respect.
- Services were responsive to the needs of patients, parents and families and were working towards delivering sustainable seven-day services.
- Staff felt that local leadership was strong with visible supportive and approachable managers.
- The child health directorate was continually developing patient services to ensure innovation, improvement, and sustainability.

## However:

- There were not always effective systems in place regarding the storage and handling of medicines in the children's outpatient department. The trust took immediate action to address this once we raised it as an urgent concern.
- Children or young people on Paddington ward could access the corridor to the delivery suite. This was a risk particularly for patients who may be at risk of self-harm or suicide. The trust took immediate action to address this once we raised it as an urgent concern.
- The pathway for patients who needed to cross the road between buildings had not been reassessed to ensure opportunities to prevent or minimise further harm were not missed. The trust took immediate action to address this once we raised it as an urgent concern.
- The child abduction policy was in draft and awareness was lacking in some areas of the service. The trust took immediate action to address this once we raised it as an urgent concern.

# Summary of findings

## Outpatients and diagnostic imaging

Good



Overall, we rated outpatients and diagnostics as good. We inspected but did not rate the effectiveness of the service, as we are currently not confident that we are collecting sufficient evidence to rate this key question for outpatients and diagnostic imaging. We rated this service as good because:

- Staff were aware of their responsibilities and understood the need to raise concerns and report incidents. Staff told us they felt fully supported when raising concerns.
- Generally, the design, maintenance, and use of facilities and premises met patients' needs. The maintenance and use of equipment kept patients safe from avoidable harm. Improvements had been made in some areas in the outpatient environment, which included the expansion of the chemotherapy suite and new equipment in the diagnostic imaging department.
- Appointments were prioritised according to referral requests from GPs with urgent requests and cancer referrals booked within two weeks. The imaging department prioritised reporting higher risk examinations not seen by other clinicians.
- We found that medical and nursing staffing levels and skill mix were planned and reviewed so that patients received safe care and treatment.
- Care and treatment was delivered in line with national guidelines. Staff within the service had the appropriate skills, qualifications, and knowledge to complete their roles safely.
- All teams reported effective multidisciplinary working.
- Patients were treated with compassion, dignity, and respect.
- Feedback from patients and those close to them was positive about the way they were treated.
- Staff made patients' appointments according to the needs of the individual. This included moving them to allow work and other appointments to take place.
- The service consistently met the referral to treatment standards over time. Waiting times for diagnostic procedures was lower than England average. The service was meeting cancer targets for referral to treatment times at the time of the inspection.
- The "did not attend" (DNA) rate for the trust from June 2016 to May 2017 was 7% and this was same as the England average of 7%.

# Summary of findings

- Outpatient specialties ran additional evening and weekend clinic lists to reduce the length of time patients were waiting. The radiology department offered a walk in service for all plain film examinations.
- Services were tailored to meet the needs of individuals and offered flexibility in choice with appointments being flexed across a seven day service within the diagnostic imaging department.
- The service had a challenging and innovative strategy that supported the trust vision. This included redesign of departments, introduction of support systems to improve performance and repatriation of services to improve patient experience.
- Staff had awareness of the trust vision and strategy. Staff were aware of the risks within their departments. Staff were proud to work at the hospital and passionate about the care they provided.
- The service had leadership, governance and a culture which were used to drive and improve the delivery of quality person-centred care.
- Staff felt that managers were visible, supportive and approachable. Specialties were focused on developing services to improve patient care.

## However, we also found that:

- We found concerns about the fire exit in the fracture clinic. This had been addressed by the unannounced inspection and we found the service had also reviewed all fire exits throughout the service.
- We observed poor infection control practices in both the blood-taking unit and the pain relief clinic. We raised this with the service, and immediate actions were taken to review infection control precautions to mitigate risk. This had been addressed by the unannounced inspection.
- We found issues with the storage of controlled drugs in the pain relief clinic. However, when we raised this with the service, senior managers took immediate action to address storage of these drugs. This had been addressed by the unannounced inspection.
- Not all staff had received the required frequency of mandatory training, including safeguarding. Plans were in place to address this.

## Summary of findings

- We observed poor infection control practices in both the blood-taking unit and the pain relief clinic. We raised this with the service and this had been rectified by the time of our unannounced inspection.
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# Northampton General Hospital

## Detailed findings

### Services we looked at

Critical care; Maternity and gynaecology; Services for children and young people and Outpatients and diagnostic imaging.

# Detailed findings

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### Detailed findings from this inspection

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## Background to Northampton General Hospital

Northampton General Hospital (NGH) is an 800-bedded acute hospital. There are approximately 713 general and acute beds with 60 maternity beds, and 16 critical care beds. The trust employs 4,875 staff, including 531 doctors, 1,487 nursing staff and 2,857 other staff.

It has an income of approximately £250 million and a workforce of around 4,875 staff. It provides general acute services to a population of 380,000 and a hyper-acute stroke, vascular and renal services to people living throughout the whole of Northamptonshire. The hospital is also a cancer centre, delivering cancer services to a wider population of 880,000 in the whole of Northamptonshire, and parts of Buckinghamshire.

The hospital has dedicated beds at the Cliftonville Care Home, Spencer Care Home and Angela Grace Care Home for patients who no longer require acute inpatient care. NGH are responsible for the medical care of patients transferred to one of the care homes with all nursing care and management being the responsibility of the home.

For 2016/17 the trust's financial position was a deficit of £10.5 million as of December 2016. This was better than predicted.

We determined the extent of the inspection following a review of information gathered and the findings from our previous inspection. This included an analysis of the trust's performance and information from stakeholders. The trust was previously inspected under our comprehensive methodology in January 2014, when the overall rating for the trust was requires improvement. We

rated the end of life services as inadequate. The hospital was rated requires improvement overall and was required to complete a number of actions to ensure compliance with the Health and Social Care Act 2008.

The hospital had a focused inspection in September 2014 to look specifically at the non-compliance identified on the previous inspection. There was no change to the ratings. However, we found the trust had taken significant actions to meet the concerns raised from the January 2014 inspection. We also carried out a focused inspection in January and February 2017, when we found significant improvements had been made in all the four core services inspected (urgent and emergency care, medical care, surgery and end of life care) which were all rated as good.

We spoke with a range of staff, including black and minority ethnic staff, nurses, junior doctors, consultants, midwives, healthcare assistants, student nurses, administrative and clerical staff, allied health professions, porters and the estates team. We also spoke with staff individually as requested.

The inspection team inspected the following four core services at Northampton General Hospital.

- critical care.
- children and young people.
- maternity and gynaecology.
- outpatient and diagnostic imaging services.

# Detailed findings

We did not inspect urgent and emergency care, medical care (including older people), surgical care or end of life care as we had inspected these core services in February 2017.

## Our inspection team

Our inspection team was led by:

**Head of Hospital Inspections:** Bernadette Hanney, Care Quality Commission (CQC). The Inspection Manager was Phil Terry and the trust's relationship inspector was Justine Eardley.

The team included seven CQC inspectors, one CQC pharmacist inspector and a variety of specialists including consultants, senior nurses, and trust wide governance experts.

## 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?

We carried out this inspection as part of our routine focused inspection programme completed a short notice focused inspection on the 25 to 27 July 2017 and an unannounced inspection on 9 August 2017.

Before visiting, we reviewed a range of information we held about Northampton General Hospital and asked other organisations to share what they knew about the

hospital. These included the clinical commissioning group, NHS improvement, the General Medical Council, the Nursing and Midwifery Council, the royal colleges and the local Healthwatch.

We talked with patients and staff from all areas and departments. Some patients and staff shared their experience by email or telephone.

We held drop in sessions with a range of staff. These included nurses, doctors, consultants, health care assistants, allied health professionals, administrative and clerical staff, porters and the estates team, and black and minority ethnic staff. We also spoke with staff individually as requested.

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 Northampton General Hospital.

## Facts and data about Northampton General Hospital

Northampton General Hospital NHS Trust employs 4,875 staff, including 531 doctors, 1,487 nursing staff and 2,857 other staff.

For 2016/17 the trust's financial position was a deficit of £10.5 million as of December 2016. This was better than predicted.

### Activity

The trust admitted 87,198 patients from April 2015 to March 2016. There were 549,293 attendances to outpatients and 114,170 attendances to the emergency department. This was an increase in attendances across all areas in comparison to data collected for April 2014 to March 2015.

Bed occupancy on the day of inspection was 104%.

### Population served

# Detailed findings

The trust provides hospital care for a population of 380,000. The local population from April 2015 to March 2016 was predominantly white (86%), with 3% Asian, 2.5% black and 1.2% mixed.

Northamptonshire is a centrally situated county incorporating a mix of urban and rural areas. The population density is in the lowest 25% of upper tier authority areas within England. In spite of this, the county has seen one of the most significant levels of growth during the past 30 years, well in excess of national and regional growth trends. Whilst the population has grown across all broad age groups, this has been particularly high in those aged 65 and above. This is expected to continue in projections to 2021, with particular emphasis on the group aged 70 years and above. In spite of this growth at the top end of the age profile, the proportion of those aged 65 and above within Northamptonshire remains comparatively low against the national profile, with the child population (0-15 years) comparatively high.

## Deprivation

Socio-economic deprivation is considered to represent an important health determinant. This is supported by the notable difference, which has been recorded between

life expectancy in the most deprived and the most affluent areas of England. The extent of socio-economic deprivation in Northamptonshire is not as considerable as other parts of England, but specific pockets can be identified, particularly in the Corby and Northampton areas. Deprivation has a tendency to be concentrated in urban areas of the county. Health deprivation however has a higher occurrence at the most significant level in the county than overall deprivation. This is found within areas of Corby, Northampton, and to a lesser extent Kettering. The link between health deprivation and other forms of deprivation considered determinants is by no means explicit. Whilst 57% of those areas experiencing health deprivation amongst the top 30% in England also recorded similarly high levels of income deprivation, for environment deprivation, this was 22% and for barriers to services was just 8%.

## Population age

The majority of local population in April 2015 to March 2016 was 18 to 74 year (67%) with a further 21% over 75 years. Data shows that the age of the local population is stable and similar to data collected in April 2014 to March 2015.

## Our ratings for this hospital

Our ratings for this hospital are:

|  | Safe | Effective | Caring | Responsive | Well-led | Overall |
|--|------|-----------|--------|------------|----------|---------|
| Critical care                          | Good | Good      | Good   | Good       | Good     | Good    |
| Maternity and gynaecology              | Good | Good      | Good   | Good       | Good     | Good    |
| Services for children and young people | Good | Good      | Good   | Good       | Good     | Good    |
| Outpatients and diagnostic imaging     | Good | Not rated | Good   | Good       | Good     | Good    |
| Overall                                | Good | Good      | Good   | Good       | Good     | Good    |



# Detailed findings

## Notes

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

# Critical care

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

## Information about the service

Critical care services at the Northampton General Hospital (NGH) consist of an intensive therapy unit (ITU) and a co-located high dependency unit (HDU). Both units are managed by the theatres, anaesthetics and critical care directorate. The trust has a total of 16 critical care beds across ITU and HDU for the care and treatment of people aged 16 years and above. There are eight 'intensive care' (ITU) beds for complex level three patients who require advanced respiratory support, or at least support for two organ systems. The eight 'high dependency' (HDU) beds are for level two patients who require very close observation, pre-operative optimisation, extended post-operative care, or single organ support, and this included those 'stepping down' from level three care. The critical care service can flex ITU and HDU bed numbers to meet patient needs, subject to safe staffing requirements. The unit has two side rooms, for the safe management of patients who required isolation for infection control purposes.

Patient care is consultant led and consultant cover is available 24 hours a day, seven days a week, ensuring out of hours and weekend cover was provided. Both ITU and HDU are staffed from the same cohort of specialist critical care nurses who rotated between the units.

The critical care services also provide a critical care outreach team, who provide support across the hospital for the management and monitoring of acutely unwell patients. The service is provided 24 hours a day, seven days a week.

There were 911 admissions to the unit from 1 April 2016 to 31 March 2017 with 198 elective or planned admissions following scheduled surgery.

We spoke with 15 staff including consultants, doctors, junior doctors, nurses, the pharmacist, and healthcare assistants. We met with two patients who were able to talk with us, and their relatives and friends. We checked the clinical environment, observed care and treatment, and looked at 13 patients' records and data. We also carried out an unannounced inspection of the service on 9 August 2017.

# Critical care

## Summary of findings

We rated this service as good because:

- There was a strong culture of reporting, investigating and learning from incidents. Learning was shared throughout the team.
- Adequate medical and nursing staff was provided to meet the recommended staff to patient ratio, as defined in the core standards for intensive care units.
- There were effective systems in place to protect patients from avoidable harm and improve compliance with standards on a continuous basis. The principles of the duty of candour were well understood by all staff.
- Patient records provided a clear record of the patient's care and treatment and showed both patients and those close to them were directly involved in their care.
- The critical care units appeared visibly clean and promoted patient safety through established infection control processes.
- There was clear evidence and data upon which to base decisions and look for improvements and innovation. The unit participated in the Intensive Care National Audit and Research Centre (ICNARC) audit and performed better or as expected in six out of eight indicators.
- The critical care outreach team provided 24 hour, seven days a week cover and assisted with the monitoring and treatment planning of deteriorating patients throughout the hospital, ensuring risks were responded to appropriately.
- Staff were very caring and kind and provided emotional support for patients and relatives, for example, through the use of patient diaries.
- The individual needs of patients were met and personalised nursing care was provided.
- There was a positive commitment to education and training and over 50% of nursing staff held a post registration qualification in critical care.
- Staff assessed, monitored and completed risk assessments and met patients' pain, nutritional and hydration needs in a timely way.

- All staff had an understanding of the need for consent and the processes required to ensure compliance with the Deprivation of Liberty Safeguards.
- Patients and their relatives were supported during their stay within critical care services and staff provided opportunities to discuss care and treatment. This was delivered in a way that promoted dignity and confidentiality at all times.
- The service had a clear vision, strategy, and objectives based on improving quality and safety in line with the overall trust vision.
- Leadership was well established and there was a clear focus on improvements and patient safety.
- Structured meetings were held throughout the directorate to review all aspects of quality, risks and performance and high risks were escalated and monitored effectively.
- Effective governance arrangements were in place. There were structured meetings to review all aspects of performance, quality and risks and high risks were escalated through the directorate.
- Innovation throughout the staff team was encouraged.

However:

- The pharmacy team were aware of the shortfall in band 8a specialist pharmacist support and were providing cover with a band 7 pharmacist. A business case had been put forward, which if successful, would ensure standards were being met.
- Medicines were not always stored safely behind locked doors or in restricted areas. We raised this with the trust and this was rectified immediately by the trust.
- There was effective working relationships and commitment to critical care between members of the multidisciplinary team. However, the trust was not meeting the national core standards for employment of allied professionals within critical care services.
- The unit did not comply with the Department of Health's Health Building Note 04-02 critical care unit's standards; however, this had been risk assessed and was under review. Refurbishment plans were in place to address this.

# Critical care

- Not all medical staff had completed the required mandatory training.
- Hospital wide bed capacity affected the ability of the service to discharge patients to wards at the most appropriate time. Over eight hour delayed discharges were higher than the national average, however, action had been taken and improvement observed for patients waiting 24 to 48 hours.
- Single sex accommodation was not always maintained due to hospital wide bed pressures. Action was taken to protect patient's dignity at all times.

## Are critical care services safe?

Good



We rated safe as good because:

- There was a culture of reporting, investigating and learning from incidents. Nursing and medical staff had an effective understanding of the Duty of Candour.
- Medical and nurse staffing levels met patients' needs at the time of inspection.
- There were effective systems in place to protect patients from avoidable harm.
- Patient records were current, clearly laid out and provided a clear record of the patient's care and treatment.
- Staff knew how to identify when patients were at risk of harm or abuse and safeguarding processes were well understood.
- The environment and equipment was clean and supported safe care.
- Staff complied with infection prevention and control guidelines and encouraged visitors to maintain hand hygiene.
- Medicines, including controlled drugs, were managed appropriately to keep patients safe. Storage was not always secure for staff access only but the service took immediate actions to address this during the inspection.
- All patients were reviewed a minimum of twice daily by a consultant. Appropriate systems were in place to manage deteriorating patients.
- The service provided critical care outreach 24 hours seven days a week with support for deteriorating patients throughout the hospital wards.

However:

- The pharmacy team were aware of the shortfall in band 8a specialist pharmacist support and were providing cover with a band 7 pharmacist. A business case had been put forward, which if successful, would ensure standards were being met.
- The trust was not meeting the national core standards for employment of allied health professionals within critical care services.
- The unit did not comply with the Department of Health's Health Building Notes 04-02: however, this remained on the risk register and subject to regular review.

# Critical care

- Not all medical staff had completed the required mandatory training.

## Incidents

- Staff understood their responsibilities to report incidents and patients were informed when things went wrong.
- There was a consistent understanding by staff of the incident reporting system and trust policy. Nursing and medical staff were aware of the need to report incidents such as patient falls, equipment errors, medicines errors and admissions and discharges to the unit between the hours of 10pm and 7am. Staff told us they were actively encouraged to report incidents when something went wrong, or should have been done better.
- We saw detailed reporting which confirmed staff were competent at reporting safety concerns and near misses accurately.
- There were no never events between July 2016 and June 2017. Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers.
- There were 440 incidents attributed to the critical care services between the reporting period July 2016 to June 2017. One incident met the serious incident (SI) criteria, which was appropriately reported using the Strategic Executive Information System (STEIS). The incident related to an invasive procedure and was under investigation at the time of the inspection.
- Three of the 440 incidents were graded as moderate harm incidents with no themes or trends. Of the remaining incidents reported in low or no harm categories, the most common themes related to medication incidents, tissue viability incidents (including pressure ulcers), delays in discharge from critical care to other wards due to a lack of beds within the hospital, and out of hours transfers. Actions were in place to embed learning.
- We saw action was taken to reduce medication errors in critical care. A standardised risk assessment was used and a library of medicines had been uploaded directly onto the medicine infusion pumps that provided an extra safety check. Nursing staff involved in a medication incident had been stopped from administering medication until further training and assessment was completed. The number of medication incidents had fallen in the six month period January 2017 to June 2017 when there were 29 incidents compared with a total of 41 incidents reported in the six month period July 2016 to December 2016.
- Appropriate action was taken relating to tissue viability incidents, with involvement from the tissue viability team where necessary.
- We saw actions in place to address incidents of delays in discharge and out of hour's transfers. A bed manager reviewed patients ready to move to a ward area twice a day. Before each bed capacity meeting a surgical manager attended critical care and considered elective (planned) and emergency surgical bed requirements and bed availability. Actions from this review were discussed at the bed capacity meetings.
- The trust simulation team was used by critical care services to reconstruct scenarios based on common errors that occurred in healthcare. Staff we interviewed spoke positively about the learning and told us it enhanced patient safety and experience.
- Mortality and morbidity reviews took place as part of the surgical division meetings every month and within quarterly departmental meetings. Mortality and morbidity meetings were peer reviews of the care and treatment patients received with the objective to learn from them. Consultants identified those patients from the previous month to review and identify areas of learning. Minutes were circulated to ensure all staff had access to the cases discussed and junior doctors told us the learning was positive.
- From November 2014, NHS providers were required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person.
- Staff understood what duty of candour meant and told us that they would share information with patients and their parents or carers following an incident. Staff had attended duty of candour training and a 'Duty of Candour guide for staff' was available on the wards. We observed in patient notes we reviewed a duty of candour sticker had been used. The sticker identified where a discussion (around the duty of candour) had taken place and documented in the patient's notes.

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Staff were aware of the thresholds for when duty of candour processes applied. For example, following a pressure ulcer incident where moderate harm had occurred due to a lapse in care, staff had informed the patient and their relatives, offered an apology and involved them in the actions taken as a result of learning that took place.

## Safety thermometer

- The NHS Safety Thermometer is a national tool for measuring, monitoring and analysing common causes of harm to patients such as new pressure ulcers, patient falls with harm, catheter and urinary tract infections (UTI and UTIs), and venous thromboembolism (deep-vein thrombosis). This information provides a means of checking performance and is used alongside other measures to direct improvement in patient care.
- Information relating to these areas was displayed at the entrance to the unit for staff, patients and visitors to see. The display of data was meaningful for patients and was updated each day of our inspection. On 26 July 2017, the board showed there had been no avoidable pressure ulcers for 42 days and no missed medications during the month.
- Staff informed us when incidents of pressure ulcers or UTIs were identified, they not only reported but also considered the possible actions they needed to take immediately and shared the information at handover sessions. We observed nursing staff discussing such issues in the handover meeting.
- We observed safe practice in critical care for completion of venous thromboembolism (VTE) risk assessments on admission and prescription of prophylaxis. There were zero reported incidents for VTE in 2016/17 in critical care services.
- The safety thermometer showed that critical care services performed well in relation to protecting patients from avoidable harm. In the most recent published data for July 16 to June 17, critical care reported 100% harm-free care in seven of these 12 months.

## Cleanliness, infection control and hygiene

- At the time of our inspection, high standards of cleanliness were maintained cross the department, with reliable systems in place to prevent healthcare-associated infections. All clinical areas we

visited were visibly clean. Cleaning audits had been completed and actions taken. 'I am clean stickers' were consistently used in all areas and all equipment we checked was marked and dated appropriately.

- Staff received training in infection prevention and control (IPC) during their induction and annual mandatory training. Completion of the training was 93% (above the trust target) for nursing staff and 73% for medical staff, which was below the trust target of 85%. Performance was discussed at monthly senior nurse meetings and time was allocated for mandatory training completion within six monthly nursing staff team days to improve compliance.
- We observed staff and visitors used the hand gel dispensers at the entrance and hand wash sinks in the unit on entering the unit. Staff followed the uniform and 'arms bare below the elbows' policies and wore personal protective equipment (PPE), such as gloves and aprons appropriately. There was an adequate supply of PPE equipment available for staff in critical care services.
- Critical care services audited IPC practice in relation to hand hygiene, wearing of personal protective equipment, aseptic technique, and safe disposal of sharps. There was a compliance of 90% in ITU and 99% in HDU in June 2017. Review audits had been completed by the IPC team and the matron told us infection control was discussed in weekly meetings and audits shared to improve compliance.
- Waste management was handled appropriately with separate colour coded arrangements for general waste, clinical waste, and sharps bins.
- Domestic staff worked to cleaning schedules, which were displayed across the units. Staff had a thorough understanding of what was required within the ITU and how to record what cleaning had been carried out.
- Disposable curtains were used: these were clean, with due dates for changing them visible.
- The most recent patient led assessment of the care environment (PLACE) score, completed in 2016 scored 100% for cleanliness across the trust, which was higher than the national average of 98%.
- Patients admitted to the ward were screened for MRSA on admission and service information confirmed that during 2016/2017 all patients admitted to the ITU were found to be MRSA free. According to the data published by the Intensive Care National Audit and Research

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Centre (ICNARC) the unit performed in line with the national average for unit acquired Methicillin Sensitive Staphylococcus Aureus (MSSA) infections and Clostridium Difficile infections over the same period.

- ICNARC data indicated that high-risk sepsis admissions to the units were 13.7% during the reporting period 1 April 2016 to 31 March 2017. This was not significantly above the national data of 10.8%.

## Environment and equipment

- The design, maintenance and use of facilities and premises generally kept patients, staff and visitors free from avoidable harm.
- The unit was accessed from a corridor with clear signage for handwashing and a display of information for patients and staff.
- The environment was well lit and corridors were free from obstruction to allow prompt access, ensuring people were kept safe.
- The unit was secure with the entry to critical care services controlled by an intercom and visitors were required to identify themselves on arrival. Throughout the inspection, we saw that staff were aware of their surroundings and were vigilant when entering units. A non-clinical member of staff challenged members of the inspection team when they attempted to enter the unit demonstrating effective safety awareness.
- The bed space area in critical care services did not comply with the national standards Health Building Notes 04-02 and was significantly smaller than what is recommended. This meant critical care staff often provided care in a restricted space. However, we did not see that the non-compliance was affecting patient care. To address the concern the services were working on a five-year business plan to resolve the situation. The matron told us the nurse station in the intensive therapy unit (ITU) would be updated and reduced in size to provide more ward space. This would improve the environment for patient care as there would be more space between patient beds and the nurse station and increase access for manoeuvring equipment and patients. A refurbishment plan was in place with the anticipated timescale being within one year.
- Staff had adequate supplies of equipment to provide care for up to 16 ventilated patients. In addition, there

was an anaesthetic machine available for use in the theatre recovery area to mechanically ventilate a patient in the short term, when there was no bed available in the critical care services.

- Technical support and care of the equipment was provided by a team of operating department practitioners (ODPs) during day shifts. Out of hours cover was provided from ODPs in theatre, and staff told us that the emergency engineering cover was effective. However, we saw in the June 2017 governance minutes that a recruitment campaign was in progress to provide a consistent and effective service.
- A checklist of daily tasks to be carried out in each unit was completed by the ODPs. We saw that all resuscitation equipment was fit and safe for use in an emergency and was checked daily, and documented as complete and ready for use. Medication nearing its expiry date was highlighted.
- The invasive procedure trolley, difficult airway trolley and emergency tracheostomy trolley were all marked as cleaned appropriately and were well-stocked.
- Critical care services complied with core standards for critical care 'Guidance for the Provision of Intensive Care Services' (GPICS 2015) safe use of equipment standard. Staff received training in equipment used across the service and a practice educator monitored completion of staff competencies on each piece of equipment.
- The service had appropriate systems to manage waste. All staff used appropriate clinical and general waste bags that were segregated and removed at regular intervals by the domestic team. We saw that single use items were disposed of appropriately in either clinical waste or sharp bins. Critical care services was the first department in the hospital awarded a sustainability award for the increase in recyclable and decrease in domestic and clinical waste.
- Storage of equipment was well organised and there were systems in place to maintain, service and replace equipment to ensure patients were safe. We observed that electrical appliances and equipment were tested and had stickers with appropriate dates.
- Staff told us that high visibility jackets were not available to staff completing out of hospital patient transfers as recommended in the Guidelines for the Transport of the Critically Ill Adult. We observed this was appropriately listed and reviewed on the departmental risk register and a request was made with the health and safety department to obtain the equipment.



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- Systems were in place to allow timely review of electrical items; a schedule was in place to identify when items required the next safety check. Electrical appliances and equipment had been electrical equipment tested to ensure they were safe to use and each had a stickers with appropriate dates. If an item of equipment was found to be faulty this would be reported and replacements for all equipment were available on the ward.

## Medicines

- Medicines, including controlled drugs, were managed appropriately to keep patients safe. Storage was not always secure for staff access only but the service took immediate actions to address this during the inspection.
- Patients' medicine requirements were checked on admission and a pharmacist reviewed all patients' prescriptions to ensure medicines were prescribed safely, and were being managed according to best practice guidance and trust policy.
- During our inspection, we found that medicines were not always stored safely behind locked doors or in restricted areas. A refrigerator storing medicines was not locked and intravenous fluids were stored in open drawers in an area that was not secure. We were informed that this had been risk assessed but this was not available. We escalated this to the matron and a secure lock was immediately put in place on the same day, which ensured medicines were secure and only accessible by appropriate staff.
- Medicines were not always stored safely inside cupboards. Loose strips of different medicines were stored in a basket in medicine cupboards in the critical care units. On informing the matron of the potential risk of a medicine error, the baskets were removed immediately and the medicines destroyed following trust procedure. The trust took immediate action to arrange a pharmacy audit of the service.
- We checked the storage of medicines on our unannounced inspection and found that all medicines were being stored securely and that additional signs had been placed in the store cupboards to inform all staff of the trust's policy for medicine's storage. All store cupboards were secure and well-organised, with no loose strips of medicines found.
- Medicines requiring cool storage were stored appropriately in locked medicine refrigerators. Daily temperature records for the medicine storage room and for the medicine refrigerator documented that medicines were stored within safe temperature ranges. Fridge and ambient room temperatures were recorded in the medicine and storeroom daily and checks recorded. Staff knew what to do if temperatures were too high to ensure medicines were stored correctly.
- Controlled drugs (CD), which are medicines that require extra checks and, were stored appropriately. This included when patients brought in their own CDs. We checked CD records and found that administration and storage were documented correctly. Ward stocks of CDs were reconciled on a daily basis and we observed two members of staff completing checks appropriately following guidance procedures.
- Safe systems were in place for the disposal of controlled drugs and staff knew their responsibilities in relation to this. Staff could explain and demonstrate how to manage controlled drugs and how this was required to be checked and documented in line with hospital policy and national guidance.
- We reviewed medicine charts of five patients and found that they accurately reflected the prescribed and administered medications for that patient. Medicine charts and patient records also clearly documented any patient allergies. Checks to ensure that any known allergies or sensitivities to medicines were recorded accurately on patients' prescription charts within 24 hours of admission. This information is important to prevent the potential of a medicine being given in error and causing harm to a patient.
- The service was not meeting the national core standards for Intensive Care Units, which state that there should be at least a 0.1 WTE 8a specialist clinical pharmacist for each single level three bed and for every two level two beds. The pharmacy team were aware of the shortfall and were providing cover with a band 7 pharmacist. A business case had been put forward, which if successful, would ensure standards were being met.

## Records

- Patients had individual care records that were written and managed in a way that kept them safe from avoidable harm. A paper system was used which amalgamated medical and nursing records to enable a contemporaneous record of events. All records were securely stored in lockable trollies.



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- Medical notes were well maintained and information was easy to access. All entries in the records were complete and were signed, dated and had patient names recorded.
- We reviewed 13 sets of nursing and medical records, which were complete, legible, and entries timed, dated and signed for. There was a clear written diagnosis of the patient's condition and a comprehensive management plan. Records contained evidence of consultant-led ward rounds, input from the multidisciplinary team, care plans, and risk assessments.
- There was evidence in the medical records of discussions with the patient and their relatives regarding progress and treatment planned.
- All notes were photocopied when a patient transferred to another hospital as no electronic sharing was available. A handover chart was used for patients 'stepped down' from critical care services to a ward area that ensured patient notes had been completed and were transferred appropriately.
- Staff compliance with mandatory information governance training was 95%, which was above the trust target of 85%. Ongoing training sessions had been arranged.
- The intercollegiate document 'Safeguarding children – Roles and competencies for healthcare staff' published by the Royal College of Paediatrics and Child Health (RCPCH) 2014 provides guidance on the level of safeguarding training required for different staff groups. The document states that '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' should be trained in safeguarding for children levels one, two and three'.
- Three members of senior staff had safeguarding children level three training. As the service admitted young people between the ages of 16 to 18 years this did not meet the RCPCH guidelines or those contained in the intercollegiate document which states that clinicians who are potentially responsible for assessing, planning, intervening and evaluating children's care, should be trained to level three safeguarding. Two 16 to 18 year old younger people had been admitted to the unit in the three months prior to the inspection. All young people admitted to critical care services had a named paediatric consultant who was responsible for their care and treatment and risk assessments completed.

## Safeguarding

- Appropriate arrangements were in place to ensure patients were kept safe from potential abuse. The hospital had safeguarding policies and procedures available to staff on the intranet, including out of hours contact details for hospital staff. There were posters displayed with contact details of the hospital's safeguarding team.
- The trust safeguarding policy was known by all staff and the unit had an organised approach to provision and staff attendance of safeguarding training to protect vulnerable adults and children.
- As of July 2017, 88% of nursing and midwifery staff and 80% of medical staff had completed safeguarding adults' level two training against a target of 85%. The service had an on-going action plan to deliver safeguarding level two training in line with guidance.
- As of July 2017, 86% of nursing and midwifery staff and 78% of medical staff had completed safeguarding children's level two training against a target of 85%. The service had an on-going action plan to deliver safeguarding level two training in line with guidance.
- Nursing and medical staff were able to explain safeguarding arrangements, and what actions they would take to protect the safety of vulnerable patients. There was a prompt for medical and nursing staff to be alert to safeguarding on the patient's daily review chart.
- Contact details of the trust safeguarding team were on display and staff provided examples of when they had sought advice from the safeguarding link nurse. Clinical leads would share any learning in team meetings.

## Mandatory training

- The trust provided core elements in mandatory training to include fire, information governance, health and safety, safeguarding adults and children, manual handling, equality and diversity, infection prevention practice, safeguarding vulnerable adults, and trust induction.
- Nurse mandatory training was compliant with the trust attendance target of 85% in all elements. Overall, nurse compliance with mandatory training was 95%.

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- Completion of mandatory training by medical staff was 86% for safeguarding children Level one and 88% for safeguarding adults level one. There was an attendance rate of 73% for health and safety training, 66% for the trust induction, and 73% for infection prevention practice in June 2017. An action plan to gain medical staff compliance with the trust target of 85% for completion of mandatory training was in place.
- The nursing staff were divided into six teams each with a critical care sister as a lead. The critical care matron had overall responsibility for each team and sent regular emails to each sister who had responsibility for ensuring mandatory training was completed by their team. Performance was discussed in monthly senior nurse meetings and completion data was also displayed on staff notice boards.
- Each team was allocated two set days a year to refresh mandatory training and complete new identified training. The matron told us, and we saw that there was now an organised approach to improving compliance with mandatory training.
- Staff could access mandatory training in a number of ways, online e-learning modules and face-to-face sessions delivered by key trainers.

## Assessing and responding to patient risk

- Risks to patients were assessed and their safety monitored and maintained. The nursing team and medical staff assessed and responded well to patient risk through regular review.
- On the ITU, patients were closely monitored so staff could respond to any deterioration. The ITU did not use the national early warning score assessment system as critical care patients were continuously monitored and their clinical observations recorded a minimum of hourly. Patients were nursed in line with Intensive Care Society guidance on a one to one or one to two basis dependent on their level of care. The service had medical cover 24 hours a day seven days a week so escalation of a deteriorating patient was instantly communicated. All patients were seen a minimum of twice a day by the multi-disciplinary team led by the consultant and comprehensive treatment plans were documented. We saw the appropriate staffing levels were maintained throughout the inspection period.
- There were systems in place to assess patient's risk using assessment tools based on national guidance. These were assessed and documented in the patient's

records on admission and 24 hours later in line with best practice. This included Malnutrition Universal Screening Tool (MUST) assessment, moving and handling, tissue viability, venous thromboembolism (VTE), infection control and falls risk. We reviewed thirteen patient records and found that they were updated regularly and completed appropriately according to the patient's condition.

- Comprehensive risk assessments were carried out during pre-operative visits for patients who came in for elective procedures. All emergency admissions had their risk assessments completed within 12 hours or as soon as possible following admission to the units.
- Nursing staff implemented care and treatment to address any issues that were identified with the risk assessments. For example, increased repositioning or additional pressure relieving equipment was used for patients who were identified at high risk of pressure tissue damage.
- The ward clerk updated the patient board each day to confirm if all patients had an appropriate VTE assessment and review. A sticker was added to patient notes to remind doctors to complete the assessment. We saw in patient's records that they were assessed on admission and 24 hours later in line with best practice.
- Patients within critical care services were continuously monitored which meant that any changes in condition or deterioration could be quickly identified. The same nurses cared for patients where possible to ensure consistency.
- A critical care outreach team provided a 24 hours a day, seven days a week service to monitor acutely ill patients on main wards.
- There was a hospital policy for management of sepsis and a sepsis bundle care pathway could be implemented if sepsis was suspected. ITU had access to appropriate antibiotics in a 'sepsis box' when required to facilitate immediate antibiotic treatment for those patients with suspected sepsis.
- The outreach team member communicated daily with the patient's responsible consultant and requested urgent review of a patient if required. Referral for admission to critical care was on a consultant to consultant basis.
- Within critical care, the nursing team and medical staff conducted twice daily ward rounds which helped with

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responding to the changing needs and the related risks. There was input to the ward rounds from unit-based staff at all times including the doctors and the nurses caring for the patient.

- Nursing staff used pain, agitation, and delirium guidelines (care bundles) for adult critical care patients. They were mindful of the complexity when assessing and determining patients whether they were suffering from delirium or whether they had lost capacity to make decisions. Delirium assessments were routinely observed in patient's records.
- Staff could explain patient transfer processes, and what actions needed to be in place to keep patients safe whilst not on the ward. There was an accessible policy that described the transfer process clearly.

## Nursing staffing

- Staffing levels, skill mix and caseloads were planned and reviewed so that patients received safe care and treatment at all times, in line with relevant tools and guidance. Actual staffing levels met the planned levels at the time of the inspection. Arrangements for using bank, agency and locum staff were appropriate, including ensuring appropriate induction processes and records were completed.
- The service was managed by one critical care matron who was supported by nine whole time equivalent (WTE) band 7 sisters and a team of 77 WTE other grade nurses. The nursing staff were supported by 12 WTE health care assistants and four WTE operating department practitioners.
- The high dependency unit (HDU), intensive therapy unit (ITU) and critical care outreach team were staffed from the same cohort of specialist critical care nurses. Within ITU and HDU staff rotated between the units, spending two months at any one time on HDU. Nursing staff working within the outreach team worked up to half their contracted hours within the HDU or ITU and the remainder within the outreach service. Staff numbers were allocated in line with those recommended in the core standards for critical care Guidance for the Provision of Intensive Care Services (GPICS 2015).
- Nurse staffing turnover in critical care services was 8% in December 2015 compared to 3% in June 2017, demonstrating significant progress in retention.
- The service used the hospital's own bank staff or agency staff to ensure staffing levels remained safe during staff

sickness or other absence. During the month of June 2017, the service used a total of 60 hours of agency and bank staff (equivalent to five shifts) which was within the service establishment.

- Patients were cared for by levels of nursing staff recommended in the core standards for critical care (GPICS 2015). Patients classified as requiring level three support were cared for by one nurse for each patient. Patients who needed high dependency type care (level two) were cared for by one nurse to two patients. Throughout the inspection, we observed appropriate staffing levels were maintained.
- Staffing numbers were displayed on the entrance to critical care services. We saw this was updated daily and was an accurate reflection of staff on the ward.
- We were told and saw that the nurse in charge of the service was always supernumerary (does not have a patient allocated to them) leaving them free to co-ordinate the shift and offer support to staff when activity increased.
- Nursing handover was completed at the beginning of each shift and given by the outgoing nurse in charge. All oncoming staff attended a handover which included the patient's name, age, diagnosis and any changes in condition or planned activity. Once this was completed, nurses were allocated a patient (or patients if level two), and then received a detailed handover about their allocated patients by the patient bedside. The nurse in charge detailed verbal handover for all patients following the initial shift handover. We saw the handover during inspection and found that it was thorough, detailed and followed an effective system focusing on patient risk.
- Senior staff met every morning to review critical care concerns and discharges in a safety huddle.
- The critical care outreach team was led by two sisters, who shared the role and a small team of band 5 and band 6 nurses. They worked up to half their time with the outreach team, and half their hours within the critical care service. Three band 5 nurses assisted the team in a developmental, rotational post and shared their time between the clinical and outreach service.
- During our previous inspection, staffing of the outreach team was on the anaesthetic and critical care risk register. This was because when staffing was low or there was an absence on ITU or HDU, the outreach nurse would be required to cover the shortfall meaning that the outreach service was not covered. During this

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inspection, there was a significant improvement in staffing. Data showed that from January 2017 to March 2017 the outreach service was available for 95% of the time requested for support. This concern had therefore been removed from the risk register.

## Medical staffing

- Critical care services were led by a consultant in intensive care medicine, which complied with the GPICS 2015 standard 1.1.1. There were 10 dedicated consultants (who had no other responsibilities) and worked full time in the department working a rotational rota to provide continuity of care.
- Three consultants covered critical care services in a seven-day period. Two consultants provided cover from 7.30am to 6pm weekdays and one nominated consultant was on call outside of these hours and at weekends. GPICS 2015 defines the standard that the consultant in intensive care medicine must be immediately available by telephone 24 hours a day, seven days a week, and be able to attend within 30 minutes. There were no recorded incidents of consultants being unable to meet this standard within the year prior to our inspection.
- In addition to the consultants, there were 14 junior doctors who provided care to patients under the supervision of the consultant. Two junior doctors at core trainee year one (CT1) or above provided cover in critical care services 24 hours a days, seven days a week.
- During the last inspection, patients classified as requiring level two support remained under the care of their medical consultant. Following restructure, HDU and ITU amalgamated and all patients were overseen by consultants within critical care services, and escalation of risk was timely.
- At shift change, the medical staff team, including all grades of doctors, used a safety handover process to ensure appropriate information was shared, and any problems were highlighted and discussed to maintain patient safety.
- Cover for staff absence was managed by the use of internal bank doctors and external cover was rarely used. At the time of the inspection, there were no locum doctors in critical care services.
- Staff were clear about their roles and responsibilities, communicating well between one another. Consultant staff to patient ratios were in line with GPICS 2015. There were consultant led unit ward rounds where all level

two and level three patients were reviewed twice daily. Attendance by the multidisciplinary team (MDT) was encouraged by the consultant team, but restricted by staffing resources. A physiotherapist did not attend the ward round however a daily plan was provided.

- A consultant provided clinical leadership to the critical care outreach team.

## Allied health professional staffing

- Critical care services were resourced with allied health professionals such as physiotherapists, speech and language therapists, pharmacists and microbiologists to support patients' rehabilitation and recovery.
- The national core standards state that there should be at least one whole time equivalent (WTE) band 8A specialist clinical pharmacist for each single level three bed and for every two level two beds. A band 7 dedicated pharmacist was covering the critical care unit Monday to Friday. Although they were supporting the service to improve safe and effective use of medicines, a band 7 is considered a training grade for specialist pharmacist services and should therefore have access to a more senior critical care pharmacist. Staff commented that the pharmacist was very much integrated into the critical care team. The pharmacy team were aware of the shortfall and a business case had been put forward which, if successful, would ensure standards were being met.
- There was safe provision of physiotherapy for patients, although not enough therapy staff to meet the requirements of the Faculty of Intensive Care Medicine (FICM) Core Standard 1.3.7 or National Institute for Health and Care Excellence (NICE) guidance. There was a team allocated to critical care but the shortfall of 0.5 WTE hours meant there was no physiotherapy input at daily team meetings, although a daily plan was submitted. The Rehabilitation after Critical Illness (2017) gap analysis found that 30% of patients who received rehabilitation had not received the required 45 minutes of active therapy for a minimum of five days a week. Evidence from research demonstrates that early physiotherapy for critically ill patients affects quality of life, functional independence, and hospital length of stay.
- During this inspection, the microbiologist attended ward rounds three days a week. The GPICS 2015 suggest

# Critical care

there should be microbiology input into the daily ward rounds but due to staffing pressures, a microbiologist had not attended daily. Plans were in place to improve this.

- The support from dietitians was 0.8 WTE hours below the recommended standard hours of cover within critical care services. The British Dietetic Association recommends that there should be 0.05-0.1 WTE dietitian per one bed. Support from a speech and language therapist was provided, however, we were told this had been assessed and was not yet appropriately resourced to provide an effective service to meet patient need.
- Critical care services had recognised it was not meeting recommended multidisciplinary staffing levels to provide effective care and we observed this was included in the department's risk register. An action for a business case to be made by the end of September 2017 was recorded in the July 2017 governance minutes.

## Major incident awareness and training

- Potential risks to the service were anticipated and planned for in advance.
- A major incident and continuity plan was in place and available to staff on the intranet. However, this policy expired in January 2017. We saw in the clinical governance meeting minutes dated July 2017, that this had been allocated for review.
- Staff were aware of the policy and how to access this and could describe the actions that would be taken in the event of a major incident. The critical care evacuation plan was clearly displayed on a notice board.
- Doctors told us the hospital's simulation team carried out unplanned, emergency incident scenarios in critical care and provided positive feedback of the learning.
- We were told some critical care consultants attended a major incident network meeting and lessons learned from national major incidents were shared with staff throughout the service.
- Staff were aware of the fire evacuation policy and procedures and during the inspection staff remained calm during a routine fire alarm test of the equipment. All equipment seen met fire safety regulations.
- A fire safety risk assessment review of critical care was completed in July 2017.

- Fire refresher mandatory training had been completed by 93% of nurses and 80% of doctors as of July 2017 of staff against an 85% target. Further training dates had been arranged, on an ongoing basis.

## Are critical care services effective?

Good



We rated effective as good because:

- The service used evidence-based treatment pathways based on relevant national guidance.
- Patient outcomes were used to drive improvements in the service. Critical care performed as expected or better for six out of eight indicators within the Intensive Care National Audit and Research Centre (ICNARC) audit.
- Policies and procedures were accessible, and staff were aware of relevant information. Care was monitored to demonstrate compliance with standards.
- Patients were cared for by appropriately qualified nursing staff. The service had a commitment to education and training and over 50% of nursing staff had a post registration award in critical care
- Staff at all levels had an understanding of the need for consent and systems were in place to ensure compliance with the Deprivation of Liberty Safeguards.
- Patient's pain management and nutrition and hydration needs were closely monitored.
- Medical and nursing staff told us they had sufficient support for revalidation.

However:

- The microbiologist did not attend every daily ward round due to staffing issues, but telephone advice was available.

## Evidence-based care and treatment

- Patients' needs were assessed on admission and their care planned in line with best practice and national guidance. Critical care services admitted patients according to their needs and within timescales outlined within guidance from the Department of Health and Faculty of Intensive Care Medicine.
- The service used a combination of national guidelines and policy to determine the care and treatment



# Critical care

provided. These included guidance from the National Institute for Health and Care Excellence (NICE), Intensive Care Society, the Faculty of Intensive Care Medicine and the Midlands Critical Care and Trauma Network.

- The service followed the trust policy for suspected sepsis and a sepsis bundle care pathway based on the national 'sepsis six' guidance was used if sepsis was suspected. Care bundles are a group of best evidence based interventions to support improved outcomes.
- Care bundles were in place for ventilated patients, and a series of checklists based on guidance from the intensive Care Society were in place governing clinical procedures (for example, nasogastric tube insertion, tracheostomy, bronchoscopy, chest drain insertion and intubation). From patients' records seen, these checklists had been completed in accordance with trust policy.
- Patients at risk of venous thromboembolism were risk assessed and prescribed prophylaxis in accordance with NICE Quality Standard 3 'Venous Thromboembolism in adults' and pathway. Audit and monitoring was carried out to ensure compliance targets were maintained in critical care.
- The service provided a designated follow-up clinic for patients who had spent over four days in critical care and was compliant with NICE Clinical Guidance 83 'Rehabilitation after critical illness'.
- Delirium scores were completed in almost all patient records we reviewed. The Rehabilitation after Critical Illness Gap Analysis (2017) found the standard was partially met with 80% of patient records recording a score. Mortality for those diagnosed with delirium in hospital is twice that of patients with similar medical conditions without delirium.
- Adherence with NICE CG83 pathway for rehabilitation after critical care was not fully met during this inspection. Collection of data in 2017 found that 20% of cases did not contain a rehabilitation prescription transfer of patient information within pre-discharge plans as required. A rehabilitation prescription is a tool used to hold detailed assessments concerning rehabilitation needs, recommendations and referrals, and the measures used to record complexity and outcomes.
- We found almost all local critical care services policies had been reviewed and were in date. However, the review date of one policy 'Guidelines for the Use of

Sedation in Critically ill Ventilated Patient's had expired in March 2016. We observed the guidelines were in the process of being reviewed by the responsible anaesthetist at the time of the inspection.

## Pain relief

- Pain of individual patients was assessed and managed appropriately. Staff used a pain score tool to assess and monitor patient's pain levels. They also assessed by observing non-verbal signs and facial expressions or agitation as well as listening to patient's own expression of pain if they were able to verbalise.
- Staff administered prescribed analgesia regularly and as required. We observed nursing and medical staff reviewing the daily plan of care and patients were given pain relief as part of planning to support their comfort when they were moved out of bed.
- Staff told us they could access the trust's specialist pain team for support to manage patient's pain effectively. The matron was a lead for the management of acute pain in critical care and attended ward rounds Monday to Friday. A consultant worked in the unit at all times and was available to deliver effective pain control at the right time to meet the needs of patients.
- Patient records we reviewed showed that pain had been risk assessed four-hourly, or more frequently when required, using a tool measuring levels on a five-point scale.
- There was no specific pain tool used for patients unable to communicate or for those with a learning disability. However, staff told us a picture assessment tool would be introduced to effectively assess whether a patient's pain was worsening or improving in response to interventions. This new system was being reviewed by the consultant team and was about to be introduced.
- Patients referred to the critical outreach team had their observations, including pain assessment outcomes, recorded on the trust's patient clinical monitoring system. The outreach team reviewed the outcomes and escalated patients for review if extra support was required to manage pain effectively.

## Nutrition and hydration

- The Malnutrition Universal Screening Tool (MUST) was used to assess patient's risk of malnutrition. We saw 100% compliance with completion of MUST scores.

# Critical care

- The critical care service had a dedicated dietetic support that had expertise in critical care in order to support patients effectively. Staff followed the trust's standard feeding protocols to ensure ventilated patients received adequate nutritional intake. This included the target rates for feeding according to the patient's weight.
- Patients were commenced on feeding regimes as soon as possible after admission to the unit. Nursing staff were knowledgeable and skilled in the critical care nutrition needs of patients and had protocols that supported commencing nasogastric and total parenteral nutrition. (Feeding through a tube inserted through the nose into the stomach or artificial feeding through a vein). This was monitored and reviewed on the consultant round and in the twice daily handovers.
- We reviewed seven patient records and found the fluid balance and nutrition charts fully completed and demonstrated that patient's nutrition and hydration needs were being met.
- Patients whose condition had improved were offered drinks by staff and assisted as needed. Nutritional intake was also documented.

## Patient outcomes

- Critical care services could demonstrate continuous patient data contributions to the Intensive Care National Audit and Research Centre (ICNARC). A dedicated staff member was in post to support ICNARC data collection and reporting. The designated ICNARC data clerk collected performance and outcome measures for critical care patients and uploaded information into a national database. Data collected from the audit was analysed and actions taken to improve patient experience and outcomes.
- ICNARC supports critically ill patients by providing information and feedback data on specific quality indicators as part of its case mix programme (CMP). Critical care units can benchmark their practice and services against 90% of other units. This was in line with the recommendations of the Faculty of Intensive Care Medicine Core Standards (FICM).
- ICNARC data for the period 1 April 2016 to 31 March 2017 showed that ITU performed as expected and slightly better than similar organisations in eight out of the ten quality indicators. This included the number of unit-acquired blood infections, the number of non-clinical transfers to another unit, and out of hours discharges to the wards.

- The service performed worse than similar organisations for the remaining two indicators with more delays greater than eight hours for patients deemed fit for discharge and with high-risk admissions from the ward. The data showed that the number of high-risk admissions of patients with four or more organ dysfunctions was 12.5% compared to a national average of 9.6%. Staff observed the increased number of high-risk admissions corresponded with a high predicted starting mortality and action was being taken to review the admission category of patients in more detail. Audits were discussed during departmental meetings and actions agreed.
- For the same period, the crude proportion of out of hours discharges to the ward (not delayed) was 1.7%, better than the national average at 2.5%.
- For the ITU, the risk adjusted hospital mortality ratio for all patients was 0.9. This was within the expected range. The figure in the 2015 annual report was 0.9. The risk adjusted hospital mortality ratio for low risk patients (with a predicted risk of death of less than 20%) was 0.9. This was within the expected range. The figure in the 2015 annual report was 0.7.
- The service participated in the national care bundles audits (evidence-based procedures) which formed part of the trust's annual audit programme. Monthly audits and results in June 2017 were central venous catheter care (88% compliance), peripheral intravenous cannula care (90% compliance), and urinary catheter care (100% compliance). We saw actions had been taken to improve outcomes to use learning from audits, which included reminding staff to record the insertion date of cannulas on a patient's dressing.

## Competent staff

- Staff within the service had the appropriate skills, qualifications, and knowledge to complete their roles safely. Both medical and nursing staff completed trust-wide and local induction programmes on commencement of post.
- There was a dedicated practice development nurse working in critical care services that was responsible for coordinating the education and training of new staff, this was in line with GPICS 2015.
- Third year student nurse placements were provided within critical care. One student told us they had regular supervision, teamwork was supportive, and their learning objectives had been met.

# Critical care

- The clinical nurse educator would induct all new nursing staff to the service. Supernumerary status was allocated whilst the six-week training programme was completed, and a dedicated mentor worked alongside staff until they were competent to work alone. The clinical nurse educator was also responsible for coordinating the education, training and continued professional development framework for critical care nursing staff and pre-registration student allocation.
- We saw that over 50% of nursing staff had gained the post registration award in critical care nursing which was in line with the Guidance for the Provision of Intensive Care Services, 2015 (GPICS).
- All substantive members of the critical care outreach team were experienced critical care staff who held post registration critical care qualifications or relevant experience, and Advanced Life Support qualifications.
- Consultants had ten hours a week built into their contract for continued professional development.
- A weekly training and teaching timetable for junior doctors was scheduled from August 2017.
- Medical and nursing staff told us they had sufficient support relating to revalidation. Revalidation is a process by which doctors and nurses can demonstrate they practice safely.
- The service had monitoring processes in place to ensure that doctors were working within the General Medical Council (GMC) revalidation guidelines and would be able to revalidate in line with the scheduled date. Medical revalidation was introduced in 2012 to ensure that all doctors were up to date and 'fit to practice'. All of the consultants had either been revalidated or were working towards revalidation in line with the timescale notified to them by the GMC.
- Nursing revalidation was supported by the hospital working within the nursing and midwifery council guidelines and nurses would be able to revalidate in line with the scheduled date. Nursing staff told us they were given assistance and support to complete the appropriate reflective accounts, and training to complete this.
- All unit sisters had completed a leadership programme and junior sisters had opportunities to attend development days. Each of the six critical care nursing teams had dedicated development days twice a year.

- Staff told us that one to one nursing supervision was not yet routinely established, however this was in progress. Staff reported informal 'ad hoc' supervision was available whenever required.
- Trust data for June 2017 showed that 95% of critical care nursing staff had received their appraisals against a trust target of 85%. Nursing staff told us the appraisals were valuable and that they were challenged to consider new training.
- As senior nurse was completing an external senior leadership programme that included quality improvement, leading people and managing change.
- We observed all bank and agency staff provided certificates of competencies that was documented in a file with a copy of their induction and orientation to the ward.

## Multidisciplinary working

- We observed effective working relationships and commitment to critical care from many different, experienced members of the multidisciplinary team (MDT). All necessary staff were involved with the planning, assessing and delivery of patient care.
- We saw that the daily MDT meeting was led by the consultant on call and that staff were able to discuss any concerns or ideas openly. There was input from the speech and language therapist, a dietitian, the pharmacist, a microbiologist and nursing and medical staff.
- A shortfall in WTE hours meant that there was no physiotherapy input at daily team meetings. However, we observed a daily physiotherapy plan was submitted to the meetings and that team communication supported effective delivery of care and treatment.
- The GPICS 2015 suggest microbiology input into daily ward rounds, but due to staffing issues a microbiologist attended on three days a week, however telephone advice was available.
- Staff told us the meetings helped provide effective care to patients as a prompt response to risks was made.
- Throughout our inspection, we saw the consultants on call communicating with all staff to achieve the best possible care for individual patients.
- The critical care outreach team was available 24 hours a day, seven days a week, and patients being discharged



# Critical care

from critical care were reviewed prior to the ward move, and a checklist completed as to ongoing needs and treatment. This was in line with NICE guidance CG83 Guidance for Rehabilitation after Critical Care.

## Seven-day services

- The service had intensivist (consultants trained in intensive care medicine) cover 24 hours a day, seven days a week. Out of hours, the on-call intensivist was immediately available for telephone consultation and could access the hospital within 30 minutes. This was in line with the GPICS 2015.
- Once admitted to critical care, a consultant intensivist led the patient's care as defined by the Faculty of Intensive Care Medicine. The consultant saw all patients under their care at least twice daily, which included weekends. This was in the form of a structured bedside round where management plans were discussed and reviewed with the critical care team.
- Patients were reviewed by a consultant intensivist within 14 hours of their admission. This met the standard outlined in GPICS 2015.
- There was access to other services seven days a week. Radiology, pharmacy, physiotherapy, and microbiology were all available seven days a week, with out of hour's access available where required through the trust's on-call system. The physiotherapy team provided cover seven days a week.

## Access to information

- Staff had access to relevant information to assist them to provide effective care to patients during their stay in critical care. The unit had two administration staff that could coordinate the provision and supply of patient records. This included obtaining medical records and historical notes as required.
- Policies, procedures and other supporting information were available on the trust's intranet to support and guide staff's practices.
- A discharge-planning template was completed and shared with the outreach team and therapists prior to a patient's discharge to a ward. This promoted the continuity of care and was in line with NICE CG50 guidance and meant all staff were involved and aware of the patient's ongoing treatment plan.

## Consent and Mental Capacity Act

- Patient's consent was obtained in line with hospital policy and statutory requirements.
- Staff received specific training in the relevant consent and decision-making requirements relating to the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS).
- The hospital had set procedures in place for assessing patient's capacity, whether they came into the hospital as an emergency or as a planned admission. There was a trust policy to ensure that staff were meeting their responsibilities under MCA and DoLS.
- Medical and nursing staff could describe the process for making an application for requesting a DoLS for patients and when these needed to be reviewed. Staff provided experiences of application in practice in the critical care environment. We also saw detailed mental capacity assessments recorded in patients' notes seen.
- Staff understood consent, decision making and guidance and we observed consent was well-documented in patient records.
- Patients gave their consent when they were mentally and physically able. Staff acted in accordance with MCA when treating an unconscious patient, or in an emergency.
- During the inspection, we observed staff responding to an incident with a patient with mental health needs and policies and procedures were followed appropriately.
- Staff were aware of the trust's sedation protocol that took account of the potential need to use restraint if a patient became delirious.

## Are critical care services caring?

Good



We rated caring as good because:

- Patients and their relatives were treated in a compassionate, respectful manner in all interactions observed.
- Staff provided a confidential and supportive environment and were positive and motivated and, without exception, delivered care that was sensitive, kind and promoted dignity.
- Patients and relatives told us they received a very good standard of care and they felt well looked after by nursing, medical and allied professional staff.

# Critical care

- The critical care team involved patients in their care and treatment and kept them up to date with their condition, and how they were progressing.
- Patient diaries had been introduced to support patients who attended the follow up service with rehabilitation and recovery.
- Staff provided emotional support to patients and staff directed patients to access the hospital multi-faith chaplaincy service and external support services, when required.

## Compassionate care

- We observed staff to be caring and compassionate with patients and their relatives without exception during the inspection, at all times. Staff promoted privacy, and patients were treated with dignity and respect.
- Curtains were used across all clinical areas to ensure privacy during treatments and personal care. Patient confidentiality was maintained throughout and conversations with relatives were held in quiet rooms within the unit. Multidisciplinary team meetings were held in a quiet room away from the main wards to prevent conversations being overheard.
- Staff told us about their support for the “hello my name is...” campaign to ensure patients received a more personal and better experience in the critical care unit. During the inspection, we saw staff introduced themselves to patients and provided sensitive and person centred care.
- We observed letters and cards of thanks from patients and relatives on display on a noticeboard. One patient commented “It’s down to the staff that I have made such a good recovery. Wonderful staff, caring, friendly and supportive”. A further quote from a relative stated “We can’t thank the ITU team enough. You are an amazing team”.
- Staff members spent time with the patients, and interacted with them during any tasks or clinical interventions. We saw staff talking to patients, explaining what was happening and what actions were being taken or planned.
- We saw many examples of the positive and caring approach by doctors and nurses during the inspection. One example we observed on the unannounced inspection, when we saw one nurse, after doctors had reviewed an agitated patient’s sedation, sitting with and providing comfort and support to the distressed patient.
- We reviewed patients’ files and saw nursing notes made by staff were respectful and considerate of the patients’ families.
- The NHS Friends and Family test (FFT) is a satisfaction survey that measures patients’ satisfaction with the healthcare they have received. We saw June 2017 results, which showed 94% of patients would recommend critical care services to family and friends. The response rate was 62% and staff told us they continued to seek feedback when appropriate.
- We spoke with two patients and two relatives who all had positive feedback about the nursing, medical and other staff in critical care. They told us that when they experienced pain and discomfort staff responded appropriately with different approaches, for example, repositioning, pain control and medication and caring reassurance.
- One patient told us; “I’ll give them five stars. The consultants are ‘brilliant’, treatment is superb and the matron comes to talk to me whenever she goes past”.

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

- The nature of the care provided in a critical care unit meant that patients could not always be involved in decisions about their care. However, whenever possible, the views and preferences of patients were taken into account. One patient told us the consultant always involved him and asked if he wanted to join in with discussions during the ward round, or if he would prefer to listen and have information explained at the end.
- Relatives told us they were involved in care planning and had regular contact with consultants caring for their carers. We saw nursing staff encouraged those close to patients to be involved in their care and we observed one visitor supported to give oral fluids to a patient.
- We saw examples of documented discussions between medical staff and patients and families in records. Relatives we spoke with said they had been given time with the nurses and doctors to ask questions and this had been done in a private room if appropriate. Patients and relatives knew which doctor was looking after them.
- The service provided interpreters for relatives and patients who did not speak English.

# Critical care

- One relative told us that the hospital had been very accommodating and responsive in allowing them open visiting. This reduced the stress of having to meet the regular visiting times and provided more time for them to understand the treatment and care of their loved one.

## Emotional support

- Staff provided emotional support to patients and staff directed patients to access the hospital multi-faith chaplaincy service and external support services, when required.
- Relatives we spoke with said they had felt very well supported, and that communication from both medical and nursing staff had been very open, with clear explanations about treatment.
- All appropriate critical care patients and relatives received an invitation to the critical care follow up clinic that promoted both physical and psychological recovery after discharge from hospital.
- A monthly support group for patients, called ITU Steps, was run by the follow up nurse. The clinic was held away from hospital grounds where patients and those close to them could talk to others about their journey of recovery and share experiences.
- Nursing staff across the hospital, not working in critical care services, were supported to gain additional competence to help patients moving from a higher dependency care setting to a ward environment. This gave the staff enhanced skills to support patients with their discharge plans.
- Staff referred relatives to the patient advice and liaison service (PALS), bereavement service and chaplaincy services as required. The bereavement service was available Monday to Friday and was located within the hospital. Staff spoke highly of this patient support service.
- We saw that an organ donation link nurse directly promoted and supported staff and relatives with the organ donation programme.

## Are critical care services responsive?

Good



We rated responsive as good because:

- The service was able to meet the individual needs of patients and provided personalised care and treatment.
- The service provided flexed capacity to meet patients' needs for level two and level three clinical care and treatment.
- Access to the service was timely and similar to comparable peer services.
- Follow up clinics, in line with national guidance, were in place for critical care patients who had experienced a stay of longer than four days.
- Quiet rooms were available for staff to speak to relatives confidentially and facilities were provided to support relatives during their carers' stay in critical care.
- The service had effective systems in place to address formal and informal complaints.

However:

- Hospital wide bed capacity affected the ability of the service to discharge patients to wards at the most appropriate time. Over eight hour delayed discharges were higher than the national average, however, action had been taken and improvement observed for patients waiting 24 to 48 hours.
- Single sex accommodation was not always maintained due to hospital wide bed pressures. Action was taken to protect patient's dignity at all times.

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

- The critical care service planning and delivery was managed as part of the surgical division in the trust. There was evidence of consistent and collaborative working with internal and external partners during our inspection and in the review of minutes of senior meetings.
- There was involvement in the Midlands Critical Care and Trauma Network and good practice and learning was shared across the region.
- The service admitted both elective surgical patients who required close monitoring post operatively and emergency patients. The critical care operational policy contained details on admission to the ward and the routes this may be from, including admissions through the emergency department and admissions from theatre.

# Critical care

- There was a recovery area within theatres, which had equipment to safely monitor and care for critically ill patients.
- Follow up clinics, in line with Guidance for the Provision of Intensive Care Services (GPICS 2015) were in place at the hospital for critical care patients who had experienced a stay in critical care of longer than four days. This gave the patient opportunity to gain further explanation of events and access screening for critical care complications.
- Visitors had access to a waiting room that could be split into two separate areas, and a kitchen area was provided where hot and cold drinks were available. There was one room for visitors to stay overnight when requested. One family told us that the overnight room had been in use and they were required to stay overnight in the waiting room.
- A room was available away from the main ward area where staff could talk privately with relatives.
- Visiting times were between 1pm and 7pm each day. However, the unit's visiting times could be flexible to meet the needs of patients and carers.
- There was a list of named specialist link nurses in the matron's office and staff were aware of how to access support when required.
- Patients with learning disabilities had a healthcare passport to help staff understand their communication and individual needs.
- There was a link nurse for organ donation to directly promote and support staff and relatives with the organ donation programme.
- The wards hired special equipment such as beds and hoists for bariatric patients in a timely way.
- Immediate support for patients and relatives was through the chaplaincy services, which was available 24 hours a day. A hospital chaplain was available for people of all faiths and none, to support them with their spiritual and religious journeys and staff directed patients to access the services when required. The chaplaincy service provided a 24-hour service and offered support to patients and relatives, multi-faith services were available where requested.
- The main relative's room was situated outside at the entrance to critical care services and was clean, adequately equipped and provided facilities for visitors to have hot and cold drinks.
- Patient meals were delivered to the ward on a hostess trolley.

## Meeting people's individual needs

- The criteria for admission to the critical care service did not discriminate against patients by their age, gender or ethnicity. At the time of the inspection, mandatory training in equality and diversity was completed by 77% of medical and nursing staff against a trust target of 85%. Staff had had dementia awareness training.
- Information for families and friends was available in the visitor's room and included details about access to the patient advice liaison service (PALS) should relatives have a concern about the service. Information leaflets were available in large print and different languages.
- Patients living with dementia were identified using a discreet logo on a patient board, which allowed staff to be aware of the patient's individual needs. Special cutlery and finger food boxes were available to support patients living with dementia or other individual needs.
- There were telephone and face-to-face translation services available in the hospital. The necessary contact details for this were available to staff. There were also posters around the ward to allow patients and relatives to identify their language to staff and allow timely access to the correct interpreters.

## Access and flow

- Critical care services had a clear admission policy and guidance, which staff followed. All patients were admitted under a consultant. Admissions to the unit included elective admissions (post-operative patients), and emergency admissions from all other specialities within the trust. Other admissions included requests and transfers into the service from other hospitals.
- Admissions to the service were following a consultant-to-consultant referral. The critical care outreach team kept the unit staff aware of deteriorating patients around the hospital that may require an ITU or HDU bed. Medical staff told us in the event of critical care bed not being available, patients requiring level two or level three support were nursed in the post-anaesthetic recovery area. Staff said this happened rarely and there were no incidents reported during the year 2016 to 2017.

# Critical care

- In the ICNARC 2016 annual report, there were 508 admissions, of which 0.2% had a non-clinical transfer out of the unit. Compared with other units, this service was within the expected range. The figure in the 2015 annual report was 0.6%.
- Bed occupancy during April 2017 was 78%, which was below the England average of 80%. During January, February, March, and May 2017, bed occupancy was between 85% and 86%, which was above the England average. Between March 2016 and April 2017, the service had seen bed occupancy fluctuate around the England average.
- In the ICNARC 2016 annual report, there were 2,920 available bed days. The percentage of bed days occupied by patients with discharge delayed more than eight hours was 3.5%. This was better than the national average of 5.2%.
- From April 2017 to March 2017, ICNARC data showed that the service was similar to the England average for high-risk admissions from the ward and high risk admissions with sepsis.
- ICNARC data for the period April 2016 to March 2017 showed 11.5% of discharges from critical care services to a ward or home environment were delayed over eight hours, which worse than similar units' average of 6.8%. This meant patients remained on ITU when their needs could be met in an alternative setting. This was reflective of the hospital wide pressures on bed capacity and demand.
- The service was actively managing patient flow; however, this was affected by the hospital wide capacity issues. New operational standards had been implemented which required critical care to have two empty beds at all times to avoid scheduled theatre cancellations. During our inspection, we saw that this standard was met on all days. Another standard was to step down a minimum of two patients before 12.00 noon each day if it was safe to do so. This new requirement was that no patient should be delayed for more than 48 hours. Some improvement to patient discharge delays at 24 to 48 hours was observed as this new procedure was becoming embedded in the service.
- Staff reviewed all patients daily to ensure level two and level three patients were being cared for in the most appropriate clinical area. We saw that consultants had discussions with nurses in charge of all units to arrange transfers between the areas, enabling patients to be admitted to critical care.
- In the ICNARC 2016 annual report, 0.7% of admissions were non-delayed, out-of-hours discharges to the ward. These are discharges which took place between 10:00pm and 6:59am. Compared with other units, this unit was within the expected range. The figure in the 2015 annual report was 0%.
- The ICNARC audit outcomes for the period April 2016 to March 2017 showed the trust had 0.6% out of hours discharges between 10.00pm and 6.59am, which was better than similar units of 1.9%.
- During 2016/17, there were two transfers to other units for non-clinical reasons, which was in line with the regional data provided by ICNARC.
- From April 2016 to March 2017, ICNARC data showed a slight fall in unplanned readmissions from 1.9% to 1.6%.
- Activity within the Intensive Therapy Unit (ITU) was monitored closely and 'mixed sex accommodation' breaches were recorded as an incident. Patients who were ready for transfer to wards but whose discharge was delayed were declared as a 'mixed sex accommodation breach' after the decision to discharge had been made.
- There were seven breaches of same-sex accommodation during the reporting period July 2016 to June 2017. We observed that the breaches had been identified and reported in line with national guidance and that actions had been taken to ensure patient's privacy and dignity was respected whenever possible.

## Learning from complaints and concerns

- The service had an effective process for categorising and handling complaints and concerns.
- People were able to raise their concerns with staff on the units or with the patient advice and liaison service (PALS) or make a formal complaint to the trust.
- The complaint policy and the procedures were well advertised and there were leaflets and posters available throughout the ward to advise patients, visitors, and family on how to make complaints. Managers told us they tried to resolve complaints on the ward as they occurred.
- The service used the trust policy for managing complaints. The most relevant person would investigate any concerns, for example, complaints about nursing staff were investigated by the matron, or treatment concerns investigated by the lead clinician.



# Critical care

- Staff told us of feedback and learning that was shared following a relative complaint this year. No complaint investigations were ongoing at the time of the inspection.

## Are critical care services well-led?

Good



We rated well-led as good because:

- Leadership was well established and there was a clear focus on improvements and patient safety.
- The service had a vision and strategy that was in line with the overall trust vision and focused on improving quality and safety.
- Effective governance arrangements were in place. There were structured meetings to review all aspects of performance, quality and risks and high risks were escalated through the directorate.
- We observed strong local leadership and staff said all managers were supportive, accessible and approachable. Innovation throughout the staff team was encouraged.
- Senior staff shared information with staff in a variety of ways to reinforce the quality agenda with good effect.
- There was an investment in leadership programmes and staff development. It was clear that learning was shared and that staff had a shared purpose.

### Leadership of service

- Critical care was part of the surgical division. The service was led by a clinical lead consultant, a matron and general manager who reported to the surgery divisional director, divisional manager and associate director of nursing. Senior nursing staff were available 24 hours a day seven days a week.
- The senior team structure was established and understood by staff we interviewed. However, some junior medical staff we interviewed were not familiar with the clinical director or organisational structure.
- The nursing leadership was visible and involved in the day-to-day management of the unit. Staff were complimentary about the matron and senior nursing staff, and we were told that they were well supported and committed to providing support to the team. Nursing staff said the matron was visible on the unit and provided immediate support when issues escalated.

- Medical staff, including junior doctors, told us the consultants were highly visible on the unit and supportive towards them.
- Senior staff responsible for critical care consistently reported that they felt supported by the executive team.
- Leadership development was a key strategy and priority in the trust for all levels of staff. Staff said that the strategy was applied to practice and clinical leaders were supported to attend external Leadership Academy programmes. Courses covered topics including managing quality and quality improvement, leading people, managing change, strategic effectiveness and financial effectiveness.
- The critical care team were identified in photographs on the unit display boards visible to all staff and patients.

### Vision and strategy for this service

- Staff in critical care were familiar with the trust's values to put patient safety above all else, aspire to excellence, reflect, learn and improve, and respect and support each other.
- The vision of critical care was in line with the vision of the trust, which was to provide the best possible care for all patients.
- The local vision for the service included the requirement for critical care services to be relocated to meet the national standards Health Building Notes 04-02; 'The provision of psychology support for patients reviewed in follow up clinic'; and a review of the outreach service to include physiotherapy support. The refurbishment plans for ITU had a timescale of two years for this to be completed. Not all staff were aware of the strategic plans for the service.

### Governance, risk management and quality measurement

- Governance arrangements were clear. Critical care was represented at board and trust level and information was shared across the service.
- A dedicated data administrator produced the critical care Intensive Care National Audit and Research Centre (ICNARC) submission, by working closely with the consultants and clinical team. There was consistent submission of information to the ICNARC case mix programme (CMP).

# Critical care

- The service measured itself against the Guidance for the Provision of Intensive Care Services (GPICS 2015) standards, which underpinned the service specification used by the Midlands Critical Care and Trauma Network (MCCTN) to provide benchmarked peer reviews.
- The risk register for critical care was comprehensive with progress and ownership being documented as part of the directorate's overall risk register. The risks included non-compliance with 'National Critical Care Building Standards' 04-02, unmet standards concerning multi-disciplinary presence at daily ward rounds, and a lack of high visibility clothing required for safe patient transfers. Almost all risks in the service had been assessed, but we found that the medicines' storage issue had not been recognised by the service. However, senior managers took immediate action once we have raised it as a concern.
- We saw reviews and action plans associated to risk, with the items on the risk register reflecting what we observed and discussed with staff as their concerns. However, we observed that the department would not meet the deadline for refurbishment by the September 2017 deadline due to financial pressures. Critical care staff were working on a five-year business strategy to resolve the situation.
- There was an embedded approach to sharing performance information with staff in way that could be understood and interpreted as part of improving quality, safety, experience and activity. This included 'We See' reports and bulletins. The matron and senior staff shared information in a variety of ways to reinforce the quality agenda with good effect.
- Staff attended monthly mortality and morbidity meetings with a focus on quality improvement and improving patient outcomes post critical care.
- The unit performed monthly audits, which included infection control, ventilator acquired infection, and central lines in line with the trust audit calendar. This approach was consistent and the feedback communication to the team in ward meetings was evident.
- There was an open and transparent culture. Staff were encouraged to share concerns or comments they had about patient care, colleagues or the service. We did not hear of any complaints or conflict amongst staff in critical care.
- Collaboration was effective within the surgical division, the wider trust team and across the region in the critical network.
- Staff, without exception, told us that they were proud to work for the trust and, in particular, they were proud of the improvements that had been made in recent years.
- Staff used positive statements to describe the culture in critical care.

## Public engagement

- There was no general public involvement with how the service was run, but patients and their relatives were asked to comment on their care.
- Patients and relatives were encouraged to participate in the Friends and Family Test and results were shared with staff who could contribute ideas to improve patient experience of their care and treatment.
- Information leaflets were available in the relative's room and we saw some positive comments from patients displayed on the feedback notice board.
- A critical care monthly support group was held in a community venue, away from hospital grounds, that provided support for patients discharged from hospital.

## Staff engagement

- The message board in the staff room was well-used and included information about safeguarding, health and safety and training opportunities.
- Staff were encouraged to use the staff suggestion box to raise ideas for improvements for patient safety or staff wellbeing.
- A critical care newsletter was supported by the practice educator to share training opportunities and policy updates.
- The hospital had launched a new award scheme for patients and their families to thank a nurse for who made a real difference to their care. A member of nursing staff from critical care had been invited to attend the launch in August 2017.
- Staff could access a 'closed' Facebook page for learning outside of critical care. Links to educational websites,

## Culture within the service

- All staff expressed how supportive the ward culture was and that there was great teamwork amongst all staff.

# Critical care

PowerPoint presentations, national guidelines, and internet videos were available. Motivational messages included number of days of harm free care, including avoidable new pressure ulcers.







- Two staff members had been nominated for the trust's 'Best Possible Care' awards for the difference they had made to a patient's hospital experience and the care the patient received.

## **Innovation, improvement and sustainability**

- Patients in HDU remained under the care of the responsible consultant from the medical or surgical team at the time of last inspection. HDU and ITU had since merged and a dedicated consultant team worked across both areas and could see a deteriorating patient without delay.
- Nurse staffing levels had improved greatly to ensure patients were provided with safe care.
- Nursing leadership within critical care meant concerns were addressed in a timely way and quality oversight had improved.
- The service allocated team study days for mandatory and new training to be completed.
- Critical care follow up service had introduced patient diaries to allow patients to process the impact of critical illness, improve memory recall and support staff to respond more holistically to patient's needs. Staff spoke positively about the introduction of patient diaries and the extra support that would give relatives.
- The outreach team was fully staffed and provided a 24 hour a day, seven days a week service.
- The simulation team provided practical, learning support to staff to improve patient safety and experience every two months. Simulation exercises focused on incidents that had occurred and included learning from mistakes.
- The hospital told us they were innovative in their approach to filling consultant vacancies. A recent vacancy offered an opportunity for the applicant to undertake half consultant and half intensivist role.
- The service was affiliated to the local university and there was interest in accreditation of the newly developed trust wide critical care course.
- The service was the first department in the hospital to be awarded a sustainability award for the increase in recyclable and decrease in domestic and clinical waste.



# Maternity and gynaecology

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

## Information about the service

The department of obstetrics & gynaecology (women's services) provides the following services at Northampton General Hospital:

- Gynaecological cancer services.
- Endometriosis service.
- Maternity Services.
- General Gynaecology.
- Fertility Services.
- Incontinence & Prolapse Clinic (Urogynaecology).
- Abnormal Smear Clinic (Colposcopy).
- Emergency Gynaecology.

There were 4,869 babies delivered at Northampton General Hospital in 2016. The maternity unit has 60 beds across antenatal, intrapartum and postnatal care. The labour ward is subdivided into eight delivery rooms, seven with no ensuite facilities and a birthing pool room with toilet ensuite; a birthing pool; a 17-bedded maternity observation ward (MOW); and two obstetric theatres. There is also a dedicated bereavement facility within the unit called the Snowdrop Suite

The hospital has a midwife-led unit called the Barratt Birth Centre, which consists of four rooms with ensuite bathrooms and kitchenettes. It includes three birthing pools. This provides an alternative for women with low risk pregnancies who did not want home births and did not need consultant-led care.

Gynaecology inpatient services are provided on Spencer Ward, which has recently increased from 15 to 23 beds following a recent reconfiguration. The additional eight

beds are specifically for divisional oncology patients. It also has outpatient facilities and an emergency clinic including an early pregnancy assessment area and a termination of pregnancy service. In the past year, 103 medical and surgical terminations were carried out at the hospital.

We visited the antenatal, labour and postnatal wards, birth centre and the day assessment unit. We spoke with 27 members of staff including maternity support workers, midwives, matrons, sonographers, trainee doctors, consultants, allied health professionals, senior staff and domestic staff. We spoke with six patients and four relatives. We reviewed nine care records. We observed staff interactions with women and those close to them. During and following the inspection, we requested data in relation to the service, which we also reviewed and considered when making our judgements.

# Maternity and gynaecology

## Summary of findings

We rated the service as good because:

- Staff were aware of their roles and responsibilities in the management and escalation of incidents.
- The service completed the national maternity safety thermometer and monitored safety performance through clinical dashboards.
- There were effective systems in place to ensure that standards of cleanliness and hygiene were maintained.
- The design, maintenance and use of facilities and premises met all patients' needs. There were systems and processes in place to ensure that the maintenance and use of equipment kept patients safe.
- Medicines were stored and handled in line with the hospital's medicines management policy.
- Individual care records were written in a way that kept patients safe.
- There were effective processes in place to ensure that adults and children in vulnerable circumstances were safeguarded from abuse.
- Effective systems were in place to assess risks to patients and to recognise deterioration, including the use of early warning score assessments.
- Medical, midwife and nurse staffing levels, skill mix and caseloads were planned and reviewed so that patients received safe care and treatment at all times, in line with relevant tools and guidance.
- The service had effective contingency plans in place for managing major incidents which covered staffing and closure of the unit.
- Policies were based on national guidance produced by National Institute for Health and Care Excellence (NICE) and the royal colleges.
- Pain of individual women was assessed and managed appropriately.
- Patients' outcomes were being measured and were generally in line with national average. Action plans were in place to drive improvements.
- There were systems and processes in place to ensure that staff had the necessary qualifications, skills, knowledge and competencies to do their jobs.
- Effective multidisciplinary working was clearly evident throughout the department.
- There were appropriate processes and systems in place to ensure that information needed to deliver care and treatment was available to relevant staff in a timely manner.
- Patient's consent was obtained in line with trust policy and statutory requirements.
- All women and those close to them were extremely positive about the care and treatment they had received.
- Staff were very kind and caring towards patients on all interactions we observed.
- The Friends and Family Test results were better than the England averages and were improving.
- All women said they were involved in their birthing plans and their choices were listened to and respected.
- All women told us that they had felt involved in their care and treatment. We saw that all patients were kept informed about the treatment plans at all times.
- All women told us that they were happy with the care they had received and spoke very positively about the staff that were caring for them.
- There was excellent support for those who had suffered bereavement from the specialist midwife.
- The service worked effectively with a variety of stakeholders and commissioners to plan delivery of care and treatment and was a proactive partner in shaping community provision.
- Services had been planned to take into account the needs of different people, for example, on the grounds of age, disability, gender or religion.
- Care and treatment was only cancelled or delayed when absolutely necessary.
- Access to services was generally effective and timely.
- The service managed complaints swiftly, openly and constructive as part of a co-ordinated patient feedback system.
- The service leadership team was cohesive and inclusive and was focused on delivering safe, high quality care and treatment for all patients.
- There was clear and effective leadership at a local level with wards and units being well managed and supported.

# Maternity and gynaecology

- The trust had a clear and effective vision for maternity and gynaecology services to deliver high quality person-centred care, which staff were committed to.
- The focus on safe patient care was clearly evident in all areas and from all staff.
- There were effective and clear governance systems in place to escalate issues and risks to the service leaders and to the trust board.
- The service risk register reflected the risks within the service and there was evidence of ownership, mitigations having been implemented and ongoing monitoring.
- Staff believed in the leadership of the service and were proud of the organisation and its culture.
- The service was very proactive in supporting and engaging with all staff and patients.
- Staff within the service recognised the importance of gathering the views of patients and actively sought feedback to drive improvements in the service.

However:

- Not all doctors, nurse and midwives had had annual refresher training for safeguarding adults at level two. Action plans were in place to address this.
- The service had had higher than expected caesarean rates and perinatal mortality rates over time. Whilst actions and mitigating actions had been taken, these had not always improved outcomes. The service continued to monitor and assess these potential risks to patients.

## Are maternity and gynaecology services safe?

Good



We rated safe as good because:

- Staff were aware of their roles and responsibilities in the management and escalation of incidents.
- The service completed the national maternity safety thermometer and monitored safety performance through clinical dashboards.
- There were effective systems in place to ensure that standards of cleanliness and hygiene were maintained.
- The design, maintenance and use of facilities and premises met all patients' needs. There were systems and processes in place to ensure that the maintenance and use of equipment kept patients safe.
- Medicines were stored and handled in line with the hospital's medicines management policy.
- Individual care records were written in a way that kept patients safe.
- There were effective processes in place to ensure that adults and children in vulnerable circumstances were safeguarded from abuse.
- Effective systems were in place to assess risks to patients and to recognise deterioration, including the use of early warning score assessments.
- Medical, midwife and nurse staffing levels, skill mix and caseloads were planned and reviewed so that patients received safe care and treatment at all times, in line with relevant tools and guidance.
- The service had effective contingency plans in place for managing major incidents which covered staffing and closure of the unit.

However:

- Not all doctors, nurse and midwives had had annual refresher training for safeguarding adults at level two. Action plans were in place to address this.

## Incidents

- Staff were aware of their roles and responsibilities in the management and escalation of incidents. Staff told us that they were able to raise concerns and were confident that their concerns were listened to.

# Maternity and gynaecology

- The department had a monthly dashboard that was used to set the targets for safety performance and also used nurse sensitive indicators such as compliance with infection control protocols and care associated risk assessments. The dashboard also included the numbers of incidents and complaints, which were discussed at governance meetings and as 'hot topics' at daily nursing and medical safety huddles. Our observations and discussions with staff at all levels confirmed that they were aware of the 'hot topics' within the department.
- There was a positive culture towards reporting incidents and learning from these to improve patient safety. Staff at all levels understood their responsibility to report incidents both internally and externally.
- All staff had access to the hospital's electronic system for reporting incidents and staff that we spoke with described the process they followed.
- There were no never events reported for this service from July 2016 to June 2017. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need to have happened for an incident to be a never event.
- The hospital's incident management policy was in line with the serious incident framework 2015, which states that all serious incidents should be investigated to identify opportunities for learning and implement actions to minimise the risk of the incident re-occurring. From July 2016 to June 2017, there was one incident regarding a cannula site infection categorised as a serious incident in the department.
- The serious incident was thoroughly investigated using root cause analysis methodology and opportunities for learning were identified. Changes were made to practice when necessary and this was disseminated to all necessary staff. We saw that cannula care plans were enhanced and staff had had refresher infection control training regarding cannula care sites.
- We saw that 1,113 maternity (midwifery and obstetrics) incidents and 198 gynaecology incidents were reported between July 2016 to June 2017. No incidents were classified as causing major harm, eight moderate harm, 59 minor harm and 1,244 no harm. Around half the incidents were categorised as relating to labour or delivery. We observed that all incidents were reviewed daily and where necessary investigations, including root cause analyses, were carried out. Senior staff held twice-daily meetings to identify where trends had occurred and put in place systems to prevent similar occurrences. They also monitored whether the required actions had been addressed. We saw detailed immediate actions had been put in place together with ongoing shared learning for all incidents.
- All incidents were reviewed by the matrons and lead midwives. Incidents were discussed at the women's' and children's governance meeting, which was attended by the senior management team. Incidents regarded as serious were reported to the hospital wide governance for consideration and review if any further action was required for example review of status or instigate an investigation.
- The service met the Royal College of Obstetrics and Gynaecology (RCOG) 'Improving Patient Safety' they held a monthly meeting to review perinatal and maternal mortality and morbidity. It was attended by the multidisciplinary team members. We saw the minutes and lessons learnt were shared widely across the service.
- We spoke with staff about learning lessons from incidents in the maternity and gynaecology service told us they received direct feedback regarding incidents they had been involved with. Almost all staff told us they received feedback about incidents that had occurred within the service.
- From November 2014, NHS providers were required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. 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 reasonable support to the person.
- The hospital had a duty of candour policy (being open), which staff could access via the hospital intranet. Staff were aware of the importance of being open and honest with patients and relatives when something went wrong. Staff were able to describe examples where the duty of candour should be applied and know the trigger for application of duty of candour was for those incidents classified as moderate harm and above.
- We saw the service reported all births between 22+0 and 23+6 weeks gestational age who did not survive the

# Maternity and gynaecology

neonatal period to the Maternal, Newborn and Infant Clinical Outcome Review Programme' (MBRRACE-UK) as per recommendation 8 of the MBRRACE report published June 2015.

## Safety thermometer

- The service completed the national maternity safety thermometer. The maternity safety thermometer is a national system that collates safety and quality information on a given day each month and relates to women in the hospital at that time. The thermometer allows maternity teams to take a 'temperature check' on harm and records the proportion of mothers who have experienced harm free care, and also records the number of harm(s) associated with maternity care. The maternity safety thermometer measures harm from perineal and/or abdominal trauma, post-partum haemorrhage, infection, separation from baby and psychological safety.
- For June 2017, the service achieved 100% harm free care for women's perception of safety better than the national average of 93%. For harm free care (all indicators), the service achieved 61% against the national average of 74%.
- For June 2017, the percentage of women who had a maternal infection was 18%, compared to the national average of 6%. However, for the preceding five months, the service performed better than the national average.
- For June 2017, the service had a 7% proportion of women experiencing a third or fourth degree perineal tear worse than the national average of 2%.
- For June 2017, the proportion of women experiencing a post-partum blood loss (of more than 1,000mls) was 18%, compared to the national average of 9%.
- The clinical governance arrangements in the maternity services were recently reviewed to ensure there was an overarching, proactive approach to clinical governance with clear lines of escalation from 'ward to board'.
- The maternity services had been using a maternity dashboard since 2008 as a means of monitoring performance and governance. In March 2016, the 'Patterns of Maternity Care in English NHS Trusts' report was published by Royal College of Obstetrics and Gynaecology (RCOG). The report contained an analysis of the maternity Hospital Episode Statistical data recorded in 2013/14 and provided a national picture of

clinically relevant indicators adjusted for maternal characteristics and clinical risk factors. The indicators focused on women whose maternity care was most affected by clinical uncertainty.

- In the trust's quality governance committee maternity assurance report in March 2017, the hospital was not a statistical outlier for any of the RCOG maternity clinical Indicators. New clinical indicator maternity dashboards were developed and implemented. The aim of the dashboards was to enable the service to gain a full understanding of the patterns of care delivered. The information provided within the dashboards enabled the service to identify priority areas for improving the outcomes for women and their babies.
- For April 2017 to June 2017, the maternity dashboard (midwifery) showed 1,145 deliveries with 35 planned deliveries at home. One staffing incident causing harm was report in this period.
- The NHS Safety Thermometer is an improvement tool for measuring, monitoring and analysing patient harm and 'harm free' care. This enabled measurement of the proportion of patients that were kept 'harm free' from pressure ulcers, falls, and urine infections (in patients with a catheter) and venous thromboembolism (the formation of blood clots).
- The gynaecology service collected an appropriate range of safety information and it was being monitored by the service. The service collected information about safety risks to patients. This information included the total number of hospital acquired pressure ulcers and infections, the number of medication administration errors, friends and family test response rates and the percentage of respondents who would recommend the service, maternity documentation standards and maternity staffing levels. The NHS safety thermometer results were displayed publically and staff were aware of the outcome measures and performance. We saw that action was taken to improve safety performance when indicated. For example, we saw changes in practice to reduce risks of hospital acquired pressure ulcers.

## Cleanliness, infection control and hygiene

- There were effective systems in place to ensure that standards of cleanliness and hygiene were maintained.
- Reliable systems were in place to prevent and protect people from a healthcare associated infection in line with National Institute of Health Care Excellence (NICE)



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guidelines, NICE Quality Standard 61, 2014 (QS61). For example, patients received care from staff who had decontaminated their hands immediately before and after every episode of direct contact or care.

- All areas visited were visibly clean and there was a dedicated team of domestic staff responsible for ensuring that all areas were kept clean. Cleaning schedules were on display.
- The hospital's infection prevention team conducted monthly audits for all areas of the hospital. The hospital-wide audits included monitoring compliance to protocols related to hand hygiene, commode cleanliness, isolation room use and spot checks for areas such as decontamination processes. The hospital's target for compliance to hand hygiene protocols was 90% and any area that scored less than 90% was re-audited after two weeks. From April 2017 to June 2017, the service scored 100% for compliance to hand hygiene protocols: this included adherence by medical, nursing, midwifery and administrative and clerical staff. The infection prevention team produced a monthly report of the result of their findings: this was distributed to all matrons and included action plans for all identified areas for improvement.
- In addition to the hospital-wide audits, domestic supervisors conducted monthly infection control audits for all areas in the service and these results were included in the departmental quality dashboards. Overall compliance in the environmental audits for April 2017 to June 2017 was 98%, better than the service target of 90%.
- Dedicated isolation rooms were available in the Barret Birth Centre.
- We observed domestic staff using equipment such as colour coded mops and buckets in line with guidance. Cleaning chemicals were stored in the domestic cupboards in line with Control of Substances Hazardous to Health national guidelines, including clear written instructions for each substance. In addition, the guidance was attached to cleaning trolleys used by domestic staff throughout the department.
- There were hand hygiene posters based on the World Health Organisations guidelines 'Five moments of hand hygiene' (August, 2009) above handwashing sinks throughout the service, including public areas. There was sufficient hand sanitising gel dispensers throughout the department including at the entrances.

- There was personal protective equipment such as disposable aprons and gloves available throughout the department for all staff. We observed these being used appropriately to aid effective infection prevention.
- Nursing and medical staff observed the trust's 'arms bare below the elbows' policy.
- From July 2016 to June 2017, there were no cases of MRSA or Clostridium Difficile reported for the maternity and gynaecology units.
- As of July 2017, 85% of nursing and midwifery staff and 78% of medical staff had completed infection control annual refresher training against a target of 85%. We saw further training sessions had been arranged.

## Environment and equipment

- The design, maintenance and use of facilities and premises met all patients' needs. There were systems and processes in place to ensure that the maintenance and use of equipment kept patients safe.
- The antenatal, labour and postnatal wards, birth centre and the day assessment unit all had appropriate security systems in place with video intercom access and CCTV coverage at all entrances and exits.
- Equipment was clean and fit for purpose. Portable appliance testing or external company servicing of all equipment that we looked at was found to be in date, meaning equipment was safe for use.
- The service had all equipment recommended by the safer childbirth document. Emergency clinical equipment such as resuscitation, oxygen, resuscitaires (used to support new born babies who may need extra warmth or resuscitation after delivery) for new-born babies on the maternity unit and suction equipment was stored appropriately so that it was available for use at short notice. It was checked each day to ensure it was in working order. We saw records to confirm this.
- A cardiotocography (CTG) machine was used for women whose babies needed monitoring in labour. CTG machines are used to monitor the baby's heart rate and the frequency of contractions when a woman is in labour. This involves two straps being applied across the woman's abdomen that are attached to the machine and does restrict movement. CTG machines were checked daily.
- Fetal blood analysers, fetal heart rate monitoring for high risk pregnancies were available and accessible and were checked daily. We saw records that the

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post-partum haemorrhage trolley weekly checks were being carried out in a timely way. The anaesthetic machine in theatres was checked daily before every surgical case.

- We spoke with staff from all wards within the maternity and gynaecology services. They told us they had adequate supplies of medical equipment.
- Maternity staff knew the birth pool cleaning and evacuation procedures. A booklet on the delivery suite contained photographs demonstrating evacuation of the pool. There was a net available in each pool room, in order to support the evacuation of women from the pool.
- We saw emergency equipment was carried by community midwives such as oxygen, with suitable equipment for neonates and adult such as masks. They also carried emergency drugs such as medicines for the management of post-partum haemorrhage and catheterisation equipment. All equipment was checked on a weekly basis. Equipment was transported securely and was compliant with local protocols and legislation.
- The service had appropriate facilities for the safe storage of breast milk.

## Medicines

- Medicines were stored and handled in line with the hospital's medicines management policy.
- Nurses and midwives were aware of the correct processes and procedures for the administration and recording of medications.
- Medicine incidents were recorded onto an electronic recording system. Learning from incidents was shared although there had been no medicine incidents reported in July 2017.
- There was an effective system in place to share learning and updates in the service. This included 'Stork Talk' where managers would update staff as well as review knowledge skills and keep up to date. For example, a recent update on the safe destruction of controlled drugs was discussed.
- There was access to emergency medicines, such as those used for allergic reactions and for treating low blood sugars to prevent further complications. Emergency medicines were stored securely on emergency trolleys. This meant they were available in an emergency.
- Although the wards had no regular clinical pharmacist they were able to contact the pharmacy for support and

advice. In particular, pharmacy had been helpful and supportive in developing a system to dispense an injection to stop blood clots forming within the blood to patients directly from the ward. This helped to reduce waiting times for discharge from the ward.

- Medicines were stored securely with secure access limited to nursing staff and medical staff. Controlled drugs (CDs) which require special storage and recording were stored following effective guidance procedures including daily checks by two nurses on quantities and records. We saw that all the CD records were accurate and up to date and nursing staff were aware of Nursing and Midwifery Council (NMC) standards for administration of CDs.
- Medicines requiring cool storage were stored appropriately in locked medicine refrigerators. Daily temperature records for the medicine storage room documented that medicines were not always stored within safe temperature ranges. An action plan was available from pharmacy to inform staff what to do if the temperatures were consistently above the safe range. Staff were aware of the temperature thresholds and what to do if temperature thresholds were breached
- Sealed medicine packs were dispensed by the pharmacy for community midwives to supply and administer. This was best practice and ensured the medicines had been checked for safe administration.
- We reviewed nine sets of patient records and found that allergies had been clearly documented in patient's records. All prescribing charts showed when medicines had been requested and who had requested them, the charts showed when the medication had been given and by whom.
- In the period from April 2017 to June 2017, eight medication incidents had been reported, with all causing no or low harm. Actions plans were in place to embed learning from these.

## Records

- Individual care records were written in a way that kept patients safe. We reviewed nine patients' healthcare records and found that they were accurate, complete, legible, contemporaneous and up to date.
- Records had been completed with relevant current and previous clinical information. Information needed to deliver effective care and treatment such as risk



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assessments such as diabetes, pre-eclampsia, high body mass index and venous thromboembolism (which is a condition where a blood clot forms in a vein). and test results were recorded.

- Records used in the service were a mixture of electronic and paper-based. Requests for tests and diagnostics were made through the electronic system.
- Paper records were stored securely in locked trollies throughout the service.
- Staff told us that there was a formal and informal system for auditing records. Staff advised us that senior nursing staff would conduct random spot check audits and deliver informal feedback if there were any areas for improvement. Audits of records were formally conducted on a monthly basis and reported as a part of the nursing quality and care indicators.
- Overall compliance in the records' audits for April 2017 to June 2017 was 100%, better than the service target of 90%.

## Safeguarding

- There were effective processes in place to ensure that adults and children in vulnerable circumstances were safeguarded from abuse.
- All staff were clear about their responsibilities and were able to tell us the indications of suspected abuse, for both adults and children.
- There was a specific symbol on the electronic patient record system that allowed staff to highlight any patient that they had assessed as being at 'high risk' of abuse.
- The intercollegiate document 'Safeguarding children – Roles and competencies for healthcare staff' published by the Royal College of Paediatrics and Child Health (RCPCH) 2014 provides guidance on the level of safeguarding training required for different staff groups. The document states that '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' should be trained in safeguarding for children levels one, two and three'.
- At the time of our inspection, 84% of nursing and midwifery staff and 84% of medical staff had completed

safeguarding children's level three training against a target of 85%. The service had an on-going action plan to deliver safeguarding level three training in line with guidance.

- As of July 2017, 62% of nursing and midwifery staff and 62% of medical staff had completed safeguarding adults' level two training against a target of 85%. The service had an on-going action plan to deliver safeguarding level two training in line with guidance.
- There was information relating to female genital mutilation (FGM) and child sexual exploitation (CSE) on the trust's intranet. All staff that we spoke with were aware that there were arrangements in place to safeguard women and children at risk and told us that the topic had been covered during safeguarding training. Child sexual exploitation (CSE) is a form of sexual, emotional and physical abuse of children.
- Some staff had undergone PREVENT training in line with the government's strategy to ensure that individuals are safeguarded from radicalisation. The training was planned as a mandatory topic in the service's 2017/18 training action plan. The main aim of Prevent is to stop people from becoming terrorists or supporting terrorism. At the heart of Prevent is safeguarding children and adults and providing early intervention to protect and divert people away from being drawn into terrorist activity.
- There was a named safeguarding midwife who supported staff in the service whenever required. All staff we spoke to knew how to raise safeguarding concerns appropriately.
- Staff told us that the hospital safeguarding team delivered bespoke training for staff in the service when required and directed us to information on their dedicated intranet page regarding topics such as CSE. Staff said the safeguarding team were very visible in the department and were always available to give advice.
- The trust had developed a specific child and baby abduction policy, which reflected national guidance. The policy was due to be ratified and implemented in August 2017. Babies were seen to have correctly labelled identity bracelets on an ankle and on a wrist.

## Mandatory training

- Mandatory training for medical and nursing staff in the service consisted of statutory training modules such as information governance, health and safety, equality and diversity and fire safety.

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- There was mandatory training in “PROMPT” (Practice Obstetric Multi Professional Training) this covers learning about obstetric emergencies. The training was carried out for multidisciplinary groups that included consultants, staff grade doctors (such as registrars and senior house officers) junior doctors and all grades of midwives. The training included classroom sessions and simulations of events.
- Maternity specific training included management of obstetric emergencies. Staff had an opportunity to practice emergency drills and emergency scenarios such as postpartum haemorrhage, shoulder dystocia, eclamptic fit and vaginal breech. This included exercises in community settings to practice emergency scenarios six times a year.
- Staff said training was accessible, met their needs and they were given time to attend when required. Staff gave feedback saying that the PROMPT course content was relevant to them and was effective in understanding and assessing patient risk and safety.
- Each midwife received 12 hours of fetal monitoring training per year including a full half day update session.
- The trust’s target for mandatory training completion was 85%. At the time of our inspection, mandatory training completion for nursing, midwifery and medical staff was 82% overall. Managers had plans in place to address this and these were being monitored.
- All staff told us that they were up to date with their mandatory training.
- The dedicated practice and development educator facilitator worked with managers and kept a record of all mandatory and role specific training. They developed an annual plan to address and identify mandatory training needs.

## Assessing and responding to patient risk

- At the antenatal booking appointment all women had a full assessment of their physical, social and mental health needs carried out. They were then allocated either consultant or midwife led care, depending on their needs. This ensured women with risk factors were seen by appropriately trained professionals.
- All midwives were involved in the triage process. A woman could telephone, or arrive on the midwife-led unit called the Barratt Birth Centre or consultant-led labour ward, and be assessed and triaged by any of the midwives on duty. The policy about maternity triage had clear guidelines on the criteria of admission and treatment of women to the maternity unit. The policy was evidence based and referred to Royal College of Obstetricians and Gynaecologists guidelines regarding preterm premature rupture of membranes (PPROM), foetal movement guidelines and foetal monitoring guidelines.
- CTG monitoring was used when it was clinically indicated as per NICE guidelines. Senior midwives carried out regular safety rounds to check all patients.
- A modified early obstetric warning score (MEOWS) assessment was used to detect signs of deterioration. This allowed staff to recognise the deteriorating patient and when to escalate any concerning observations to senior staff. This included a full set of vital signs (heart rate, respiratory rate, temperature, blood pressure and oxygen saturations, fluid charts and a pain score) recorded four hourly unless stated otherwise. Staff were trained during induction on the use of this early warning score. The service used audits to monitor the use of the MEOWS. On the day of our inspection, a MEOWS audit was carried out and performance was 100%, above the trust target of 90%. We looked at six patients’ MEOWS records and found all were completed accurately.
- Staff told us that if they escalated concerns to a senior midwife or a doctor they would get a quick response. If one doctor was busy and unable to come, they would escalate to a more senior colleague. The service had appropriate escalation of concerns processes in place.
- Women with high risk pregnancies due to pre-eclampsia, diabetes, obstetric cholestasis, intrauterine growth retardation, for example, were regularly monitored and reviewed by an obstetrician for medical advice.
- There had been no maternity outliers such as puerperal (a bacterial infection) sepsis and other puerperal infections, elective caesarean section, emergency caesarean section, neonatal readmissions and maternal readmissions reported since the last inspection of the service.
- The service followed the trust’s sepsis policy, which gave guidance to staff to recognise and treat sepsis quickly. The service also had a specific maternity sepsis policy and both policies conformed with national recommended guidance. The service had introduced specific maternity sepsis boxes in clinical areas which were checked daily to ensure they were fit for use. From August 2016 to July 2017, there had been no reported cases of sepsis.

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- For maternity and gynaecological surgery, the service used the World Health Organization (WHO) 'Five Steps to Safer Surgery', which is a surgical safety checklist. The overall compliance with checklists audits in April 2017 to June 2017 was 100%. We examined three patients' checklists and found they had all been completed accurately.
- In nine sets of patient's records we viewed, there were venous thromboembolism (VTE) assessments completed in accordance with trust policy. VTE is the term given to blood clots. Treatment to prevent blood clots was prescribed and administered in accordance with the hospital policy. Women were re-assessed within 24 hours of admission for risk of VTE and bleeding which met National Institute for Health and Care Excellence (QS3 statements 1 and 4). In June 2017, the service's audit showed 99% compliance with VTE risk assessments being completed, better than the trust target of 95%.
- We saw completion of certificate for terminations was in line with the Abortion Act (1967) and Abortion Regulations (1991). Forms were signed by two clinicians, which was in line with the legislation. We saw this was completed in the three sets of termination of pregnancy notes we reviewed. For June 2017, the proportion of women experiencing a post-partum blood loss (of more than 1,000mls) was 18%, compared to the national average of 9%. Action plans were in place to address this.

## Midwifery and nurse staffing

- Staffing levels, skill mix and caseloads were planned and reviewed so that patients received safe care and treatment at all times, in line with relevant tools and guidance. Actual staffing levels met the planned levels at the time of the inspection. Arrangements for using bank, agency and locum staff were appropriate, including ensuring appropriate induction processes and records were completed.
- The hospital used Birthrate Plus, which is a midwifery workforce planning tool that demonstrates required versus actual staffing need to provide services. Birthrate Plus is recommended by the Department of Health, endorsed by the Royal College of Midwives and incorporated within standards issued by the NHS

Litigation Authority. It enables the workforce impact of planned changes to be clearly mapped, in order to support service improvement and planning for personalised maternity services.

- The service undertook a comprehensive review of midwifery staffing using the Birthrate methodology in 2005 and 2013. In both reviews, the midwife to birth ratio was assessed as being one midwife for every 29 births.
- The midwifery staffing ratios were monitored and were reported through the maternity dashboard on a monthly basis. The calculation was based on clinical midwifery staff in post at the end of each month and birth numbers for the previous 12 month period (annualised birth rate). The figure fluctuated each month but in the year March 2017, it had remained between 1:28 to 1:29. Monitoring the overall midwife to birth ratio enabled trends to be identified. At the time of our inspection, the ratio was 1:29.
- Staffing levels on the maternity and gynaecology wards was reviewed by the senior team monthly. A staffing 'heat map' was produced which highlighted when staffing establishment fell below 95% and this was presented to the nursing and midwifery staffing group committee monthly.
- A strategic review of working models and skill mix was underway at the time of the inspection by the senior midwifery team to enable a full analysis of current and planned working models. Methodology for this review was based on the Birthrate Plus calculation, NICE guidance and professional judgement.
- There was a standard operating procedure for setting and reviewing midwifery staffing and establishments met the requirements of the service. There was a documented and appropriate process to calculate the number of midwives required on each shift. A local staffing escalation process was been documented and communicated to relevant staff. Potential fluctuations in birth rates were managed and escalated. Systems were in place to ensure that the actual numbers of midwives on each shift were appropriate.
- The service employed 173.53 whole time equivalent midwives (wte) to provide antenatal, intrapartum and postnatal care to women: this included 10 specialist clinical posts, such as the bereavement midwife, infant feed lead midwife, safeguarding midwife and a clinical quality and safety midwife. There were no vacancies at

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the time of the inspection. 12 newly qualified midwives were due to start in the autumn. Antenatal and community midwifery services were provided by five geographically based teams.

- The shift pattern was 12 hour shifts for day and nights. We observed a maternity handover and saw that it was detailed and all relevant patient information was discussed and handed over.
- We reviewed the rotas for April to June 2017 and saw that no agency midwives had been used in the Barret birth centre. For day shifts over these four months, 78 hours per month were filled by regular bank midwives (equating to six and half shifts per month). For night shifts over these four months, 36 hours per month were filled by regular bank midwives (which equated to three shifts per month).
- For April to June 2017 no agency midwives had been used in the labour ward. On day shifts over these four months, 335 hours per month were filled by regular bank midwives (equating to 28 shifts per month or 8% of shifts). For night shifts over these four months, 331 hours per month were filled by regular bank midwives (which equated to 28 shifts per month or 8% of shifts).
- In gynaecology, care was provided by 16.18 wte nurses, as well as seven specialist clinical posts, including a nurse consultant, fertility nurse specialists and Macmillan cancer nurse specialists. The nursing establishment had been increased to accommodate the additional eight beds meaning there was currently a 5.64 wte nursing vacancy factor; however these had all been recruited to and were awaiting a start date following completion of the human resources process. There were no nurse vacancies within the ambulatory care services in gynaecology.
- For April to June 2017 for Spencer ward, 192 hours per month were filled by agency qualified nurses (equating to 16 shifts per month or 20% of shifts). For night shifts, over these four months, 46 hours per month were filled by agency qualified nurses (which equated to four shifts per month or 6% of shifts).
- The service's sickness level was 4.5 % just above the trust wide rate of 3.5%.
- The service had effective agency staff induction processes in place for use when required.
- Staffing numbers were on display outside all inpatient areas in line with NHS England/CQC: 'Hard Truths'

guidance (2014). All areas reported planned and actual staffing levels using safe staffing protocols and the daily shift cover of midwives and healthcare assistants was on display in each area we visited.

## Medical staffing

- As of February 2017, the proportion of consultant staff reported to be working at the trust was the same as the England average and the proportion of junior (foundation year 1-2) staff was about the same.
- Obstetrics and gynaecology medical cover provided at the time of inspection was:
  - Four consultant obstetricians.
  - Four consultant obstetricians and gynaecologists.
  - One consultant urogynaecologist.
  - Two consultant gynaecology oncologists.
- There was a consultant resident on the labour ward from 8am to 8pm Monday to Friday and 8am to 1pm on Saturday and Sundays. Outside of these hours there was a consultant on call. The labour ward was always staffed by a senior trainee doctor (ST 4 to 7) or a trust grade obstetrician as well as a junior trainee (ST1 to 3). In addition there was a consultant obstetrician rostered to carry out the elective caesarean section list every day.
- Anaesthetic consultant cover was available 24 hours a day, seven days a week. Duty on call rotas were accessible for all staff.
- The 'Safer Childbirth' report, which was published in 2007 by the Royal College of Obstetricians and Gynaecologist Guidelines (RCOG), set out the requirement for consultant presence on the labour wards. The provision of additional consultant time on the labour ward was to ensure that doctors in training are fully supported to develop skills in the management of a labour ward and to maximise training opportunities. The RCOG state that consultant presence on the labour ward should only include the time when the consultant has no other commitments and can therefore utilise the time completely to support the trainees.
- In line with the majority of maternity units across the country, the hospital had not been able to provide the level of consultant presence recommended in the 2007 RCOG report. Based on the number of deliveries, the hospital should have been providing 98 hours of consultant presence on the labour ward per week but were providing 64 hours. Outside of these hours, there was a consultant obstetrician on call able to attend labour ward at short notice.

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- We saw that the planned and actual consultant rota provided 64 hours consultant presence per week on the delivery ward. No locum staff were being used at the time of inspection. The service had effective locum induction processes in place for use when required.
- The report 'Providing Quality Care for Women, Obstetrics and Gynaecology Workforce' published in November 2016 by the RCOG provided an update to the guidance with the 'Safer Childbirth' report. It recognised that there was huge variability of service provision around the country in terms of workload complexity, geography and current middle grade staffing and for this reason the report concluded there was no single staffing model which was suitable for all UK units. The report also stated that 'it is no longer possible to make recommendations about hours of consultant presence on the labour ward based on number of deliveries because of the diversity of consultant contracts and working practices'.
- The 12 recommendations from this report had been reviewed by the department and the plan was to split the obstetrics and gynaecology rota and employ four new consultant obstetricians.
- There was a consultant-led hospital antenatal clinic which ran every week day morning and a maternity day unit (MDU) for outpatient antenatal assessment which ran seven days a week. Midwife led scan clinics operated within the antenatal clinic/MDU.
- We observed one medical handover, which was thorough. Patient care was discussed and discharges planned. The doctor leading the handover worked systematically through the current patients and included discussions regarding women who were on the antenatal ward who may later require care on the delivery suite. For example, inductions of labour, raised blood pressure at term, planned caesarean section, and those in early labour.

## Major incident awareness and training

- The service had effective contingency plans for major incidents affecting maternity and gynaecology services, which covered staffing and closure of the unit. All staff were aware of these plans. Staff were aware of the procedures for managing major incidents and fire safety incidents.
- Potential risks were taken into account when planning services, for example, seasonal fluctuations in demand, the impact of adverse weather, or disruption to staffing

- Between August 2016 and June 2017, the maternity unit was closed once due to being full with no available beds. We saw that the service had effective escalation plans in place with other local acute NHS trusts.
- There were arrangements in place should maternity services be suspended. These were outlined in the escalation policy.
- Appropriate systems were in place regarding fire safety with essential checks having been carried out on all fire system equipment. Staff were aware of evacuation plans in event of a fire. At the time of inspection, compliance with fire safety refresher training was 81% for doctors and 80% for nurses, which was below the trust target of 85%. We saw that managers had plans in place to provide additional training sessions.

## Are maternity and gynaecology services effective?

Good



We rated effective as good because:

- Policies were based on national guidance produced by National Institute for Health and Care Excellence (NICE) and the royal colleges.
- Pain of individual women was assessed and managed appropriately.
- Patients' outcomes were being measured and were generally in line with national average. Action plans were in place to drive improvements.
- There were systems and processes in place to ensure that staff had the necessary qualifications, skills, knowledge and competencies to do their jobs.
- Effective multidisciplinary working was clearly evident throughout the department.
- There were appropriate processes and systems in place to ensure that information needed to deliver care and treatment was available to relevant staff in a timely manner.
- Patient's consent was obtained in line with trust policy and statutory requirements.

However:

- Perinatal mortality rates were higher than the national average over time. The service had detailed actions plans and service improvement plans to improve this.



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- The trust had historically had a high caesarean section rate and was consistently higher than national average for many years. We saw detailed action plans were in place regarding the rise in caesarean section rates.

## Evidence-based care and treatment

- Policies were based on national guidance produced by National Institute for Health and Care Excellence (NICE) and the royal colleges. Staff had access to guidance, policies and procedures via the hospital intranet.
- Antenatal, intrapartum and postnatal care was provided in line with NICE quality standards (QS) based on the notes we saw and the policies we reviewed within the service reflected these guidelines.
- The care of women using the maternity services was in line with Royal College of Obstetricians and Gynaecologist Guidelines (RCOG) including 'Safer Childbirth: minimum standards for the organisation and delivery of care in labour' (2007). These standards set out guidance for the organisation, which included safe staffing levels, staff roles and education, training and professional development, and the facilities and equipment to support the service. The service had monthly meetings to review perinatal and maternal mortality and morbidity, any equipment recommended by the safer childbirth document and to ensure the mandatory training provided by the service met with the recommendations.
- Care was provided in line with the NICE Quality Standard 22. This quality standard covers the antenatal care of all pregnant women up to 42 weeks of pregnancy, in all settings that provide routine antenatal care, including primary, community and hospital-based care.
- Women were cared for in accordance with NICE Quality Standard 190 Intrapartum care. This included having a choice as to where to have their baby, care throughout their labour, monitoring during labour and care of the new born baby.
- Care of women who planned for or needed a caesarean section was managed in accordance with NICE Quality Standard 132.
- NICE Quality Standard 37 guidance was adhered to in respect to postnatal care. This included the care and support that every woman, their baby and, as

appropriate, their partner and family should expect to receive during the postnatal period. For example, on the post-natal ward staff supported women with breast feeding and caring for their baby prior to discharge.

- Care was provided in line with the NICE guideline (CG110) 'Pregnancy and complex social factors: A model for service provision for pregnant women with complex social factors'. This guideline covers the care of vulnerable women including teenagers, substance misuse, asylum seekers and those subject to domestic abuse.
- Blood was tested at the initial assessment to determine Rhesus factor and Anti-D immunoglobulin administered to women who were found to be rhesus negative in line with best practice.
- Choice was offered in line with RCOG Evidence-based Clinical Guideline Number 7: The Care of Women Requesting Induced Abortion. Following consultation in a designated termination of pregnancy clinic, women could choose to have early medical abortion (EMA), late medical abortion or surgical treatment under general anaesthetic.
- RCOG Clinical guideline No. 7 advises that information about the prevention of sexually transmitted infections (STIs) should be made available. All women were tested for chlamydia infection prior to any treatment (chlamydia is a sexually transmitted bacterial infection). Women with positive test results were referred to sexual health services. Women were also referred to sexual health services for further screening for other STIs and treatment.

## Pain relief

- Pain of individual women was assessed and managed appropriately. Women on both the maternity and gynaecology wards told us that their pain and administration of pain relieving medicines had been well managed.
- We observed staff discussing pain management with patients and saw from patient records that actions had been taken to assist with patient comfort.
- Pain relief was managed in line with NICE CG190: 'Recommendations for non-regional and regional pain relief during labour'.
- The service was compliant with the Faculty of Pain Medicine's Core Standards for Pain Management (2015) acute pain management guidelines.

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- On the maternity ward, we saw a variety of pain relief methods available including TENS (transcutaneous electrical nerve stimulation) machines and a medical gas mixture of 50% nitrous oxide and 50% oxygen that provides short term pain relief.
- Epidurals were available 24 hours a day and were in line with the Association of Anaesthetists of Great Britain and Ireland (AAGBI) guidance.
- The service complied with RCOG guidance “The care of women requesting induced abortion” and offered pain relief during surgical and medical abortion.
- Pain levels were routinely assessed during the completion of patient observations and were recorded on patients’ modified early obstetrics warning score (MEOWS) charts. We looked at six patients’ MEOWS records and found all pain assessments were completed accurately.

## Nutrition and hydration

- Women said they received support and advice for breastfeeding their babies. On this inspection. The initiation of breast feeding rate was 78% between April 2017 and June 2017, which was in line the national average of 77% and above the trust target of 75%.
- The hospital had received the UNICEF (United Nations Children’s Fund) Baby Friendly Initiative accreditation for its maternity department. The Baby Friendly Initiative, set up by UNICEF and the World Health Organisation, is a global programme which provides a practical and effective way for health services to improve the care provided for all mothers and babies. The Baby Friendly award is given to hospitals that are deemed to have best practice standards in place to strengthen mother-baby relationships and to support mothers who chose to breastfeed.
- All maternity staff including midwives, obstetricians, maternity support workers and healthcare assistants had completed recognised breast feeding training
- Adequate arrangements were in place to ensure women and their babies received nutrition and hydration.

## Patient outcomes

- In the year from January 2016 to December 2016, there were 4,539 deliveries. The number of normal deliveries (non-assisted) was 2,735 at 60% of the total number of deliveries. This was in line with England average.
- The trust historically had a high caesarean section rate and was consistently higher than national average for

many years. This issue was raised some years ago through refreshed governance processes, and the maternity services had put significant time and effort into understanding the reasons for this. Actions had been put into place to ensure that women and babies received safe, appropriate, evidenced based care, which was not only based on national guidance but on their individual specific needs. The data seen demonstrated that the actions implemented were having an effect on the caesarean section rates and in 2015 to 2016, for the first time in over 10 years; the trust’s caesarean section rates were consistent with the national figures.

- Between January 2016 and December 2016, the total number of caesarean sections was similar to expected. The standardised caesarean section rates for elective sections were similar to expected and rates for emergency sections were also similar to expected. The service’s total caesarean section rate for 2015 to 2016 was 28% against the national rate of 27% and the Midlands and East of England Commissioning region’s rate of 27.5%.
- Between January 2016 and December 2016, the proportions of deliveries recorded by method in comparison to the England average were:
  - There were 592 elective caesarean deliveries in this period, at 13% of all deliveries which was in line with the England average of 12%.
  - There were 690 emergency caesarean deliveries in this period, at 15% of all deliveries which was the same as the England average of 15%.
  - There were nine breech deliveries in this period at 0.2%, marginally better than the England average of 0.4%
  - There were 321 forceps deliveries in this period at 7%, higher than the England average of 4%.
  - There were 180 ventouse deliveries at 4%, in line with the England average of 5%.
- The maternity dashboard for the first quarter from April to June 2017 showed:
  - Normal births were 62% of all deliveries.
  - Instrumental births for first time mothers was 22%, better than the trust target of 24%.
  - Instrumental births for second time mothers was 3%, better than the trust target of 7%.
  - Elective caesarean rates for first time mothers was 3%, in line with the trust target of 3%.
  - Elective caesarean rates for second time mothers was 19%, higher than the trust target of 13%.



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- Emergency caesarean rates for first time mothers was 20%, higher than the trust target of 11%. This was also higher than the national average of 11%.
- Emergency caesarean rates for second time mothers was 5%, higher than the trust target of 3%. This was also higher than the national average of 3%.
- We saw detailed action plans were in place regarding the rise in caesarean section rates.
- In the trust's quality governance committee maternity assurance report in March 2017, there was an occurrence of less than 6% per month for all third and/or fourth degree tears, slightly higher than the national average of 5%.
- From the maternity dashboard for April 2017 to June 2017, the percentage of first time mothers experiencing third or fourth degree tears was 2.6%, better than the trust target of 4.1%. The percentage of second time mothers experiencing third or fourth degree tears was 0.8%, better than the trust target of 1.5%.
- In the 2015 National Neonatal Audit Northampton General Hospital's performance was as follows:
  - For the audit measure of whether all babies of less than 28 weeks gestation have their temperature taken within an hour of birth, there were 39 babies born at before 32 weeks included in this audit. 82% of these babies had their temperature measured within an hour of birth; this was below the national average, where 93% of eligible babies had their temperature measured within an hour of birth.
  - For the audit measure for all mothers who deliver babies between 24 and 34 weeks gestation inclusive given any dose of antenatal steroids, there were 94 eligible mothers identified for inclusion in this audit. 89% of these mothers were given a complete or incomplete course of antenatal steroids; this was above the national average, where 85% of eligible mothers were given at least one dose of antenatal steroids.
  - For the audit measure for what proportion of babies of less than 33 weeks gestation at birth were receiving any of their own mother's milk at discharge to home from a neonatal unit, there were 40 babies born at less than 33 weeks who met the criteria for inclusion in the audit. 71% of these babies were receiving mother's milk exclusively, or as part of their feeding at the time of their discharge from the neonatal unit; this was above the national average, where 58% of eligible babies were receiving any mother's milk at the time of their discharge from neonatal care.
- As of June 2017 the trust reported no active maternity outliers.
- The trust took part in the 2014 'Maternal, Newborn and Infant Clinical Outcome Review Programme' (MBRRACE Audit) and the stabilised and risk-adjusted extended perinatal mortality rate (per 1,000 births) was up to 10% higher than the average for the comparator group. The comparator group was 4,000 or more births per annum at 24 weeks or later.
- The service had produced a detailed action plan to address the findings of the second MBRRACE audit, published in 2016. The 4,376 births in 2014 that were including in this audit put the hospital in the middle third of all trusts and health boards in the UK.
  - The mothers giving birth in the trust lived in areas of similar deprivation to those giving birth across the UK as a whole.
  - The proportion of babies of black or black British ethnicity was higher than that of the UK as a whole: 6.8% vs 4.4%. Mortality rates were higher in these groups of babies overall.
  - 10 babies (0.2%) were born at 24-27 weeks gestation, lower than the 0.4% seen in the UK as a whole.
  - However the percentage of babies born at 28 to 31 weeks gestation was similar: 1.1% vs 0.9%, as was the percentage of babies born post term (42 weeks or greater).
  - Eight neonatal deaths were reported (six within NGH and two in other trusts) in this second audit. The stabilised and adjusted mortality rate has been compared with other trusts and health boards in the 4000 or more births comparator group and had been found to be more than 10% higher than the average for the group.
  - A post mortem was offered for 100% of stillbirths and neonatal deaths compared with 96% and 91% UK wide.
  - The number of births at 22 and 23 weeks gestation stage reported by the trust but not included in this report was similar to what would be expected by the number of births.
- The third MBRRACE audit was published in June 2017. This looked at UK perinatal deaths for births from January to December 2015. The service was in the

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process of reviewing the audit outcomes and reviewing its action plan based on the previous audits. The stabilised and risk-adjusted extended perinatal mortality rate (per 1,000 births) was again up to 10% higher than the average for the comparator group.

- This third MBRRACE report reflected the service had a higher than average perinatal mortality over a period of time. The service had analysed the findings of this report and carried out detailed case reviews to understand these outcomes. We were provided with comprehensive actions plans that showed the range of actions the service was taking to improve outcomes for all patients. The service had incorporated the MMBRACE findings into its Maternity Safety Improvement Plan and Saving Babies Lives Action Plan. We saw the following actions had been taken:
  - A multi-disciplinary detailed local review was held in July 2017 to try to assess the deaths that were potentially avoidable and investigate local factors that might explain the rates being reported. Three areas of focus were identified:
    - Overall reporting system: what the service reported, the level of report, who the service reported to.
    - Relationship between neonatal and obstetrics teams with more MDT working and joint review of cases.
    - Intrapartum management with regards to recognition of the stages of labour and recognition of deviations from planned care and potential outcomes.
    - To review training needs analysis of staff in the service.
  - Other actions taken included:
    - A review of reporting system had taken place and the clinical quality and safety midwife was the main point of contact with MBRRACE to ensure robust, consistent and clear reporting. The service was awaiting the national tool for reporting this data which was due for general release to trusts later in the year.
    - A working group had been developed to improve communication and development of a service improvement plan between the maternity and neonatal services.
    - The service was to carry out a review of intrapartum monitoring in conjunction with the East Midlands Clinical Network.

- In the trust's quality governance committee maternity assurance report in March 2017, the service's unplanned readmission to hospital for mother within 42 days of deliveries (for normal vaginal deliveries) was 2%, in line with the national average.
- One patient was admitted to intensive care from the maternity service in the period from April 2017 to June 2017.
- The gynaecology ward was monitoring outcomes via the nurse sensitive indicators reporting to the ward dashboard and generally met the services' targets in terms of quality and safety.

## Competent staff

- There were systems and processes in place to ensure that staff had the necessary qualifications, skills, knowledge and competencies to do their jobs. There were systems in place to enable staff to take on new responsibilities and on a continual basis.
- At the time of our inspection, 96% of midwifery and nursing staff and all administrative and clerical staff had up to date appraisals against a trust target of 85%. Midwives and nursing told us that their appraisals gave them an opportunity to discuss their individual training needs and the requirements of the department.
- The induction programme for new permanent staff and students included mandatory training and competency based ward skills. New staff were inducted to the clinical area.
- Student midwives spoke highly of their mentors and felt well supported. Newly registered nursing staff were supported through the preceptorship programme, which offered role specific training and support.
- Developing and supporting midwives and maternity support workers (MSW) practice was fundamental to the safe delivery of care to our women and their babies. With a newly qualified midwife, this began with a preceptorship programme lasting a year to facilitate their transition from a band 5 to a band 6. The programme was based on an existing competency framework. The programme was reviewed yearly and competencies changed or added in relation to current professional practice. The midwives were given support and guidance by the practice development midwives and their mentors in all clinical areas to undertake this new role and its responsibilities.
- All newly appointed midwives had a bespoke induction programme including all mandatory, role specific and

# Maternity and gynaecology

maternity specific training. They are given an individual training record which identified how to access all their training needs and space to document dates of attendance which was presented at their yearly appraisals to evidence greater than 85% training compliance.

- The maternity practice development team worked closely with the trust practice development team and met monthly to discuss current themes. They also worked alongside the trust's training and development team and the resuscitation department to incorporate elements of mandatory and role specific training into two midwifery training days per month. All training days were facilitated by midwives and doctors who were practising in their area of their speciality demonstrating clinical credibility.
- Staff received supervision when required. The service recorded training and preceptorship as part of supervision for midwives and gynaecology nurses. Supervision occurred on an as required basis and was an on-going element of the appraisal process.
- Statutory midwifery supervision ended on 31 March 2017. At this time NHS England (NHSE) was yet to release guidance on what was to replace supervision. The service therefore used a bridging arrangement of five ex-supervisors of midwives (SOMs) who continued to provide non-statutory 'clinical supervision' for midwives until such time as NHSE guidance was released and the new employer-led model of supervision fully developed and implemented. Senior midwives had taken on the regulatory side of supervision. The service continued to provide access to a senior midwife for both women and midwifery support if needed. A plan and business case to support the new model of supervision was to be submitted for approval by the trust's board in September 2017.
- The service had monitoring processes in place to ensure that doctors were working within the General Medical Council (GMC) revalidation guidelines and would be able to revalidate in line with the scheduled date. Medical revalidation was introduced in 2012 to ensure that all doctors were up to date and 'fit to practice'. All of the consultants working in obstetrics and gynaecology departments had either been revalidated or were working towards revalidation in line with the timescale notified to them by the GMC.
- Nursing revalidation was supported by the hospital working within the nursing and midwifery council

guidelines and nurses would be able to revalidate in line with the scheduled date. Nursing staff told us they were given assistance and support to complete the appropriate reflective accounts, and training to complete this.

## Multidisciplinary working

- Effective multidisciplinary working was clearly evident throughout the department.
- Staff reported effective multi-disciplinary (MDT) working. Staff reported medical and nursing / midwifery staff worked very well together.
- We saw effective communication between consultants and midwives. Communication with community maternity teams was efficient.
- A multidisciplinary handover took place twice a day on the delivery suite and included an overview of all maternity and gynaecology patients.
- The handover also included discussion regarding women who were on the antenatal ward who may later require care on the delivery suite, for example: inductions of labour, raised blood pressure at term, planned caesarean sections and women in early labour.
- In the community, we were told of effective multidisciplinary teamwork between community midwives, health visitors, GPs and social services. The teams worked closely together, the community team told us they often provided cover for the hospital during peaks in activity.
- In the maternity records we reviewed, we saw detailed discharge letters to the mothers' GP informing them of the current medical situation for the mother and their baby.
- We observed the discharge arrangements made for patients accessing the termination of pregnancy (TOP) service, and saw detailed discharge letters and a review of contraception in all records reviewed
- The ward informed community midwives and GPs when a woman had suffered a pregnancy loss. They informed the obstetric office so that ongoing appointments could be cancelled.
- We saw patients were referred to specialist consultants internally and externally if their condition required specialist care.

## Seven-day services

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- Access to medical support was available seven days a week throughout the service. Consultant cover was provided seven days per week with on-call arrangements out of hours.
- Local diagnostic services were available daily with out of hour's facilities for emergency procedures such as x-ray, computerised tomography (CT), ultrasound sonography and pathology out of hours.
- Antenatal and postnatal services were available to community-based mothers in emergencies.
- All women could report to the hospital in an emergency by ringing through to the triage midwives.
- Community midwives were on call over a 24-hour period to facilitate home births.
- An anaesthetist was available for emergency work on the delivery suite 24 hours seven days a week.
- Staff received specific training in the relevant consent and decision-making requirements relating to the Mental Capacity act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS).
- The hospital had set procedures in place for assessing patient's capacity, whether they came into the hospital as an emergency or as a planned admission. Staff talked confidently about mental capacity assessments within the remit of their role.
- We saw the consent form was reviewed prior to surgical procedures, which was good practice. Nine records we looked at included signed consent forms. The five steps of the World Health Organisation checklist 'Five step to safer surgery' had been followed.
- We observed patients giving verbal consent before staff provided care or treatment.
- Women we spoke with in the maternity and gynaecology services, including TOP, told us staff always asked for permission before providing care.
- Staff told us that MCA training was an on-going process within the department and we saw that there were specific sessions planned as part of the annual training programme.
- All staff were able to describe instances when they would use 'best interest decisions' in line with legislation if the patient lacked capacity.
- Staff demonstrated how Gillick competence and Fraser guidelines related to the consent process in their practice. Gillick competency and Fraser guidelines refer to children (under 16 years of age) and as to whether they are able to consent to their own medical treatment, without the need for parental permission or knowledge.
- Completion of certificates for terminations, in line with the Abortion Act (1967) and Abortion Regulations (1991), was carried out by two clinicians, which was in line with the legislation. We saw this was completed in the five sets of TOP notes we reviewed. The abortion notification forms (HSA4) for termination of pregnancy were recorded within a designated HSA4 sent log book. Patient numbers corresponded with the serial number and the date sent. This was kept with all the TOP documentation in a secure location on the ward.

## Access to information

- There were appropriate processes and systems in place to ensure that information needed to deliver care and treatment was available to relevant staff in a timely manner.
- Intranet and e-mail systems were available for all staff, which enabled them to keep pace with changes and developments elsewhere in the service, and access guides, policies and procedures to assist in their specific role.
- Midwives told us and from looking at records that information from community and antenatal clinic appointments were available to women.
- Women's medical and obstetric history was recorded for staff to consider when there were concerns about pregnancy, labour and during the postnatal period.
- We were told information needed to deliver effective care and treatment such as care and risk assessments such as diabetes, pre-eclampsia, high body mass index and venous thromboembolism (when a blood clot breaks loose and travels in the blood), care plans, case notes and test results were accessible.
- Information was passed on efficiently during transition from one ward or service to another.
- GP's were sent discharge letters with all relevant patients' information, in a timely way.

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

- Patient's consent was obtained in line with hospital policy and statutory requirements.

## Are maternity and gynaecology services caring?

# Maternity and gynaecology

Good



We rated the service as good for caring because:

- All women and those close to them were extremely positive about the care and treatment they had received.
- Staff were very kind and caring towards patients on all interactions we observed.
- The Friends and Family Test results were better than the England averages and were improving.
- All women said they were involved in their birthing plans and their choices were listened to and respected.
- All women told us that they had felt involved in their care and treatment. We saw that all patients were kept informed about the treatment plans at all times.
- All women told us that they were happy with the care they had received and spoke very positively about the staff that were caring for them.
- There was excellent support for those who had suffered bereavement from the specialist midwife.

## Compassionate care

- Women and those close to them were extremely positive about the care and treatment they had received. Staff were very kind and caring towards patients on all interactions we observed.
- We spoke with six mothers post-delivery, one woman attending an antenatal clinic, two women on the antenatal ward, three gynaecology patients, five partners and five visiting relatives. Feedback from women and their partners was extremely positive.
- All patients and partners in all areas of maternity and gynaecology described staff as “friendly and helpful.”
- We observed all staff respecting the privacy and dignity of women at all times during the inspection. We observed staff knocking on doors, politely asking before opening curtains and waiting to be invited into rooms and cubicles. We saw constant positive interactions by staff who were kind and caring to both patients and their families.
- Thank you cards were displayed on the labour ward walls commending the friendliness, supportiveness and professionalism of staff.
- The CQC maternity survey of December 2015 surveyed women who gave birth in February 2015. A total of 170

women returned a completed questionnaire for Northampton General Hospital. Results showed that the hospital performed about the same as other trusts in all questions. This included being kind and understanding, being treated with respect and dignity and for having confidence and trust in the staff caring for them during labour and birth.

- Between July 2016 and June 2017, the hospital’s maternity Friends and Family Test (FFT) performance (% recommended) was better than the England average in all four areas of maternity. The Friends and Family Test (FFT) is a survey which gives patients an opportunity to give feedback on the quality of the care they receive. This gives hospitals a better understanding of their patients’ needs, enabling them to make improvements.
- In June 2017, the service’s performance was:
  - The hospital scored 95% for antenatal care and for birth experience, which was in line as the England average.
  - Postnatal care was better than the England average. The hospital scored 98% compared to a national average of 93%.
  - Postnatal care in the community was better than the national average. The hospital scored 99% compared to the England average of 98%.
- The FFT score for the gynaecology service in June 2017 was 87% of patients recommending this service, which was below the national average of 95%.

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

- All women told us that they had felt involved in their care and treatment. We saw that all women were kept informed about the treatment plans at all times.
- All women knew which doctor was looking after them and what treatment plans were being carried out.
- Staff spoke passionately about the importance of keeping patients informed of plans for care and treatment.
- All women were involved in their choice of birth at booking and throughout the antenatal period. This was especially the case for women who had a complicated pregnancy, for example those who had diabetes, hypertension or were at risk of pre-term birth. Women we spoke with said they were well informed and involved in their care; they understood the choices open to them and were given options of where and when to have their baby safely.



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- Staff said, and women confirmed, that birth options were discussed at booking and during the antenatal period. Matrons, midwives and the consultant team were involved in agreeing plans of care for women making choices outside of recommended guidance, for example requesting homebirth with either a current or previous high risk pregnancy or an elective caesarean section. The team clearly focused on supporting women's choices of birth while ensuring they were making fully informed choices
- All partners said they felt involved in the care and treatment of their partner and felt able to ask questions. A partner of a woman commented, "All staff we were involved with made me feel part of a team to safely deliver our baby." A pregnant woman explained how she had regular check-ups throughout her pregnancy and confirmed how her partner was always involved in conversations at her consultations.
- Staff in gynaecology recognised the individual needs of women. Women commented that they always felt able to approach staff with questions. A relative of a patient said the family and patient had felt comfortable discussing the woman's mental health needs with staff. We were told "staff in all areas of the hospital were brilliant. I can't praise them enough for the care they have shown (patient) from start to finish of her pregnancy".

## Emotional support

- A specialist midwifery team supported women with learning disabilities and mental health needs. Staff said that the team's involvement would be made clear in the notes of women so all staff would be aware and sensitive to the patient's needs.
- A bereavement midwife sensitively supported bereaved women and their partners. The bereavement midwife would follow up the care of every woman with a telephone call to ensure they had the right support arranged in the community.
- The service did not have a specific counselling service but the bereavement midwife provided information on local counselling services and helped to make initial appointments. The bereavement midwife also provided emotional support for patients from the early pregnancy unit who had suffered a loss and those who had had a late miscarriage or termination of pregnancy.

- Staff had awareness of patients with complex needs and when to provide them with additional support to minimise the potential of them becoming anxious or distressed.
- Staff signposted patients and relatives to appropriate external organisations and charities when required.

## Are maternity and gynaecology services responsive?

Good



We rated responsive as good because:

- The service worked effectively with a variety of stakeholders and commissioners to plan delivery of care and treatment and was a proactive partner in shaping community provision.
- Services had been planned to take into account the needs of different people, for example, on the grounds of age, disability, gender or religion.
- Care and treatment was only cancelled or delayed when absolutely necessary.
- Access to services was generally effective and timely.
- The service managed complaints swiftly, openly and constructive as part of a co-ordinated patient feedback system.

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

- The service worked effectively with a variety of stakeholders and commissioners to plan delivery of care and treatment and was a proactive partner in shaping community provision. This included local commissioners, GPs, local authorities, charities, other NHS trusts and local police.
- The needs of the local population were used to inform how services were delivered. For example, we saw that key demographics such as age and lifestyle factors were included in plans to inform their strategic plan.
- The maternity service met women's needs in the local community in accordance with the following NICE guidance:
  - QS22 statement 2: 'Pregnant women were cared for by a named midwife throughout their pregnancy'.

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- NICE CG 62: 'Antenatal care was readily and easily accessible to all pregnant women and was sensitive to the needs of individual women and the local community'.
  - There was a midwife led birthing unit (Barret Birth centre) at the hospital as well as the consultant-led delivery suite. Midwifery-led models of care were offered to women with an uncomplicated pregnancy as recommended by NICE CG 62.
  - As part of the directorate's two-year strategic plans, a number of initiatives were being developed with commissioners. For example, developing a hyperemesis bay in gynaecology day-case facility to prevent inpatient admissions, the antenatal service redesign to improve pathways and efficiency, formalising midwifery sonography service and formalising the midwifery 'Newborn and Infant Physical Examination Programme' (NIPE) service, and recruiting midwives to support transitional care pathways.
  - There was close collaboration with the local commissioners and other trusts to ensure future planning was linked with the Sustainability and Transformational Partnership (STP) for Northamptonshire. The NHS and local councils have formed partnerships in 44 areas covering all of England, to improve health and care. Each area has developed proposals built around the needs of the whole population in the area, not just those of individual organisations.
  - In line with 'Better Births' (2016), the NHS five year forward plan for maternity services, the community midwifery service was proactive in researching and sourcing a suitable local community venue. The local authority was approached with the proposal that the service took over the running of the local children's centre. This proposal was adopted and on 7 June 2017, the service, in active partnership with a local charity, launched the 'Family Health Hub', which ran every Wednesday. Midwives, health visitors and local commissioners, were working together to improve the health and wellbeing of families (specifically antenatal-pre-school) and bringing communities to life. Plans were to expand the service and increase the number of days it opened.
  - The service operated a 24-hour a day telephone triage service, staffed by midwives, who then alerted the delivery suite or Barret Birth centre of impending arrivals. Women were provided with the telephone number for the unit and could access it directly if they had any concerns during their pregnancy. A plan of action was agreed and the community midwife could visit the women at home as required.
  - Triage was carried out by midwives on the delivery suite in available cubicles so women with urgent health issues, such as pain, vaginal bleeding or suspected broken waters, could be assessed and reviewed on the delivery suite. Triage is the process of determining the priority of a pregnant woman's treatment based on the severity of their needs.
  - Post-natal follow up care was arranged as part of the discharge process with community midwives and, where necessary, doctors. The red book was issued on transfer to the postnatal ward and facilitated on-going care and monitoring of the baby until five years of age.
  - Between October 2015 and March 2017, the bed occupancy levels for maternity were generally higher than the England average, with the trust having 61% occupancy in January 2017 to March 2017 compared to the England average of 58%.
  - Community midwives carried out home assessments and home deliveries. There were 35 planned home deliveries in April 2017 to June 2017.
  - Care and treatment was only cancelled or delayed when absolutely necessary. If services were cancelled, reasons for cancellation were explained, and patients were supported to access care and treatment again as soon as possible.
  - During the inspection, we saw that during labour, all women were seen by a midwife within 30 minutes and that all women were seen by a consultant within 60 minutes.
  - In England, under the NHS Constitution, patients 'have the right to access certain services commissioned by NHS bodies within maximum waiting times, or for the NHS to take all reasonable steps to offer a range of suitable alternative providers if this is not possible'. Referral to treatment time (RTT) for admitted pathways are the waiting times for patients whose treatment started during the month as an inpatient or day case. The waiting time starts from the point the hospital or service receives a referral. The data shows how long a patient has waited before their treatment began.
- Access and flow**
- Women could access the maternity services via their GP or by contacting the community midwives directly.



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- For the gynaecology service, the RTT performance, for patients on an incomplete pathway for May 2017 was 90%, slightly below the national performance measure of 92%. There were no patients waiting over 52 weeks for treatment.
- For June 2017, the gynaecology department had met the referral to treatment target for
  - Maximum waiting time of two weeks from urgent GP referral to first outpatient appointment for all urgent suspect cancer referrals. The service had achieved 97% against the target of 93%.
  - 31 day wait for second or subsequent treatment anti-cancer drug treatments. The hospital had achieved 100% against the target of 93%.
  - 62 day wait for first treatment from urgent GP referral to treatment for all cancers. The hospital had achieved 78% against the target of 85%. Senior managers told us that with the introduction in October 2016 of the inter provider transfer guidance, the trust received referrals for patients on this pathway from two other local NHS trusts. If those trusts did not transfer those patients in a timely way, this could lead to a breach of the standard. However, this was not reported yet nationally as the software to do this had been delayed.
- The trust had a detailed action plan in place regarding its overall performance to meet these cancer standards.
- For June 2017, the percentage of women not attending outpatients' appointments in the service was 7.6%, above the trust target of 5%.
- For June 2017, the service's outpatient clinic cancellation rate was 1.2%, which was in line with the trust target of 1%.
- The number of cancelled operations due to clinical reasons in the service was an average of seven per month from April 2017 to June 2017.
- The number of cancelled operations due to non-clinical reasons in the service was an average of nine per month from April 2017 to June 2017.
- There was one case of a patient not treated within 28 days of a last minute cancellations for non-clinical reasons in the three months of April 2017 to June 2017.
- The service reported no mixed sex breaches reported in the period from April 2017 to June 2017.
- The length of stay in the service for June 2017 was 1.4 days, which was below the trust target of 4.2 days.
- Services had been planned to take into account the needs of different patients, for example, on the grounds of age, disability, gender, or religion.
- The maternity service had arrangements in place to support women who had complex needs, with access to clinical specialists and medical expertise. This included appropriate support from patients from diverse backgrounds.
- Booked appointments were generally held at clinics within the local community but alternative arrangements could be made to meet women's individual needs, such as home visits.
- Women were offered information so they could make an informed choice about where to give birth depending on clinical need. The maternity service offered home birth; the maternity led birthing unit or obstetric led care on the delivery suite. Four birthing pools were available in Barratt Birth centre for women who wished to use water immersion for pain relief in labour.
- Antenatal and community midwifery services were provided by five geographically based teams.
- The Snowdrop Room on Sturtridge Labour Ward provided an ensuite area with access to a small garden which was used by women and their families who have suffered a pregnancy/baby loss. This had a separate entrance so women did not have to walk through the labour ward.
- The service had a consultant-led hospital antenatal clinic which ran every week day morning and a maternity day unit (MDU) for outpatient antenatal assessment which runs seven days a week. Midwife led scan clinics operated within the antenatal clinic/MDU.
- There were effective processes for screening for fetal abnormality. Women identified with a high risk of fetal abnormality, such as Down's syndrome, were invited into the clinic for on-going treatment and referral to specialist centres if appropriate.
- The service met NICE CG 62 guidance, in that information was given in a form that was easy to understand and accessible to pregnant women with additional needs, such as physical, sensory or learning disabilities, and to pregnant women who did not speak or read English.
- A variety of patient information leaflets were available on the maternity and gynaecology wards for example; information on treatment procedures such as colposcopy (a colposcopy is a procedure to find out whether there are abnormal cells on or in a woman's

## Meeting people's individual needs

# Maternity and gynaecology

cervix or vagina), perineal repair, dilatation and curettage (D&C) and on conditions such as pelvic pain, urogynaecology (surgical and non-surgical treatment of pelvic floor disorders), prolapse vulval (become weak and collapse inwards), perineal lesions (lesions around the anus in a woman who is pregnant) and recurrent miscarriages.

- The information provided was generally in English although staff told us all information could easily be provided in other languages.
- Women, patients and their relatives had access to a chapel and multi faith room on site.
- Hearing loop facilities were available throughout the hospital.
- Some of the information leaflets available were about what to do following the death of a baby, the birth registration following a stillbirth, baby memorial book and practical help and advice.
- The service had processes in place to support patients with a learning disability. This included a flagging on the electronic patient record system and a 'passport' that highlighted the patient's specific communication needs and preferences.
- There was a dedicated bereavement room for women who had experienced a stillbirth. Cold cots were available which meant that babies could stay longer with parents. A cold cot is a specialised piece of equipment designed to keep the baby cool following a still birth. This enables the family to spend up to 72 hours with the baby.
- Staff provided women who had undergone termination of pregnancy (TOP) with an information leaflet about the disposal of pregnancy remains. Women were asked their preferred option for the dignified option of disposal. This ensured that women were given the opportunity of making informed individual choice. We saw completed documentation in TOP notes we viewed. There was guidance on the disposal of pregnancy remains following pregnancy loss or termination, which were in line with guidance provided by the Human Tissue Authority Guidance on the disposal of pregnancy remains following pregnancy loss or termination March 2015 and RCN guidance about managing disposal of pregnancy remains October 2015.

- Post-mortem examinations were offered in all cases of stillbirth and neonatal death in order to improve pregnancy counselling for parents. This was in line with Recommendation 4 of the MBRRACE UK findings (published on 10th June 2015).
- Women needing termination of pregnancy for fetal abnormality were cared for in labour by a bereavement midwife. This offered continuity of carer for the women if she wanted it.
- The hospital had a varied menu and catered to a wide range of nutritional and cultural needs.

## Learning from complaints and concerns

- The service managed complaints swiftly, openly and constructive as part of a co-ordinated patient feedback system. The department considered its handling of complaints to be fundamentally important in building its relationship with the public.
- There was clear guidance on display in all areas for those using the service to make a complaint or express their concerns.
- Complaints were managed in line with the hospital's policy and complainants received an acknowledgement within three days and an update on the investigation within 25 days. Actions taken included discussion of themes at staff handover and team meetings.
- Women we spoke with told us they knew how to make a complaint or raise concerns. They confirmed staff had explained the process.
- The service had had two complaints in the period from April 2017 to June 2017 and both had been investigated and responded in accordance with trust policies.

## Are maternity and gynaecology services well-led?

Good



We rated well-led as good because:

- The service leadership team was cohesive and inclusive and was focused on delivering safe, high quality care and treatment for all patients.
- We observed clear and effective leadership at a local level with wards and units being well managed and supported.

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- The trust had a clear and effective vision for maternity and gynaecology services to deliver high quality person-centred care, which staff were committed to.
- The focus on safe patient care was clearly evident in all areas and from all staff.
- There were effective and clear governance systems in place to escalate issues and risks to the service leaders and to the trust board.
- The service risk register reflected the risks within the service and there was evidence of ownership, mitigations having been implemented and ongoing monitoring.
- Staff believed in the leadership of the service and were proud of the organisation and its culture.
- The service was very proactive in supporting and engaging with all staff and patients.
- Staff within the service recognised the importance of gathering the views of patients and actively sought feedback to drive improvements in the service.

However:

- The service had had higher than expected caesarean rates and perinatal mortality rates over time. Whilst actions and mitigating actions had been taken, these had not always improved outcomes. The service continued to monitor and assess these potential risks to patients.

## Leadership of service

- Overall, the service's leadership team were established and experienced members of staff and staff described the leadership team as approachable, cohesive, and inclusive. The maternity service was led by associate director of midwifery and a clinical director. The gynaecology service was led by directorate manager and clinical director.
- We observed clear and effective leadership at a local level with wards and units being well managed. Local leaders demonstrated they understood the challenges to good quality care and had identified the actions needed to address them. The leadership teams were cohesive and inclusive and were focused on delivering safe, high quality care and treatment for all patients.
- There was a clear management and accountability structure in place for midwives and nurses, which included community midwifery. The service had a documented accountability structure. Midwifery leads

reported into the head of midwifery. Medical staff reported to the clinical director via the consultant obstetrician who was the medical clinical lead. They provided operational leadership.

- Senior midwifery and gynaecology management had direct access to the board. There was clear evidence to demonstrate information about how midwifery and gynaecology issues were taken to the board. We saw that midwifery issues discussed in board minutes so we were assured the board had oversight and understanding of all the issues affecting maternity and gynaecology service.

## Vision and strategy for this service

- The trust had a clear and effective vision and strategy for maternity and gynaecology services. The strategy recognised the increase in demand on the maternity service and incorporated plans for increased staffing, multidisciplinary working, as well as a range of initiatives to improve operational efficiency, clinical outcomes and patient experience.
- Each strategy objective had defined work streams with designated leads and individual action plans.
- Staff told us that the trust's values were important to ensure that the patient was at the centre of everything they did.

## Governance, risk management and quality measurement

- Governance and performance arrangements were proactively reviewed and adapted to take into account national best practice. There was a clear governance system in place and monthly meetings were held and these were well attended by staff at all levels.
- There was a holistic understanding of performance that integrated the needs of other areas in the trust and the needs of the community whilst focusing on patient safety and quality improvements within the service.
- The focus on safe patient care was clearly evident in all areas and from all staff.
- There was a positive culture towards reporting incidents and learning from these to improve patient safety in all areas inspected. Learning was effectively shared from incidents.
- There were effective and clear governance systems in place to escalate issues and risks to the service leaders and to the trust board. The effectiveness of these processes was consistent between wards and units.

# Maternity and gynaecology

- There were comprehensive systems in place to report and learn from risk with effective systems for identifying, capturing and managing issues and risks at team, ward and organisation level in the service.
- Significant issues that threatened the delivery of safe and effective care were generally identified, and risk management, including assessment, mitigating actions and effective review was demonstrated. The service had had higher than expected caesarean rates and perinatal mortality rates over time. Whilst actions and mitigating actions had been taken, these had not always improved outcomes. The service continued to monitor and assess these potential risks to patients.
- Potential risks to patient safety and the quality of care and treatment for all patients had been recognised and effective systems were embedded to maximise patient safety.
- Performance in national audits was used to drive improvements in services. The service had a clear audit programme in place to ensure it was continuously improving patient care. This programme was informed by national guidance, patterns of incidents and patient outcomes. Findings from audits were shared with staff through a variety of means, such as team meetings, safety huddles, and communication folders.
- The service risk register reflected the risks within the service and there was evidence of ownership, mitigations having been implemented and ongoing monitoring.
- The standard of the service risk register was consistent and we were assured that there was effective service ownership and scrutiny. There was a clear understanding between the risks and issues within the service and those that were on the trust board risk register. Action plans following serious incidents were completed and monitored effectively.
- We saw that 47 risks were on the service risk register and that all had clearly defined mitigating actions in place and had a named risk owner. Risks were reviewed regularly and the register updated.
- Each ward maintained a nursing quality and performance dashboard, designed in line with recommendations set out in the 'High Quality Care Metrics for Nursing' report (2012). Patient data was audited monthly against quality care indicators, which included falls/safety assessment, pressure prevention assessment, and patient observation and escalations. A traffic light system was used to flag performance against

agreed compliance thresholds. The data was reviewed monthly at the nursing and midwifery meetings and any red and amber areas were discussed and reviewed by the senior team.

- The medical, nursing and governance leads in the service had clearly defined roles and responsibilities.

## Culture within the service

- Staff spoke highly of the leadership of the service and were proud of the organisation and its culture.
- All staff were very positive about the leadership of the board and service senior managers. The level of staff support, respect and commitment to each other was clearly evident in all areas. Staff referred to the 'Team NGH' spirit and culture and were proud of this.
- Overall, almost all staff expressed high levels of satisfaction and were proud to work for the service and the trust.
- Staff reported feeling respected, valued, supported and appreciated.
- Multidisciplinary teams worked collaboratively and were focused on improving patient care and service provision.
- There was an understanding of the Duty of Candour amongst the staff, and the trust had a being open policy.
- We observed matrons attending wards and clinical areas constantly during the inspection to support staff, discuss activity and share any issues that had arisen.
- We saw that leaders encouraged supportive relationships among staff through developing 'buddy' programmes for new starters and encouraging shared learning amongst staff groups.
- The trust had embarked on a leadership training programme and some senior nursing and medical staff were taking part in the programme.

## Public engagement

- One of the service's aims was to work with patient groups and friends and family test (FFT) data to understand the needs of patients and improve the customer service aspect of care.
- Staff within all services recognised the importance of gathering the views of patients and actively sought feedback. We saw FFT questionnaires, and patient comment cards available in all areas we visited.
- Weekly 'meet the matrons' full day sessions were held, where any patients could make an appointment to meet staff and give feedback about the service. Posters to

# Maternity and gynaecology

inform patients and their relatives were on display in all areas visited. These meetings were set up with the aim of giving women a voice in the improvement of the service.

- Patient stories were shared at team meetings to help drive improvements throughout the service.
- The 'Chit Chat' group was set up by the service in 2016 to facilitate antenatal education, parenting advice and peer support for women with additional needs, including learning disabilities or anxiety. Staff said these meetings were two weekly and very well attended. This group meeting initiative had been nominated for two national awards and had won one at the time of the inspection.

## Staff engagement







- The service was very proactive in supporting and engaging with all staff.
- Staff told us of innovative ways that the service was using to facilitate staff raising ideas and solutions. Protected time was given to the project called 'pathway to excellence'.
- Staff told us they felt actively engaged and involved in the planning and delivering services.
- An example of this was the way that community midwives were instrumental in setting up the community 'Family Health Hub'.

- Staff described monthly ward meetings taking place. Minutes were available to staff who were unable to attend. Staff also received daily updates regarding any issues affecting the ward and/or trust at safety huddle meetings.

## Innovation, improvement and sustainability

- The service had an integral award winning home birth team (Birthplace Matters – Homebirth Team of the Year in 2016) who worked as part of the Birth Centre team offering antenatal care, labour and birth options at home.
- In addition, one of the Homebirth Team Midwives was runner up in the 'Birthplace Matters – Midwife of the Year' award in 2016.
- The maternity service reviewed and evaluated the provision of multi-disciplinary training when the service was chosen as one of the 10 pilot sites for enhancing patient safety. As part of the pilot, the service chose to concentrate on the fetal monitoring and team working and skills drills sections with the outcome that the service was able to deliver these training programmes completely internally (including Practical Obstetrics Multi-professional Training (PROMPT)).

# Services for children and young people

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

## Information about the service

Northampton General Hospital NHS Trust provides an integrated child health service to people living in Northampton and the surrounding areas. The service includes a level two neonatal care unit (Gosset ward), two paediatric wards (Disney and Paddington) with 34 beds and nine cubicles and a two-bedded high dependency unit (HDU). The paediatric assessment unit (PAU) is adjacent to the paediatric wards. A child development centre (CDC), children's outpatient unit, community paediatric and nursing services, audiology, physiotherapy and shared oncology are located on the main hospital site. Specialist nursing services are provided for HIV, cystic fibrosis, diabetes and epilepsy.

Paediatric wards include short stay surgery, shared care oncology, and a medical day ward undertaking tests and investigations. A school and activity centre was on Paddington ward. At time of visit there were a total of 45 beds in the service: 14 individual cubicles (two for oncology patients), 29 beds and two High Dependency Unit (HDU) beds.

Gosset ward is a level two unit with two Intensive Care Unit cots, four HDU cots and 14 special care cots.

Between February 2016 and January 2017, there were 10,450 total spells (admissions and day attendances) recorded for children and young people who accessed trust services.

During the inspection we visited the paediatric wards, PAU, theatres, outpatient services, specialist departments including the CDC. We visited a child in their home with the

community nursing service. We talked to 12 parents and children and 56 staff including consultant paediatricians, junior doctors, nurses, therapists, play specialists, domestic staff and managers. We observed interactions between staff, patients and parents. We reviewed 10 patient records and policies and procedures as well as other documentation as necessary. We received comments from people who contacted us to tell us about their experiences. Before our inspection, we reviewed performance information from, and about, the trust.



# Services for children and young people

## Summary of findings

We rated this service as good because:

- There was a well-embedded culture of incident reporting and staff said they received feedback and learning from incidents.
- Safety thermometer data from the last 12 months reported 100% of “harm free” care in the child health directorate.
- Staff followed best practice guidance for infection control to reduce the risk of infection through staff washing their hands, using personal protective equipment and following sterile techniques.
- There were clear arrangements in place to safeguard children and young people from abuse, which reflected relevant legislation and local requirements. The majority of staff had undertaken the required level of safeguarding training.
- Appropriate systems were in place to assess risk and to recognise and respond to the deteriorating patient.
- Patient’s care and treatment was planned and delivered in line with evidenced-based guidelines.
- The service performed well in a number of national audits including the National Neonatal Audit (2015) and the epilepsy 12 audit (2014). Gosset ward was to be the first neonatal unit in the country to achieve Bliss accreditation in September 2017.
- Staff had the clinical skills, knowledge, and experience they needed to carry out their roles effectively. Mandatory training and appraisal levels were above trust targets.
- Actual nurse staffing levels met planned rotas during our inspection and patient’s needs were met. Medical staffing was appropriate and there was an effective level of cover to meet patients’ needs.
- During our inspection, we observed care being delivered by nurses, play specialists, medical, therapy, and auxiliary staff that interacted with children and young people in a very positive and caring manner.
- Feedback from children and parents was consistently positive and parents told they were treated with dignity and respect.

- Services were responsive to the needs of patients, parents and families and were working towards delivering sustainable seven-day services.
- Staff felt that local leadership was strong with visible supportive and approachable managers.
- Staff felt supported and were able to raise issues and concerns and felt listened to.
- The child health directorate was continually developing patient services to ensure innovation, improvement, and sustainability.

However:

- There were not always effective systems in place regarding the storage and handling of medicines in the children’s outpatient department. The trust took immediate action to address this once we raised it as an urgent concern.
- Children or young people on Paddington ward could access the corridor to the delivery suite. This was particularly for patients who may be at risk of self-harm or suicide. The trust took immediate action to address this once we raised it as an urgent concern.
- The pathway for patients who needed to cross the road between buildings had not been reassessed to ensure opportunities to prevent or minimise further harm were not missed. The trust took immediate action to address this once we raised it as an urgent concern.
- The child abduction policy was in draft and awareness was lacking in some areas of the service. The trust took immediate action to address this once we raised it as an urgent concern.
- Paediatric wards did not have the appropriate facilities to care for the increasing number of patients with mental health issues who could be at risk of self-harm or suicide.
- Some staff reported a lack of a clear strategy for the children and young people’s service.



# Services for children and young people

## Are services for children and young people safe?

Good



We rated safe as good because:

- There was a well-embedded culture of incident reporting and staff said they received feedback and learning from incidents.
- Safety thermometer data from the last 12 months reported 100% of “harm free” care in the child health directorate.
- Staff followed best practice guidance for infection control to reduce the risk of infection through staff washing their hands, using personal protective equipment and following sterile techniques.
- Generally, appropriate systems for the handling and storage of medicines were in place.
- There were clear arrangements in place to safeguard children and young people from abuse, which reflected relevant legislation and local requirements. The majority of staff had undertaken the required level of safeguarding training.
- Mandatory training and appraisal levels were above trust targets.
- Individual care records were written in a way that kept people safe from avoidable harm.
- Appropriate systems were in place to assess risk and to recognise and respond to the deteriorating patient.
- Actual nurse staffing levels met planned rotas during our inspection and patient’s needs were met. Medical staffing was appropriate and there was an effective level of cover to meet patients’ needs.

However:

- There were not always effective systems in place regarding the storage and handling of medicines in the children’s outpatient department. The trust took immediate action to address this once we raised it with them.
- Allergy testing ampules in the children’s outpatient department were out of date, with the oldest going back to 2015. Proposed actions were put in place for the next

clinic; however, this raised concerns about the effectiveness of the tests for children who had been tested. Once we raised this as a concern, the trust took immediate action to address this.

- In the paediatric area, the corridor leading to the delivery suite presented a risk as children or young people could leave Paddington Ward and have unrestricted access to the delivery suite and consultants’ offices which had unattended rooms and equipment therein. The trust took immediate action to address this.
- Road calming measures were in place for surgical patients who needed to cross the road between buildings; however, risk assessments had not been reviewed since their implementation in 2012. The trust took immediate urgent action to address this.
- The child abduction policy was in draft and awareness of this was lacking in some areas of the service. The trust took immediate action to address this.

## Incidents

- Staff understood their responsibilities to report incidents and patients were informed when things went wrong. Incidents were reported and investigated and were subject to a high quality review by matrons in the children and young person’s service. Evidence of decisions and discussions at team meetings were consistent and learning outcomes were recorded on staff handover sheets.
- There were a total of 407 incidents in the directorate in the period July 2016 to June 2017. There were 353 incidents reported as “no harm” and 52 incidents had incurred “minimal harm” requiring extra observation or minor treatment to be undertaken.
- There were no never events in the period July 2016 to June 2017. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- The hospital used an electronic incident-reporting tool to record incidents. Staff were confident in the use of this system and told us they always reported incidents.
- Staff told us they were given feedback about incidents at daily handovers and in team meetings. Printed handover sheets contained information prompts following a patient incident. For example, staff were

# Services for children and young people

reminded to sign for medication prescribed for patients being discharge to home. Where incidents had incurred low (minimal harm) actions were identified to limit the risk of a further occurrence. Actions were monitored through divisional governance meetings and we saw this in minutes of the April 2017 meeting.

- Monthly paediatric/perinatal mortality and morbidity meetings were attended by medical staff as well as those presenting a case investigation. Discussions were held around each case presented. Learning was discussed at monthly divisional governance meetings.
- From November 2014, NHS providers were required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person.
- Staff understood what duty of candour meant and told us that they would share information with patients and their parents or carers following an incident. Staff had attended duty of candour training and a 'Duty of Candour guide for staff' was available on the wards. We observed in patient notes we reviewed a duty of candour sticker had been used. The sticker identified where a discussion (around the duty of candour) had taken place and documented in the patient's notes. Staff were aware of the thresholds for when duty of candour processes applied. None of the incidents reported had resulted in moderate or severe harm which are triggers for the Duty of Candour.

## Safety Thermometer

- Safety thermometer information was displayed on paediatric wards. The NHS safety thermometer allows teams to measure harm and the proportion of patients that are 'harm free' during a single working day. The trust monitored safety thermometer indicators including falls, pressure ulcers, nutrition, medication, safeguarding and MRSA and Clostridium difficile rates. Data was collected monthly and a quality dashboard was used to analyse key performance indicators.
- From April 2016 to April 2017, the percentage of patients receiving 'harm free' care in children's services was 100%. Data showed there were no falls, pressure ulcers

or hospital acquired infections. However, patient assessments were not always completed for falls, nutrition, medication and pressure ulcers. We saw actions plans in place to remedy this.

- The trust had a rigorous process for safety thermometer data collection, validation, and submission. Four sub-groups led by clinical experts for each category (of the safety thermometer) monitored progress and reviewed any lapses in care.
- All incidents of pressure damage were reported throughout the month via the electronic incident reporting tool. Every area with an incident attended a 'share and learn' forum. This enabled incidents to be analysed and plans developed for areas of improvement and future prevention.

## Cleanliness, infection control and hygiene

- Standards of cleanliness and hygiene were maintained in the paediatric areas we visited. We observed the paediatric wards and outpatients' department to be visibly clean and mainly clutter free.
- There were paper towels, liquid soap and pedal bins at each hand-washing basin. All taps were sensor operated. Antibacterial hand gel dispensers were at the entrance to all wards and departments. We observed staff were 'arms bare below the elbow' and wore personal protective equipment as required, which was available throughout the areas we visited.
- Monthly hand hygiene audits were undertaken in each clinical area: the paediatric wards had achieved 100% from April to June 2017.
- There had been no reported cases of MRSA or Clostridium difficile in the preceding 12 months.
- Paediatric wards had single rooms for looking after children and young people who had infections. Where children were barrier nursed, all relevant equipment was available outside the room. Information for parents and visitors was clearly displayed. We observed staff using antibacterial gels and wearing gloves and aprons when entering and leaving the room.
- Waste was appropriately segregated in clinical areas with separate colour coded arrangements for general waste, clinical waste and sharps, (needles). Bins were clearly marked and were pedal operated and within safe fill rates. However, the purpose built children's assessment unit (PAU) had limited toilet facilities and no clinical waste disposal area which could have posed a potential infection risk to people using the service.

# Services for children and young people

- We saw toys in the activity area and children's outpatients were cleaned in line with trust policy (weekly) and clearly documented.
- Cleaning schedules were clearly displayed in paediatric areas which identified the frequency of cleaning and documented when areas had been cleaned. Green stickers were placed on equipment to identify when equipment had been cleaned.
- All staff completed infection control training. Over 95% of staff had undertaken infection control training in the last 12 months. This was above the trust training target of 85%.

## Environment

- Access to paediatric wards were through a set of double doors controlled by an entry buzzer and swipe access and monitored using a CCTV security system. The system also controlled entry to Gosset and Paddington wards through a second door controlled by swipe access.
- Metal gates were in place at the entry and exit to Disney and Paddington wards to prevent younger children from exiting the ward when the door entry system was activated. When the double doors opened they took approximately 10 seconds to close which minimised the risk of 'tailgating'.
- Whilst the overall perimeter of the paediatric area was secure, the corridor (behind Disney ward) led to Paddington and Gosset ward and the maternity unit delivery suite. This presented a potential risk as patients had unrestricted access to the delivery suite with unattended rooms and equipment therein. We found the consultants' office (off the corridor) was open and not in line with trust policy. There were no risk assessments in place for this potential risk, particularly for children and young people with mental health concerns. The trust took immediate action to address this after we raised it as an urgent concern.
- We saw during our unannounced inspection that risk assessments had been completed and plans to provide additional staff swipe card access and CCTV to the corridor were in place. The plan was due to implemented during the week of the 22 August 2017.
- During the inspection, we reviewed information as to how the safety of patients with mental health issues was managed. Comprehensive risk assessments including environmental factors and associated risk management plans were in place for children and young people supported by the child and adolescent mental health service (CAMHS), and children at risk of self-harm behaviours.
- Risk assessments contained an environmental risk assessment and plan of care, including the appropriate level of observation and supervision required. Nurses had undertaken training on how to complete the self-harm assessment tool and had attended training on how to manage challenging behaviours. Ligature risk assessments had been undertaken and documented.
- Road calming measures had been put in place for the pathway for surgical patients (including children and young people) to cross the road between buildings; however, risk assessments had not been reviewed since their implementation in 2012. We were told of two 'near miss' incidents had been reported involving adult patients in 2016/17. The trust took immediate action to address this once we raised it as an urgent concern.
- We saw during our unannounced inspection on the 9 August 2017, a full review of the risk assessment had been completed to identify any risk to children in respect of adverse weather conditions and any risk to all patients, visitors, and staff with respect to the crossing and its locality. The divisional risk register was being updated. No incidents, complaints, or feedback had been received from children or parents (Friends & Family questionnaires) concerning the pathway for surgical patients.
- Staff were aware of the trust's 'Missing and Absconded Patients - Adults and Children policy' (2017). During our inspection a young person absconded from the ward. This was managed appropriately and in line with the "lockdown" arrangements and the young person was returned safely to the ward. 'Lockdown' arrangements are urgent safety process to ensure the ward is closed and all staff alerted to a missing person.
- At the time of our inspection, the specific child abduction policy was still in draft and awareness was lacking in some areas of the service. The trust took immediate action to address this once we raised it as a concern. On our unannounced inspection, we saw laminated flow charts on paediatric wards detailing staff actions in the event of child abduction, which related to the child abduction policy which was available on the trust intranet.
- On the paediatric wards, there was a lack of space around some bed areas and some cubicles were

# Services for children and young people

overcrowded. Staff made reasonable adjustments (reclining chairs for parents) but were unable to provide sufficient facilities for parents to stay overnight. Environmental issues were recorded on the directorate risk register.

- The patient assessment unit for children (PAU) was purpose built, child friendly and welcoming to children and their families. There was a good selection of toys and diversional equipment and parents told us the area was 'brilliant' and provided an 'excellent' service.
- Children's outpatient services were provided in a recently adapted environment designed to meet the needs of children and young people.

## Equipment

- Patient equipment was clean and regularly checked and was within required service dates.
- Staff told us equipment repairs were undertaken promptly and equipment failures immediately addressed. This meant that risks to children from unsuitable equipment were reduced.
- Nurses told us they had appropriate and sufficient equipment to provide safe care to children and babies.
- The trust risk register showed that equipment was monitored to show it was fit for purpose.
- Resuscitation trolleys were tamper-evident and were checked daily, which was clearly documented in each clinical area.

## Medicines

- Generally, there were suitable arrangements in place for the management of medicines, which included the safe ordering, prescribing, dispensing, recording, handling and storage of medicines. However, in children's outpatients, we found 30 allergy-testing ampules were out of date, the oldest going back to 2015. Staff made us aware of the proposed actions for the next clinic; however, we had concerns about the effectiveness of the tests for children and young people who have already been tested. The trust took immediate action to address this once we had raised it as a concern.
- At our unannounced inspection, we saw that a clinical notes review of children who had undergone allergy testing since December 2015 had commenced and would be completed by the end of August 2017. The allergy testing procedure had been revised to ensure routine checking of expiry dates were part of the

process. Pharmacy planned to include the checking of allergy testing ampules in their organisational reviews. A review had been undertaken to check expiry dates of all medicines stored in outpatient areas.

- On Paddington ward, the storage of intravenous fluids was not secured in the high dependency unit (HDU) which could pose potential a risk to the safe care of children and young people. This was raised at the time of the inspection and the intravenous fluids were immediately secured.
- Medicines were securely stored on paediatric wards, and in children's outpatients. Controlled drugs on wards were stored securely and in accordance with required legislation.
- A controlled drug (CD) register was used to record the details of the CDs received, administered as well as CDs that had been disposed. Some prescription medicines are controlled under the Misuse of Drugs legislation (and subsequent amendments). These medicines are called controlled medicines or controlled drugs. Stricter legal controls apply to controlled medicines to prevent them being misused, being obtained illegally and causing harm.
- Room and fridge temperatures were checked and were within the required temperature range and checks had been performed consistently in paediatric areas.
- The pharmacy service had developed a medicines' guidance booklet to support clinicians in the prescribing of medicines for neonatal patients on Gosset ward.
- We reviewed a sample of controlled drugs and found that accurate records had been maintained. Medication records were completed for patients and we saw that these had been completed appropriately for the patient files we reviewed. Each patient had their weight checked and prescriptions were written accordingly.
- If patients were allergic to any medicines, this was recorded on their prescription chart.
- Monthly medication audits were undertaken and reported on as part of the service dashboard. Data was collected on the number of medication incidents and errors and learning applied across the service.

## Records

- All of the 10 patient records we reviewed were well written and managed in a way that kept patients safe from avoidable harm.
- Records were stored securely and contained accurate information, were legible and up to date. There were a

# Services for children and young people

small number of issues with the accurate tracking of patients in the children's outpatient service and incident forms were raised when this occurred. No children's outpatients' clinics were cancelled due to missing notes.

- Patient records were kept in secure notes trolleys and stored in locked rooms when not in use.
- Monthly record audits took place on the quality of patient's notes for paediatric patients. Findings were reported as part of the monthly nursing indicator dashboard.
- The monthly nursing indicator audit included quality measures to ensure documentation had been adequately completed for paediatric early warning scores (PEWS). PEWS is a tool used to manage and monitor deteriorating paediatric patients. Some of the measures audited were; checking vital signs, allergy status, checking for tissue damage and medication errors.
- A revised PEWS form was implemented in the directorate in 2017 and PEWS audits had identified the new form was unable to score and calculate correctly. This meant if a child's condition deteriorated, an appropriate plan of care may not be put in place which posed a risk to children in the zero to three month age group. Therefore, the forms were removed and a contingency plan to ensure the care of the deteriorating child was managed safely was put in place while the PEWS forms were reviewed.

## Safeguarding

- There were effective systems in place to ensure safeguarding concerns were identified and referral details were recorded in patient notes. Safeguarding policies were in place and there were routine processes to check if safeguarding concerns had previously been identified or relevant checks had been undertaken.
- The number of referrals made by the trust for children at risk of suffering significant harm, and the number of paediatric liaison forms sent to the Multi-Agency Safeguarding Hub, had remained consistent from April 2016 to June 2017. This demonstrated good practice in terms of information sharing and with external colleagues and agencies.
- Staff were confident about the types of concerns that would prompt a safeguarding referral including; neglect, physical, emotional and sexual abuse, female genital mutilation and child sexual exploitation. Staff understood the referral process and how to make a referral.
- We reviewed a number of patient files and found safeguarding referrals had been made appropriately and in accordance with hospital policy. Staff praised the support and guidance they received from the safeguarding team.
- In the minutes of the directorate governance report (May 2017), Gosset ward had requested and received daily support from the safeguarding team. This was in response to an increase in safeguarding issues and the time spent by staff providing additional support to parents.
- The Intercollegiate Document, 'Safeguarding children and young people: roles and competences for health care staff, 2014' states "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 they are safeguarding/child protection concerns must be trained to Level three".
- A review of staff training data in June 2017 identified 81% of nursing staff had completed children's level three safeguarding training. This was below the trust target of 85%. However, all staff told us they had attended safeguarding level three training. Staff also said there was a delay in uploading training activity onto the training database. Training data for doctors in June 2017 identified 94% of doctors had completed level three safeguarding training.
- Following a serious case review in relation to a dog bite death in another NHS organisation, the directorate had reviewed the community and inpatient admission assessments. This ensured the risks associated with dangerous pets were assessed as part of the safeguarding arrangements for children, families, and staff.
- The hospital had a chaperone policy, which made specific reference to chaperone arrangements for children under the age of 16.
- As of July 2017, 94% of nursing and midwifery staff and 66% of medical staff had completed safeguarding adults' level two training against a target of 85%. The service had an on-going action plan to deliver safeguarding level two training in line with guidance.



# Services for children and young people

## Mandatory training

- Structured induction programmes were in place for new staff and were supported by local induction in the directorate.
- Staff received mandatory training in safety systems, processes, and practices in line with the trust's training programme.
- Mandatory training included safeguarding children and young people and vulnerable adults at level one, equality and diversity, fire training, infection prevention, information governance and record keeping, manual handling and health and safety.
- In April 2017, the directorate was meeting the trust target of 85% compliance for all mandatory training modules with an attendance rate (for all staff groups) of 91%. As of July 2017, overall training compliance was 93%.
- Staff told us they had completed their mandatory training, either through e-learning modules or 'face to face' mandatory sessions.
- Staff also told us their managers monitored staff attendance and ensured staff were meeting their mandatory training requirements.

## Assessing and responding to patient risk

- Appropriate systems were in place to assess risk and to recognise and respond to deteriorating patients. Each child and young person had a paediatric risk assessment on admission. This included risk assessments in relation to manual handling, nutrition, pain, pressure ulcer risk and mental health concerns. These were completed in all of the 10 records we reviewed during the inspection.
- On Paddington ward, 163 children and young people had been admitted since January 2017 with mental health concerns. For example, if the patient had self-harmed or attempted suicide. Patients were routinely provided with one to one care in accordance with hospital policy and were supported by the child and adolescent mental health service (CAMHS), which was provided by another NHS trust. The ward manager said there was a good working relationship with CAMHS who were responsive to the needs of patients with mental health issues. Waiting times for assessments were usually on the day of referral to the ward unless the admission occurred after midday, and then the assessment could be delayed until the next day.

- Some patient's with complex mental health issues had multiple admissions to the ward, which required an urgent plan of care to source a specialist in-patient mental health bed following discussions with the young person and their family. During our inspection we were advised there were limited beds in Northamptonshire and nationally. This was reflective of system-wide pressures.
- We saw there were formal risk assessments to determine whether one to one care was required, if the environment was suitable and whether adjustments were needed. When one to one care was required it was provided by ward staff who had received mental health training. Due to the high volume of patients with self-harming behaviours on the ward the trust security team provided support as required in addition to one to one supervision from ward staff.
- Staff were aware of the Missing and Absconded Patients-Adults and Children policy and we saw this when a young person absconded from the ward during our inspection. Staff acted in line with the policy and the young person returned safely to the ward.
- The paediatric wards and Gosset ward used age appropriate specific paediatric observation charts. This included a paediatric early warning (PEW) score that helped staff recognise when a child's condition was deteriorating and when to seek further help and support from medical staff. Staff were familiar with PEW scores and how to use them. On Gosset ward, a consultant alert system was in place which gave clear guidance regarding patient safety and when to contact a consultant.
- World Health Organisation (WHO) 'Five steps to safer surgery' safety checklists were used in day theatre. Staff were aware of the checks to be done to make sure consent had been obtained for each child and correct procedures had been undertaken. When children were moved to the recovery area staff followed discharge criteria to ensure children were safe to return to the ward. Parents were allowed to be with their child once they were awake. A paediatric trained nurse escorted the child to the ward with the parent(s) and a porter. The forms we viewed had been completed correctly.
- The child health service did not have an intensive care unit (ICU). Patients who required ICU level care were stabilised on the HDU on Paddington ward and



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transferred to a suitable tertiary care centre. Patients were collected by another NHS acute hospital retrieval team and neonates were transferred through the neonatal network retrieval service.

- A “live” skills simulation exercise was held each month using information from incidents and incorporating members of the multidisciplinary team on Gosset ward.
- The service was planning to implement the ‘Sepsis Six’ care pathway and the guideline and screening tool (age appropriate) was due to be ratified in October 2017. The screening tool had been trialled and was continuing to be used until final ratification. Use of PEWS scores were embedded on the paediatric wards and Newborn Early Warning Trigger and Track (NEWTT) assessment score were in use on the postnatal wards to identify patients for escalation for medical review. The service monitored compliance for sepsis and used patient safety thermometer data, and the neonatal clinical dashboard which demonstrated full sepsis compliance at the time of the inspection

## Nursing staffing

- We found planned met actual nursing staffing levels on the paediatric wards during our inspection, and patients’ needs were being met.
- A paediatric acuity tool calculated safe staffing ratios in line with the Royal College of Nursing (RCN) safer staffing guidance in children’s services. Staffing levels were continually reviewed to reflect the changing dependency needs of children and young people. Skill mix on the wards was 70/30. This means 70% of the team were qualified nurses and 30% were health care support workers (HCAs).
- The staffing model for the high dependency unit (HDU) was 1:2 (one trained nurse to two children) and 1:1 for intensive care stabilisation or isolation. On the wards, the allocation was 1:3 (one trained nurse to three children under the age of two years) and 1:4 (one trained nurse for children over two years). Safe staffing levels were in place throughout our inspection. However, the ongoing inability of the trust to recruit sufficient nurses (including children’s trained nurses) was a concern for the directorate and had been entered on the risk register. This was reflective of national pressures in recruitment.
- The service had one WTE Band 7 Lead Nurse for HDU and a further 8.22 WTE who held the HDU/ITU course. There were 4.83 WTE nurses who were undertaking their

HDU competency training pack, supported by the practice development team. One WTE nurse was awaiting commencement on the HDU course. The service had a system and process in place to ensure appropriate competent HDU staff were in place to cover all shifts. The service had an ongoing recruitment strategy with support from the clinical resources planning manager. This trustwide recruitment strategy had three main focus points: local, national and international recruitment.

- At the time of the inspection, there were 17.3 whole time (WTE) trained nurse vacancies and 8.8 WTE health care assistant vacancies (HCAs), of which 11.7 WTE trained nurses and one HCA had been recruited to vacant posts. There was an additional six trained nurses on maternity leave. Staff sickness rates were low in children’s services (3.4%) however; turnover rates were high at 12% in April 2017.
- The hospital had effective arrangements in place to ensure safe staffing levels were maintained. Staffing was monitored through a daily safety huddle and bed management meetings were held throughout the day. In children’s services, staff were flexed across inpatient areas. Staff worked extra shifts and bank and agency staff were used to cover nursing vacancies. Some agency staff were booked for block shifts in advance. This assisted with safe staffing levels and continuity of care. Ward staff completed induction checklists with temporary (bank and agency) staff and ensured staff were familiar with ward layouts and emergency procedures. For example, fire procedures and call bell systems.
- The trust monitored ward staffing fill rates each month. In April 2017, the fill rate for paediatric wards was above the 80% threshold for registered nurses and HCAs. However, on Gosset ward, the fill rate was above the 80% threshold for registered nurses and below the threshold (61%) for HCAs on night duty. This was due to unprecedented staff sickness which was currently being managed. The service had effective staffing escalation plans in place.
- Most nurses on the paediatric wards were registered children’s nurses. All shifts had a member of staff trained to the required level in life support. This was in accordance with the RCN ‘Defining Staffing Levels for Children and Young People’s Services (2013)’ on staffing levels which states “At least one nurse per shift in each clinical area will be trained in Advanced Paediatric Life

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Support (APLS)/ European Paediatric Life Support (EPLS), depending on the service need. We reviewed a sample of 20 whole shifts and identified that all shifts had (at least) one member of staff trained in EPLS. There were no staff trained in APLS.

- The trust provided information that staffing levels were based on the Royal College of Paediatrics and Child Health (RCPCH) 'High Dependency Care for Children –Time to Move On' October (2014). The document recommends there should be a minimum of one nurse on every shift, directly involved with caring for the critically ill child, must have completed a recognised paediatric resuscitation course. For example, Paediatric Immediate Life Support (PILS)/PLS/EPLS/APLS (Resuscitation Council UK 2010/ALSG 2011). The service was meeting these recommendations, as there was a PILS trained nurse on each shift.
- Nurses on Gosset ward undertook a post graduate neonatal programme. The trust was recognised as being the best in the network with 100% of staff achieving the trust target against the network target of 26%.
- Handovers took place twice a day and printed handover sheets were used to ensure all information was handed over to the next shift. Patients were encouraged to be present at nursing handovers. We observed a handover and found it was thorough and organised.

## Medical staffing

- Medical staffing was appropriate and there was an effective level of cover to meet patients' needs at the time of the inspection.
- Medical staffing levels and skill mix were planned in advance and were in accordance with relevant guidance to ensure patients received safe care and treatment. The Royal College of Paediatrics and Child Health 14-hour consultant review standard was being met.
- There was a 24 hour, seven day a week consultant led paediatric service in place for children and young people at the trust.
- There were two consultants of the week, each week, with one taking responsibility for the paediatric assessment unit (PAU) and one taking responsibility for the wards and the high dependency unit (HDU). Consultant paediatricians held specialist clinics in the children's outpatient department. For example, oncology, diabetes and cystic fibrosis.
- Locums were used as required to ensure gaps in the rota were filled, for example, to cover sickness or annual

leave. A standard checklist was used to induct locums into the service. Locums who worked for the service long term accessed the hospital induction programme and mandatory training.

- In February 2017, the total medical staffing establishment of 43 whole time equivalent (WTE) medical staff was about the same as the England average. The proportion of junior doctors (foundation years one and two) was also the same at the England average. However, inability to recruit sufficient junior doctor posts to the division (and the trust) was recognised as a risk and had been entered on the risk register. Consultants informed us that were occasionally required to cover any gaps in the rota by acting down, which was usually during the winter.
- In June 2017, there were two consultant vacancies due to staff retirements in the community paediatric service which had yet to be recruited to. Sickness rates in April 2017 were 3.5% with a turnover rate of 7.9%.
- Following the expansion of the paediatric assessment unit (PAU) in 2016, a dedicated consultant paediatrician provided a Monday to Friday service from 12 midday to 5pm. An additional appointment to cover the service had been advertised. The service would be extended to accommodate winter pressures through additional cover in the winter months.
- There were five WTE consultant neonatologists who covered a one in four rota on the neonatal unit. The consultants we spoke with told us this was not a sustainable arrangement but it did ensure a consultant led service 24 hours a day, seven days a week. The risk had been entered onto the risk register. There were 2.67 WTE band 8a advanced neonatal nurse practitioners (ANNP) being recruited to support the medical neonatal rota. At the time of the inspection, 1.67 WTE was in post and an additional 1 WTE was due to commence. This had helped to address some of the junior doctor recruitment issues in the directorate.
- Handovers took place twice each day and were led by a consultant paediatrician. We observed two handovers and found them to be appropriate, relevant and pertinent information was discussed with appropriate guidance for junior medical staff. The directorate had implemented the national SAFER Patient Flow Bundle in January 2017. This is a practical tool to reduce delays for children and young people by the use of simple rules to standardise ward and board round processes. The SAFER bundle blends five key elements of best practice,

# Services for children and young people

and when followed consistently reduces length of stay and improves patient flow and patient safety. Parents on Gosset ward were encouraged to be present on ward rounds and an audit of parental views on ward round changes has recently been completed.

- The appointment of a consultant with a special interest in cardiology had enabled some babies with cardiac abnormalities to be looked after at the trust in liaison with the specialist tertiary service.

## Major incident awareness and training

- The trust had appropriate policies in place with regard to business continuity and major incident planning. Staff were aware of the trust major incident policy relating to departments in the trust including the division. There were clear instructions for staff to follow in the event of fire or a major incident.
- Service managers and senior staff considered seasonal demands when planning paediatric beds within the trust. For example, additional paediatric consultant cover was planned for the winter months to help reduce waiting times for children and young people attending PAU.
- Appropriate systems were in place regarding fire safety with essential checks having been carried out on all fire system equipment. Staff were aware of evacuation plans in event of a fire. At the time of inspection, compliance with fire safety refresher training was 68% for doctors and 90% for nurses, against the trust target of 85%. We saw that managers had plans in place to provide additional training sessions.

## Are services for children and young people effective?

Good



We rated effective as good because:

- Patient's care and treatment was planned and delivered in line with evidence-based guidance.
- Pain was assessed and managed on an individual basis and was regularly monitored by nursing staff. Children and young people's nutrition and hydration needs were being met.

- The service performed well in a number of national audits including the National Neonatal Audit (2015) and the Epilepsy 12 audit 2014 Gosset ward was working towards achieving Bliss accreditation.
- The directorate participated in national and local audit activity. Staff reviewed the outcomes of audits and there was evidence of action plans and changes to practice.
- Staff had the appropriate knowledge, clinical skills, and experience to deliver effective care and treatment to children and young people.
- We saw effective multidisciplinary team working that delivered coordinated care to patients.
- Staff understood the guidance and legislation relevant to consent and informed decision making with regards to children and young people.

However:

- The lack of clinical psychologist support in the Child Development Centre (CDC) and specialist services meant the trust was not meeting service guidelines.
- There was a higher percentage of under-ones readmitted following an emergency admission compared to the England average.
- The directorate was not meeting national guidance in relation to the care of children and young people with an eating disorder.
- Children and young people aged one to 17 years with multiple admissions was above the England average.

## Evidence-based care and treatment

- Patient's care was consistently planned and delivered in line with evidence-based guidance. The service was working towards accreditation for the BLISS baby charter and Baby Friendly (UNICEF) and participated in audits which were used to monitor the effectiveness of the standard of care provided. For example, Epilepsy12 (2014) the National Neonatal Audit (2015) and the National Diabetes Children's Audit (2015/16)
- Staff followed the National Institute for Health and Care Excellence (NICE) guidance. For example, 'Transition from children to adult services' Quality Standard (QS)140, 'End of life care for infants, children and young people with life-limiting conditions-planning and management' NICE Guidance (NG) 61, and 'Eating disorders' NG69.
- Policies and procedures were developed in line with national guidance and were available for staff on the trust intranet.

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- The directorate was involved in national and local audit programmes and collated evidence to monitor and improve care and treatment. For example, national paediatric asthma, epilepsy and diabetes audits. Local audits included the medical care of the under two's with Down's syndrome and sedation in the under-fives. We saw that audit findings and recommendations were shared within the directorate and in the Women's Children's, Oncology, Haematology and Cancer Care Division and changes to local practice were made when indicated.
- Gosset ward was part of the Central Newborn Network. The group agreed guidelines for shared working and developing audit tools to assist consistency of approach and to provide continual improvement of services.

## Pain relief

- Pain was assessed and managed on an individual basis and was regularly monitored by nursing staff. The trust was compliant with the Faculty of Pain Medicine's Core Standards for Pain Management (2015) acute pain management guidelines.
- We observed nursing staff monitoring the pain levels of children and young people using age appropriate pain tools and observation sheets, recording the information and taking appropriate action to control patients' pain.
- Pain levels were routinely assessed during the completion of patient observations and were recorded on patients Paediatric National Early Warning Score (PEWS) charts. We observed nursing staff asking children and young people if they were in pain and helping them to identify where the pain was and the intensity of the pain by using pictures and diagrams to aid understanding.
- We reviewed 10 paediatric medication charts which showed the appropriate prescribing of pain relief. Medical staff prescribed anticipatory pain relief for children and young people following procedures. Staff told us medical staff would prescribe pain relief for parents to take home if required.

## Nutrition and hydration

- The service recognised the importance of good nutrition, hydration, and protected meal times as an essential part of patient care.
- Staff assessed and documented children and young people's nutritional requirements using a paediatric nutrition and hydration tool.

- Children's nutrition and hydration needs were being met. Menus identified a variety of nutritious meals that took into account the choices made by young people. Parents and children told us they were happy with the choice, variety and quality of food.
- Ten sets of records we reviewed showed fluid and dietary intake was monitored, recorded and where necessary reviewed. Neonatal feeding plans and feed charts were reviewed and were up to date and clearly documented. This ensured babies, children and young people were receiving age appropriate nutrition and hydration.
- Parents on Gosset ward were encouraged to undertake nasogastric feeding to encourage them to take on a parental role with their child while the babies were still on the ward.
- Gosset ward was accredited as part of the UNICEF Baby Friendly Awards which championed evidence based practice to promote and support breast-feeding. This meant that staff were able to support mothers to recognise the importance of breast feeding. For example, giving advice on milk supply, initiating lactation, pumping, transition to responsive feeding and other breast feeding issues.
- In the National Neonatal Audit 2015, 71% of babies born under 33 weeks at the trust were receiving mother's milk, either exclusively or as part of their feed at time of discharge from the unit compared to the national average of 58%.
- Staff were aware of how to access the dietitian service and how to order specialist menu choices such as vegetarian and gluten free meals

## Patient outcomes

- Outcomes of care for children and young people were monitored in line with national requirements. Intended outcomes varied and some were better than the national average.
- The National Diabetes Audit 2015/16 showed the trust performed at or around the national average in the majority of performance indicators. The trust performed worse than the England average for children receiving the seven key care processes recommended by NICE. These included patients having their blood pressure, cholesterol and eyes examined. The trust had developed an action plan in response to the audit; increased monitoring between appointments, regular

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and more 'age appropriate' teaching sessions, an increased establishment of the diabetes team, better data capture and improved communication with the retinal screening team.

- Multiple emergency admission rates for February 2016 to January 2017 following elective surgery for children had fewer than six readmissions per speciality and therefore comparisons with other trusts could not be made. The overall readmission rate for paediatrics was similar to the England average. There was a higher percentage of under ones (3.4%) readmitted following an emergency admission compared to the England average (2.7%).
- Children and young people aged one to 17 years with multiple admissions due to asthma within 12 months was similar to the England average and above the England average for epilepsy. The trust performance in the children's national Epilepsy 12 audit (2014) was similar to the England average. There were no issues identified that required escalation or were high risk. Patient satisfaction was above the England average, and the service scored positively for the role of the epilepsy specialist nurse.
- The trust took part in the National Neonatal Audit (2015). The trust performed above the national average in the following areas: screening of babies at risk of eye disease affecting prematurely born babies. Data showed 100% of babies underwent screening (ROP) against the England average of 98%. Documented consultations with parents in the neonatal unit within 24 hours of admission. Data showed 97% of parent consultations took place compared to the national average of 88%. Rates of normal survival at two years of age compared to babies in similar neonatal units. Data showed 79% of babies had attended their two-year health assessments at the trust compared to the national average in other units of 62%.
- Baby life support systems (Bliss) is the leading UK charity for babies born premature or sick which aims to have the best care by; providing information and support to families, influencing policy and practice and enabling life-changing research. Gosset ward was working towards achieving Bliss accreditation. This is an accredited framework to assess neonatal unit's ability to deliver family-centred care. Bliss champions family-centred care, an approach which can lower a

baby's stress levels, shorten hospital stays, reduce hospital readmissions and improve long-term health outcomes by supporting parents to provide hands on care when they are in hospital.

- NICE guidance on the management children and young people with eating disorders recommends children are looked after by paediatricians with specialist knowledge. Paediatricians in the directorate did not have specialist knowledge and patients were cared for on general paediatric wards not equipped to care for them. For example, there were no dedicated adolescent facilities and no specialist teams to care for patients with eating disorders in the trust. The directorate had raised this as a risk and entered it onto the directorate risk register.
- Staff told us there was a lack of psychologist support in the child development centre (CDC) and for specialist services. For example, diabetes, epilepsy, HIV and cystic fibrosis and in children's outpatients. This meant specialist services were unable to meet the national guidelines for the provision of psychology support, which could increase the morbidity and lead to unnecessary admissions. The directorate had raised this as a risk and entered it onto the directorate risk register.

## Competent staff

- Staff had the appropriate clinical skills, knowledge, and experience for their roles and responsibilities within the clinical area in which they worked. The service had processes in place to identify training needs and compliance, which ensured staff were confident and competent to undertake their roles.
- The directorate had implemented a competency training passport for medical equipment to ensure staff met the trust training target of 85%. At the time of the inspection staff was performing above the trust target.
- Student nurses undertook clinical placements in child health and mentorship arrangements were clearly displayed in ward offices. Disney ward had achieved an outstanding placement commendation in 2015/16.
- Staff attended trust staff induction and a local induction programme on joining the trust. Trust induction covered topics such as trust values, information governance, and clinical skills training such as basic life support and fire safety. Roles specific training was provided and staff in the directorate had met the 85% trust target for the period April to June 2017.



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- Staff had all received an appraisal. Staff appraisal rates for the period April to June 2017 were above the 85% trust target. Staff said “there are lots of training opportunities in the trust” and “I enjoy discussing how I can continue to develop my skills at my appraisal” and “my manager always supports my development”.
- A list of designated supervisors was available for staff to access on the trust intranet. Staff we spoke with said the system worked well and staff were able to access clinical supervision within a reasonable period of time. Clinical supervision was in place for community and specialist nursing services every four to six weeks. Clinical supervision enabled staff to review their clinical practice, identify issues and concerns and find solutions to help improve practice.
- The service had monitoring processes in place to ensure that doctors were working within the General Medical Council (GMC) revalidation guidelines and would be able to revalidate in line with the scheduled date. Medical revalidation was introduced in 2012 to ensure that all doctors were up to date and ‘fit to practice’. All of the consultants working in the service had either been revalidated or were working towards revalidation in line with the timescale notified to them by the GMC.
- Staff were supported with the revalidation process. Revalidation was introduced by the Nursing and Midwifery Council (NMC) in 2016 and is the process all nurses and midwives must follow every three years to maintain their registration.
- Health care assistants (HCAs) completed a four-week induction programme when they joined the trust followed by a ‘care certificate’. In children’s outpatients HCAs had completed a competency based training programme to enable them to undertake weight and height measurements of babies, children and young people.
- An outreach nurse post had been recruited to on Gosset ward to support the earlier discharge for nasogastric tube fed babies.

## Multidisciplinary working

- All appropriate members of the multidisciplinary team in the directorate were involved with assessing, planning and implementing patient care. Multidisciplinary teams involved, paediatricians, nurses, physiotherapists, neonatologists, speech and language therapists (SALT) dietitians, audiologists and play

specialists. There was a cohesive and through approach to assessing the needs of children and young people which involved setting individual goals and providing child-centred care.

- Nursing staff worked alongside therapists and specialist children’s nursing services for example, diabetes, oncology, cystic fibrosis and epilepsy to provide a multidisciplinary approach. We saw this in the patient’s records we reviewed. All staff described good collaborative working practices.
- There was a service level agreement (SLA) in place for psychology support from the local mental health NHS trust for specialist services. However, due to maternity leave, there was a gap in provision until October 2017. The trust was in discussions with service provider to try and resolve current issues.
- Multidisciplinary team meetings were held regularly and patient’s progress was discussed. Patients who were then identified as being fit for discharge would then start the discharge planning process.
- Transition arrangements for young people moving into adult or third sector services were in place. Multidisciplinary teams worked closely with young people and their families to ensure they were listened to and involved in transition arrangements. Each young person had a transition care plan with a checklist of the people who would need to be informed of the young person’s transition to adult services. For example, the named nurse/ key worker, the GP and education and employer.
- Children with developmental issues and learning disabilities attended the child development centre (CDC) where they underwent a comprehensive two-day assessment by the multidisciplinary team which comprised of; paediatricians, nurses, nursery nurses, speech and language therapists (SALT), physiotherapists and other professionals, including; clinical psychologist, orthoptists, and audiologists. Following assessment, ongoing care was provided by members of the CDC team through group or individual sessions held at the CDC, at the child’s home or at pre-schooling.

## Seven-day services

- The paediatric assessment unit (PAU) was open seven days a week from 9am to 10pm and provided a consultant paediatrician led service for children and



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young people. Children and young people who required urgent care continued to be treated in the emergency department (ED) or were referred to a bed on the paediatric high dependency unit.

- Play specialist's provided a seven day service and supported children across the directorate. For example, in children's outpatients, day theatre, in X-ray and imaging and on paediatric wards.
- There was a paediatric consultant or neonatologist presence in the directorate (including the neonatal unit) 24 hours a day seven days a week.
- There was emergency access to diagnostics, and imaging 24 hours a day. This included magnetic resonance imaging (MRI) and CT scanning. Pharmacy services were open seven days a week. Opening hours were 8.45am to 6pm Monday to Friday, 10am to 1pm on Saturdays and 1pm to 3pm on Sundays. The directorate had access to an on-call pharmacist outside of those hours.
- Children's physiotherapy services were provided on the paediatric wards and in the community five days a week. Arrangements were made for the physiotherapy department to provide care to patients out of hours as needed.

## Access to information

- Staff had access to the information they needed to deliver effective care and treatment in a timely manner.
- The children's audiology clinic had introduced a process where an electronic database was used to record information. This was printed and placed in the child's notes and replaced the handwritten information.
- Clinical staff had access to patient's test results, such as diagnostic imaging and blood test results to support them to care for patients safely.
- Paediatricians had set up a 'direct access' telephone line for GPs to aid discussions around the potential admission of children and young people to the service. This enabled any queries or concerns to be explored to ensure patients were directed to the most appropriate service.
- There were computers throughout the service and the majority of staff told us there was sufficient equipment available for them to access patient information. However, the physiotherapy team expressed concerns

about the lack of computers and administrative support available to the team and the impact this was having on the service. We were told a business case had been put forward to the directorate.

- Staff used standardised printed handover sheets to ensure there was a consistency of approach when information was passed on to clinicians who were taking over the next shift.
- A summary of the child or young person's care was sent to GPs electronically when patients were discharged.

## Consent

- Staff understood the guidance and legislation relevant to consent and informed decision making with regards to children and young people.
- We saw all grades of staff seeking appropriate consent from patients' and relatives (where required) before undertaking any intervention.
- Nursing staff gained verbal consent before undertaking interventions such as taking clinical observations or giving medication. Where children and young people were unsure about a procedure, the play specialist supported the patient to make an informed decision.
- Staff told us about the principles of Gillick competencies (used to help assess whether a child had the maturity to make their own decisions and to understand the implications) when making decisions about people's ability to consent to procedures, especially with adolescent patients.
- Staff understood the Mental Capacity Act 2005 and explained how they would assess a child's mental capacity and a decision would be made in the child's best interest and recorded in their notes.
- When seeking consent we observed a community children's nurse spending time with a child and using terminology the child could understand when explaining what they were going to do.

## Are services for children and young people caring?

Good



We rated caring as good because:

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- Staff were very friendly, professional, compassionate and helpful to patients in all interactions that we observed.
- All relatives and carers we spoke with said their child was cared for by staff that were kind, compassionate and ensured their privacy and dignity needs were being met.
- Children spoke about “the kind nurses and doctors who looked after them” and “the wonderful toys and games at the hospital”.
- Parents were involved throughout the assessment, planning, and delivery of their child’s care and were kept informed of changes and developments by the multidisciplinary team.
- There was a strong and visible child centred culture and staff and managers were fully committed to partnership working.
- We observed children were respected and valued as individuals and encouraged to self-care and were supported to achieve their potential within the limitations of their clinical condition.
- Feedback from children who used the service, those who were close to them and stakeholders were continually positive about the way staff treated people.
- We observed a children’s community nurse supporting a child with a long-term clinical condition. We observed the child was well known to the nurse who had developed a close rapport with the child and their relative. The nurse spent time reassuring the child and explained the reason for their visit. Through gentle coaxing and using a reassuring manner with the child, the nurse was able to complete the child’s treatment without causing them pain and anxiety. We observed by the end of the visit, the child and their relative had been reassured by the care given and had received guidance on how to seek support if it was required before the next visit.
- Staff on Gosset ward were compassionate, caring and insightful to parents and their families who had often been on the ward for several weeks. One parent told us their baby had been transferred from another hospital and that they were very happy with how their child was cared for. They felt the care was “excellent” and as a family they felt “well supported”.
- We observed staff supporting and treating patients in a kind and caring manner. We followed a child going for surgery on their journey to the day theatre. We saw they were supported by a play specialist who used distraction techniques to minimise distress to the child.
- Patient feedback was obtained using the NHS Friends and Family Test (FFT). This is a method used to gauge patient’s perceptions of the care they received and how likely patients would be to recommend the service to friends and family. The trust was performing above the national response rate of 24%, which indicates the sample was representative.
- In the inpatient children’s service FFT performance for the period February to April 2017, was just below the performance target of 93.5% and in the children’s outpatient service was just above the performance target. This meant that over 90% of the FFT responses would recommend children’s services to friends and family.
- Feedback from the children and young people’s survey 2014 scored positively against the 14 questions asked about staff care and was largely similar to other hospitals in England. The trust performed better than other hospitals for the question ‘Before the operation or procedure did a member of staff explain to you what would be done during the operation or procedure’ scoring 9.69 out of 10.

## Compassionate care

- Staff were very friendly, professional, compassionate and helpful to patients in all interactions that we observed.
- During our inspection, we saw interactions between staff, children and young people and their parents and carers were strong caring and supportive. Staff were skilled at communicating with children and young people; we observed this on every ward and department we visited.
- Parents/carers we spoke with told us they were very happy with the care and support they received throughout the children’s service. A parent said “the staff were always very caring and spent sufficient time with their child to ensure the child knew and understood what was going to happen to them”. Another parent said “We visit the department (children’s outpatients) regularly and I know my child will be recognised by the staff which makes them feel important and less anxious when they attend future appointments”.

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- The trust performed about the same as other hospitals for two out of three questions relating to emotional support but performed better than other hospitals for the question 'Did hospital staff tell you what to do or who to talk to if you were worried about anything when you got home' scoring 9.07 out of 10.
- In the Gosset Ward Treating Patients Well Annual report 2014-2015, parent's comments were overwhelmingly positive. For example, "found all the staff to be helpful and kind" and "very supportive of breast feeding" and "helped us make a plan and move forward to discharge" and "really impressed with the level of care" and "very professional and welcoming and answered all our questions".

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

- Patients and parents we spoke with told us communication had been very good with all members of the care team. Parents we spoke with told us throughout the inspection that staff went the 'extra mile' when delivering care and support to their children and the effort they took to involve parents and families was outstanding.
- All patients and parents we spoke with told us they felt involved in the care of their child and staff went out of their way to ensure they were involved in any changes to their child's care and treatment.
- Parents and carers told us they were listened to and their views and opinions were always considered when their child's care was being reviewed.
- We saw how staff explained things to parents, children and young people. For example, we saw a play specialist explaining a procedure to a child and their parent. We saw how this reassured the child and the parent. We observed a clinical intervention on a child. We saw how the parent and child were prepared for the procedure by a nurse who used age appropriate communication and praised the child following the procedure.
- Staff used a wide range of information that was available on the paediatric wards and in the children's outpatient department. These added to the verbal explanations children and their parents had been given. We saw staff allowed time for questions from parents or

the child themselves and checked understanding when having procedures explained to them. We saw that information had been written in a way that children and young people could understand.

- Parents on Gosset ward were encouraged to be present at nursing handovers and ward rounds to enable them to be involved in the ongoing care of their child. The ward had undertaken an audit on parental views on ward round changes.

## Emotional support

- Staff were able to build relationships very quickly with children, young people, parents and their families. We saw this in all the areas we visited. For example, in day surgery where staff were able to support the child and parent and ensured they understood the forthcoming procedure.
- Children and young people requiring surgery were accompanied by their parents to the anaesthetic room and stay with them until they were asleep. This ensured parents were able to continue to provide emotional support for their child. Parents were able to see their children in the recovery area as soon as they were awake to provide reassurance and support.
- Parents on Gosset ward undertook Kangaroo (skin to skin) care which helps to create a bond between the babies and their parents.
- Children were cared for at the end of their lives in a dedicated room as part of the pathway. Bereavement support was provided on the paediatric wards, Gosset ward and in the community.
- The Snowdrop Suite (on the maternity unit) was dedicated to supporting bereaved parents and their relatives. Facilities were used by the staff to support recently bereaved parents and their families. For example, staff arranged for photographs and foot and hand prints. Families were able to spend time in the suite and babies were placed in a special cot. Staff told us parents and families was well supported during this difficult time.

# Services for children and young people

## Are services for children and young people responsive?

Good



We rated responsive as good because:

- Services were planned and delivered to meet the needs of individual patients and that of the local community.
- Outpatient services were provided to children and young people in a designated outpatient department.
- The service had developed strong partnership working with tertiary services where specialist or intensive care services were required.
- The child development centre (CDC) provided a multidisciplinary assessment approach for children and young people with developmental delays or other special needs and was available on the hospital site.
- The paediatric assessment unit (PAU) ensured the rapid transfer of children and young people who required ongoing assessment and observation.
- The average length of stay for children and young people on paediatric wards was better the trust average.
- There were facilities to engage and support children and young people admitted to paediatric wards. Parents were complimentary about the play specialists who provided support to children and families.
- There were facilities in place to support patients with learning and physical disabilities. Translation services were provided to patients who were unable to speak English.
- Patients and their parents were supported to make complaints

However:

- Some patients admitted to the paediatric wards with mental health needs experienced delays in waiting to be assessed and discharged by the children and adolescent mental health service (CAMHS), which was provided by another NHS trust. All stakeholders and partners had taken actions to improve this.
- There was limited psychologist support for patients diagnosed with long-term conditions and children and young people attending the child development centre.
- There were limited overnight facilities for parents to stay on paediatric wards.

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

- Services were planned and delivered to meet the needs of individual children and young people in acute and community settings. Effective relationships had been established with commissioners, GPs, education, mental health services, local authorities, charities, other NHS trusts and people who used services to reflect the needs of the local community.
- The directorate was actively involved in national initiatives. For example, Sure Start, On-Track and Quality Protects who aimed to improve the lives of children and families from disadvantaged backgrounds, children at risk of offending and antisocial behaviours and looked after children. The service had developed strong partnership working with tertiary centres where specialist or intensive care was required. For example, cardiology, urology, nephrology, neurology the cleft lip team and sickle cell services.
- Children's outpatient appointments were held in dedicated paediatric facilities. Age appropriate play areas were in place for children and young people and were well supplied with toys and games. There was access to a play specialist if required. Clinics were held by acute and community paediatricians in general paediatrics and in some sub-specialties, for example, diabetes, cystic fibrosis, epilepsy, endocrinology and functions such as the shoe clinic. Visiting specialists from tertiary centres held local clinics in the outpatient department. Children's pre-operative assessments were held in the children's outpatient department.
- All children and young people were cared for on paediatric wards. Wards were not purpose built to accommodate the needs of children and young people and there were no dedicated facilities for teenagers. There was limited space around bed areas for children and families. Staff had made reasonable adjustments for example; a bed would be moved from a bay to give additional space when wards were not at full capacity. There were limited facilities for parents to stay overnight which had been identified at our last Care Quality Commission inspection in 2014. This was on the service risk register. Parents (on Disney ward) were able to access a parent's room on Paddington ward where eating and drinking facilities were available.
- Gaps in the pathway for children and adolescents mental health services (CAMHS) patients had been

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identified and shared with the service provider (another NHS trust) who had assigned a CAMHS project lead to work with the trust to help reduce delays on paediatric wards. The service had a system to collect delays in admissions and discharges in relation to CAMHS patients. Delays were recorded using the trust incident reporting tool to record ongoing concerns and were shared with commissioners of services and the service provider.

- The service was working collaboratively with partners and the local commissioners to address this issue. Between July and August 2017, the commissioners undertook an audit of all children and young people admitted to the service in May 2017 with self-harm and dysregulated behaviour. The outcome of this audit was a commitment from the commissioners to invest in the county wide CAMHS service provision and to review the CAMHS pathway across the county. This was with involvement from all key stakeholders and partners.
- Effective arrangements were in place with the paediatric wards and high dependency units across neighbouring counties as part of the regional transfer network. Critically ill children in the high dependency unit and those requiring intensive care and specialist intensive care required transfer to a regional intensive care unit.
- Gosset ward provided care for new-born babies who required specialist high dependency care or intensive care nursing. The unit was part of the Central Newborn Network and was designated a level two unit. This means it was able to practice intensive care for babies of 27 weeks' gestation or above. Babies over 34 weeks were only admitted to the unit if they required specialist care. Appropriate policies and procedures were in place to aid transfer and retrieval to ensure services were meeting the needs of children and babies.
- The most common diagnosis groups for emergency admissions for children under the age of one year were: acute bronchitis, viral infection, other perinatal conditions, intestinal infections and other upper respiratory infections.
- For children and young people aged 1-17 years, the most common diagnosis groups for emergency admissions were: viral infection, acute and chronic tonsillitis, other upper respiratory infections, intestinal infection and other upper respiratory infections. A directorate level dashboard was in place for child health, which recorded the quality of care and operational performance within the directorate. For example, complaints, day case rates and length of stay.
- In England, under the NHS Constitution, patients 'have the right to access certain services commissioned by NHS bodies within maximum waiting times, or for the NHS to take all reasonable steps to offer a range of suitable alternative providers if this is not possible'. Referral to treatment time (RTT) for admitted pathways are the waiting times for patients whose treatment started during the month as an inpatient or day case. The waiting time starts from the point the hospital or service receives a referral. The data shows how long a patient has waited before their treatment began.
- Children and young people's referral to treatment (RTT) waiting times for incomplete pathways in the reporting period (April to June 2017) performed consistently above the trust target of 92%. This meant the majority of patients had waited no more than the 18 week waiting time target from referral to treatment. Parents told us they usually waited between eight and 12 weeks but often children were seen much earlier.
- The children's outpatient department provided urgent clinics (within 48 hours) and known as 'hot clinics' for children and young people who needed an urgent paediatric referral. Pre-assessment clinics were held at least twice a week for children and young people undergoing elective surgery. The directorate consistently performed above the day case target of 80% in the period April to June 2017. There were 21 failed day cases (where inpatient admission had been required following the day case surgery) in the same period, which was below the trust target.
- The average length of stay for all children and young people staying on the paediatric wards from April to June 2017 was 1.2 days, which was better than the trust

## Access and flow

- Between February 2016 and January 2017, there were 10,450 total spells recorded for children and young people who accessed trust services. This was an increase of 2% on the previous reporting period (February 2015 to January 2016). This placed the trust in the higher quartile (activity levels) for similar trusts in England.



# Services for children and young people

target of 4.2 days. Patients staying over 30 days were 0.7% which was below the trust target of 2% and there were no delayed transfers of care recorded in the same time period.

- In the period January to June 2017, trust data identified bed occupancy levels in child health were 58% on the paediatric wards and 76% on Gosset ward. The area of highest occupancy was on Gosset wards high dependency unit, which had an occupancy rate of over 100% for five of the six months. The occupancy rate for children's high dependency unit (HDU) was 45% for the same period.
- The child development centre (CDC) provided multidisciplinary assessment for children from birth to school age. The CDC team saw pre-school children with developmental delays or other special needs. However, specialist services were unable to meet the national guidelines for the provision of psychology support due to vacancies in the service. The CDC had approached education and social services to inform them of the potential delays in assessments or incomplete assessments to organise other possible services. Waiting times for children referred for assessment in 2016 were 11 weeks, which was an improvement on the 15 week waits in 2015.
- Children accessed the paediatric assessment unit (PAU) through the emergency department (ED) after triage (assessment) or referral from a GP. At the last Care Quality Commission inspection in 2014, the PAU service was unable to meet the needs of children and young people attending the trust. The service was now provided in a purpose built unit and facilitated the rapid transfer of children requiring further assessment or paediatric observation. The service was available from 9am to 10pm seven days a week. Children were reviewed by a paediatrician and children's trained nurse. When the unit closed admissions went directly to Paddington ward. There had been no instances of the unit remaining open overnight.
- Disney ward was part of the Child Health Paediatric Shared Care Unit (POSCU) and provided care to patients with cancer on the ward. The service was part of an integrated cancer network for children and young people across three acute NHS trusts. The POSCU ensured appropriate elements of treatment and supportive care were provided to children in their local hospital, at home and in the children's outpatient department.

- The ward provided shared care oncology to children and also to children with sickle cell anaemia. A parent accessing the service said "The service is excellent and we can always get help out of hours if we have any issues or concerns about our child". The oncology matron told us the service had a flexible medical and nursing workforce which enabled the team to manage their own bed capacity in partnership with patients and their families.
- Children and young people with acute medical conditions, including, diabetes, cystic fibrosis and asthma were cared for on Paddington ward. The ward had a four bedded medical day care unit (MDCU) where children had pre-booked appointments for diagnostic tests, treatments, and intravenous medications.
- Discharge planning processes included both out of hours and nurse led discharge. Parents told us they were kept informed throughout the discharge process. A multidisciplinary approach to discharge was in place and patients would only be discharged when all services were in place.
- Looked after children on paediatric wards and Gosset ward had a clear process for discharge and multi-agencies were involved. Children's community nurses and health visitors were involved in the planning of babies discharged from Gosset ward who required long-term care and support.

## Meeting people's individual needs

- Staff on the paediatric wards welcomed the involvement of parents and carers and visiting was not restricted. Other visitors were able to visit between the hours on 2pm and 8pm and were limited to two visitors at a time. Siblings were encouraged to visit but needed to be supervised. Parents told us they were happy with the visiting arrangements and knew they could talk to staff if family members needed to visit outside the visiting hours.
- Parents on Gosset ward were actively involved in the care of their child and an integrated model of care was in place. For example, close involvement of families, bonding with babies and breast feeding. Open visiting was in place and parents were encouraged to stay with their child.



# Services for children and young people

- Children's services were planned to take into account the individual needs of children and young people. Patients with complex needs were supported by staff to access the hospital facilities. For example, access to consulting rooms for children in a wheelchair.
- Leaflets were available to children and their parents but were only printed in English. However information could be provided in other languages and formats including Braille and audio cassettes.
- Age appropriate toys were available on the wards and there was a high visibility from the play specialists who supported children in all areas of the directorate. For example, accompanying children to day theatre and supporting play in children's outpatients. There was a playroom and school facilities on Paddington ward with toys, books and sensory equipment available for children and young people of all ages.
- At our last CQC inspection in 2014, we found equipment was locked away out of hours and not available for children to access. Paediatric nurses now had access to an equipment lending library. This ensured diversional and play equipment was available to children and young people at all times.
- Play specialist's attended pre-assessment clinics where patients were shown the type of equipment to be used when they were admitted to hospital. For example, syringes, cannulas and blood pressure cuffs. Younger children had equipment demonstrated on a toy and were able to play with the equipment. Parents and children were very complimentary about the play specialists who were integral to the care pathways and provided support to children and families throughout each child's care episode.
- The trust had access to translation services. Staff told us they knew how to access the service, either in person or via the telephone system.
- Staff knew how to access advice from staff such as the trust's learning disability specialist nurse. In June 2017, all children and young people admitted to paediatric wards with a learning disability had a 'hospital passport' completed within 24 hours of admission. Hospital passports provided staff with important information about the child's health and helped inform assessments and care planning.
- From January 2017, babies transferred to tertiary centres had their progress tracked to ensure information about their condition was added to their notes at the trust. The organisation was exploring how this could be implemented in paediatrics.
- The Child and Adolescent Bereavement Services (CABS) offered individual and group bereavement counselling to children and adolescents in the Northamptonshire area. The service was reported as being at risk as capacity (within the service) was unable to meet the increasing demands as clients were presenting with more complex mental health issues. The trust was in discussions with commissioners to increase the service provision across Northamptonshire.

## Learning from complaints and concerns

- Information was displayed in wards and departments explaining how parents, children and young people could raise their concerns or complain. Staff were aware of the complaints process. Staff told us they would always try to resolve any issues immediately. Staff directed patients and relatives to the Patient Advice and Liaison Service (PALS) if they were unable to deal with their concerns directly. If issues could not be resolved, the family was directed to the complaints process.
- Staff were aware of any complaints about their ward or department and the learning from them. There were seven complaints in the directorate between April and June 2017. Themes were around waiting times, discharge delays and communication. In the minutes of directorate governance meetings in April 2017, trends and themes from complaints had been discussed and action agreed. All complaints had been investigated within the 25 days in accordance with trust policy. Actions taken included discussion of themes at staff handover and team meetings and weekly audits of notes.

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

Good



We rated well-led as good because:

# Services for children and young people

- The service had a clear statement of vision and values, which were recognised by staff and integrated into all the services we visited.
- There was clear evidence of strong local leadership by managers who were visible, supportive and approachable.
- Effective governance and risk management arrangements were in place supported by risk registers which had clear actions in place to manage risks.
- Services were well-led and there was evidence of effective communication within ward and department teams.
- Staff felt well supported and were able to speak up if they had concerns.
- Staff were very proud to work at the trust and were passionate about delivering a child centred service to children and young people.
- The service captured views of people who used the service to inform changes and improvements.
- The directorate was continually developing patient services to allow innovation, improvement, and sustainability of services.

However:

- Although the directorate had risk management arrangements in place, not all risks in the service that we found on inspection had been identified. However, the trust acted immediately by risk assessing areas and taking actions to mitigate risks to children and young people.
- Children's services were incorporated in the trust clinical strategy 2015 to 2020, and the Women's Children's, Oncology, Haematology and Cancer Services (WCOHCS) divisional plan/strategy. However, not all staff in the directorate were clear about the longer term development of children's services at the trust.

## Leadership of service

- There was strong local and service level leadership in the child health directorate and staff spoke positively about their ward sisters, matrons and managers. The service was led by a clinical director, a directorate manager and matron. Staff told us they felt supported by their managers and felt able to walk up to them with any concerns or comments they might have.

- The directorate was part of the WCOHCS division and there was a clear management structure and defined lines of responsibility and accountability. Staff were clear as to who their line managers were and told us they knew who to raise issues or concerns with.
- Leaders were aware of some of the risks in the service, which had been identified and recorded on the risk register. However, leaders had failed to recognise the significance of some risks for example the opportunity for children and young people at risk of self harm or suicide to access the delivery suite from Paddington ward where there were unattended rooms and equipment therein. The trust, directorate managers, and senior staff responded immediately to our concerns and were proactive in managing the assessment and mitigation of the risks to ensure children and young people were cared for safely.
- The matrons in the directorate provided strong and consistent leadership through the sharing of best practice, service developments and learning from incidents, complaints, and patient feedback about children's services.
- Staff meetings were held monthly to share the learning from incidents, complaints, and compliments and were recorded on the nursing performance dashboard. We saw 100% of staff meetings had occurred in the directorate in April 2017.
- All staff in the directorate told us their wards and departments were well-led and placed the child or young person at the heart of everything they did.

## Vision and strategy for this service

- The service had a clear vision and set of values focused on providing safe, effective and quality care. The trust values were included in this to put patient safety above all else, aspire to excellence, reflect, learn and improve, and respect and support each other.
- The strategic goals for the WCOHCS division 2017/18 mirrored the aims and objectives of the trust which were to focus on quality and safety, exceed patient expectations, strengthen local clinical services, enable excellence through staff and ensure a sustainable future. For example in the child health directorate; review and plan case for admission avoidance schemes, review and fully establish the medical day case unit and improve recruitment and retention in paediatric nursing.

# Services for children and young people

However, not all staff were clear about the longer term development of children's services. For example, the continuation of the integrated model of service delivery for children and young people's services at the trust.

## Governance, risk management and quality measurement

- The service had an effective governance structure and risk management framework to support the delivery of good quality care. Monthly directorate governance meetings fed into the WCOHCS divisional governance meetings, which reported to the trust governance group. We reviewed three sets of divisional and directorate minutes which showed incidents, risks, audits, safety and quality improvements, clinical effectiveness and patient experience were discussed. Action points were clearly shown.
- The directorate had an effective risk register, which identified each risk with a description of the mitigation and assurances in place and a nominated risk owner. There were 22 risks identified on the risk register. These included areas such as discharge delays in the children and adolescent mental health services (CAMHS), staffing levels in relation to the inability to recruit to the junior doctor rota and capacity issues in relation to the bereavement service and the child development centre. Risks were reviewed regular and the register updated. However, not all risks in the service that we found on inspection had been identified. For example, children and young people could access the corridor to the delivery suite, the surgical pathway for children who needed to cross the road between buildings had not been reassessed since 2012, and a service specific child abduction policy was not in place. We raised the issues with the trust as described in the safe section of our report who responded immediately to our concerns. The trust responded immediately by risk assessing areas and implementing mitigating actions to reduce risk. We reviewed the actions taken by the trust at our unannounced inspection. We saw appropriate actions had been taken to ensure children and young people were cared for safely in the trust.
- Paediatric wards maintained a nursing quality and performance dashboard, based on the recommendations outlined in the 'High Quality Care Metrics for Nursing' report (2012). Patient data was audited monthly against quality care indicators which included, falls/safety assessments, pressure prevention

assessments, child observations (documentation) safeguarding (observation) nutrition (observation). A traffic light system was used to identify performance against agreed compliance thresholds. The data was reviewed at monthly senior nurse meetings and matrons took action against performance measurements that fell below the required standard. Staff at all levels were aware of the main issues on the dashboard.

- The performance dashboard for April 2017 identified the majority of clinical indicators as being green for the directorate. This meant expected standards had been met. The results of the dashboard were discussed monthly at trust board meetings. We saw in the minutes of the board papers for April 2017 evidence where areas of non-compliance had been discussed and actions to address shortfalls put in place.

## Culture within the service

- There was a strong child-centred culture across paediatric services, which was open and transparent and allowed staff to speak up when they had concerns.
- Staff were encouraged to raise issues and concerns and felt confident to do so. Staff said they were listened to and received feedback promptly.
- We observed good working relationships across the directorate and it was evident morale was good and staff felt respected and valued.
- Staff talked proudly about being "a team" in the directorate and told us how staff would always go the "extra mile" when supporting children and families.

## Public engagement

- The trust recognised the importance of gaining the views of patients and the public. The trust used surveys and questionnaires to gather information to enable service improvement.
- Feedback from patients and the public in the form of compliments to the paediatric wards and completed Friends and Family test responses were discussed at team meetings. Information was recorded on whiteboards for patients and relatives to see.
- Children and young people were supported by volunteers on the paediatric wards. We saw volunteers were well known to patients and had developed supportive relationships with them.

# Services for children and young people

- Good relationships with parent support groups had enabled the provision of specialist cushions and 'Petal Patches' to support breast feeding mothers.
- Gosset ward held a celebration of 50 years of neonatal care at the trust where staff, retired colleagues, parents, children, and the public were invited to join the celebrations. Staff spoke very highly about this event and how senior managers had recognised the importance of celebrating the rich history of the service and its links with the local community.

## Staff engagement







- Staff at all levels felt informed about their own areas and the trust.
- Staff had attended open forums with the chief executive and managers and spoke positively about the engagement with patients and staff.
- Staff attended staff meetings and were encouraged to share their views.
- Staff from child health had been shortlisted in the trust's 'best possible care' awards in 2016. For example, staff from Gosset ward, the cystic fibrosis team, the paediatric clinical lead, play therapists, and the child health practice development nurse.
- Senior managers said they were well supported and there was effective communication with the executive team.
- The chief executive was well known in the trust and staff said they would approach her with issues and concerns.
- A regular programme of safety visits to clinical areas by non-executive directors helped staff to engage with the executive team.

## Innovation, improvement and sustainability

- The trust was continually developing children's services to allow innovation, improvement, and sustainability of services.

- Staff on Gosset ward had developed an assessment tool to improve the monitoring and assessment of baby's skin on the ward. The ward was working with neonatal services from across the world (Canada and Turkey) to further develop the tool.
- Gosset ward was working towards achieving Bliss accreditation. Accreditation focusses on integrated care involving families, bonding with babies and breast feeding.
- Staff newly appointed to the trust, received a welcome letter from the matron which invited them to contact the matron with any concerns or queries they might have to support them in their new role.
- The nurse education team had been expanded in 2015 to better meet the increasing education and training needs of staff on the paediatric wards and departments.
- Disney ward received the outstanding student nurse's placement commendation in 2016.
- Recruitment of 1.6 whole time equivalent (WTE) advanced neonatal nurse practitioners (ANNP) onto the medical neonatal rota to help address the recruitment issues the trust was experiencing within the directorate in regard to the recruitment of junior doctors.
- Nursing recruitment initiatives included the appointment of student nurses in their third year and offering them in conjunction with the paediatric wards, access to the "New Starter" week course where neonatal and paediatric teaching is given.
- The neonatal life support course was run three times a year by the trust and was based at the hospital which facilitated the attendance of nurses and midwives from the organisation.
- A joint quality and safety initiative had been undertaken with the maternity service to reduce the numbers of cold babies arriving on Gosset ward and developing hypothermia. A warming cot was now available in the maternity unit.

# Outpatients and diagnostic imaging

|            |                                 |   |
|------------|---------------------------------|---|
| Safe       | Good                            |  |
| Effective  | Not sufficient evidence to rate |  |
| Caring     | Good                            |  |
| Responsive | Good                            |  |
| Well-led   | Good                            |  |
| Overall    | Good                            |  |

## Information about the service

Northampton General Hospital NHS Trust provides outpatient and diagnostic imaging services for a population of 340,000. The outpatient service includes ophthalmology, trauma and orthopaedics, ear, nose and throat, dermatology, urology, endocrinology, cardiology and diabetes care. The diagnostic imaging services cover computerised tomography (CT), magnetic resonance imaging (MRI), plain film radiology, nuclear medicine and breast imaging. The diagnostic laboratories services include pathology, biochemistry and microbiology.

The diagnostic imaging department sits in the clinical support services division within the trust. The department currently consists of direct radiography rooms, three CT scanners, an interventional suite, a nuclear medicine department, one MRI scanner, a dual-energy X-ray absorptiometry scanner (DXA) and several diagnostic ultrasound rooms. The trust's diagnostic imaging department undertakes around 230,000 examinations each year.

The outpatient and diagnostic imaging service had been previously inspected in January 2014 and had been found to be requiring improvement in safe, responsive and well-led and good in caring. Effective was not rated.

Before our visit, we reviewed a range of information about the service. This information included findings from our previous inspection of the service in January 2014 and an analysis of the trust's performance and information from stakeholders.

We carried out this inspection on the 25, 26 and 27 July 2017 and an unannounced inspection on 9 August 2017. The trust did not have a dedicated outpatients division. Clinics were linked to the different specialities, within the four clinical divisions. We visited a number of outpatient clinics and diagnostic imaging services, including radiology, trauma and orthopaedics, ear, nose and throat, diabetes unit, cardiology, rheumatology, endocrinology, fracture clinic, the pain clinic, the phlebotomy service and dermatology.

During our inspection, we examined the records of eight patients and spoke with 14 patients and their relatives, 51 members of staff, including consultants, radiographers, radiologists, nurses, healthcare assistants, reception staff and allied health professionals. We also held a focus group attended by 71 staff from various outpatient specialties and staff groups.



# Outpatients and diagnostic imaging

## Summary of findings

Overall, we rated outpatients and diagnostics as good for safe, caring, responsive and well-led. We inspected but did not rate the effectiveness of the service, as we are currently not confident that we are collecting sufficient evidence to rate this key question for outpatients and diagnostic imaging. We rated this service as good because:

- Staff were aware of their responsibilities and understood the need to raise concerns and report incidents. Staff told us they felt fully supported when raising concerns. There was a positive learning culture regarding the management and shared learning of incidents.
- Generally, effective standards of cleanliness and hygiene were maintained across the areas we visited.
- Generally, the design, maintenance, and use of facilities and premises met patients' needs. The maintenance and use of equipment kept patients safe from avoidable harm.
- Improvements had been made in some areas in the outpatient environment, which included the expansion of the chemotherapy suite and new equipment in the diagnostic imaging department.
- Emergency medicines for resuscitation were stored on dedicated tamper evident resuscitation trolleys, and were available for immediate use.
- Generally, there were effective systems in place regarding the storage and handling of medicines.
- Patient records were maintained and stored in accordance with trust policy.
- Arrangements were generally in place to safeguard adults and children from abuse.
- Appointments were prioritised according to referral requests from GPs with urgent requests and cancer referrals booked within two weeks. The imaging department prioritised reporting higher risk examinations not seen by other clinicians.
- We found that medical and nursing staffing levels and skill mix were planned and reviewed so that patients received safe care and treatment.
- Care and treatment was delivered in line with national guidelines. Patient's pain was managed appropriately.
- Staff within the service had the appropriate skills, qualifications, and knowledge to complete their roles safely. All teams reported effective multidisciplinary working.
- Staff generally had the information they needed to deliver effective care and treatment to patients. Staff understood their roles and responsibility regarding consent and were aware of how to obtain consent from patients.
- We saw that all staff treated patients with caring, compassion, kindness, dignity and respect in all areas visited. Feedback from patients and those close to them was positive about the way they were treated.
- Patients were involved in their care and decision making processes. Staff spent time talking to patients and those close to them.
- Staff made patients' appointments according to the needs of the individual. This included moving them to allow work and other appointments to take place.
- The service worked effectively with a variety of stakeholders and commissioners to plan delivery of care and treatment and was a proactive partner in shaping community provision.
- The service consistently met the referral to treatment standards over time.
- Waiting times for diagnostic procedures was better than England average.
- The service was meeting cancer targets for referral to treatment times at the time of the inspection.
- The "did not attend" (DNA) rate for the trust from June 2016 to May 2017 was 7% and this was same as the England average of 7%.
- Outpatient specialties ran additional evening and weekend clinic lists to reduce the length of time patients were waiting. The radiology department offered a walk in service for all plain film examinations.
- Services were tailored to meet the needs of individuals and offered flexibility in choice with appointments being flexed across a seven day service within the diagnostic imaging department.
- Generally, the service had an effective process for categorising and handling complaints and concerns.
- The service had a challenging and innovative strategy that supported the trust vision. This



# Outpatients and diagnostic imaging

included redesign of departments, introduction of support systems to improve performance and repatriation of services to improve patient experience.

- Staff had awareness of the trust vision and strategy. Staff were aware of the risks within their departments. Staff were proud to work at the hospital and passionate about the care they provided.
- The service had leadership, governance and a culture which were used to drive and improve the delivery of quality person-centred care. Staff felt that managers were visible, supportive and approachable.
- Specialties were focused on developing services to improve patient care.

However, we also found that:

- We found concerns about the fire exit in the fracture clinic. This had been addressed by the unannounced inspection and we found the service had also reviewed all fire exits throughout the service.
- Not all staff had had the required frequency of mandatory training, including safeguarding. Plans were in place to address this.
- The controlled drugs cupboard in the pain relief clinic contained a variety of non-controlled drugs. This was not in line with medicines storage guidelines. We raised this with the service and this had been rectified by the time of our unannounced inspection.
- We observed poor infection control practices in both the blood-taking unit and the pain relief clinic. We raised this with the service and this had been rectified by the time of our unannounced inspection.
- Some staff in the diagnostic imaging department had limited understanding of the ionizing radiation (medical exposure) regulations (IR(ME)R) regulations themselves and five members of staff we spoke to were unable to locate where the employers' procedures were kept. We raised this with the service and senior staff took immediate action to address this.

## Are outpatient and diagnostic imaging services safe?

Good



We rated safe as good because:

- Staff were aware of their responsibilities and understood the need to raise concerns and report incidents. Staff told us they felt fully supported when raising concerns.
- There was a positive learning culture regarding the management and shared learning of incidents.
- Staff had an effective awareness of the Duty of Candour process and demonstrated an understanding of when it should be implemented.
- Generally, effective standards of cleanliness and hygiene were maintained across the areas we visited.
- Generally, the design, maintenance, and use of facilities and premises met patients' needs. The maintenance and use of equipment kept patients safe from avoidable harm.
- Improvements had been made in some areas in the outpatient environment, which included the expansion of the chemotherapy suite and new equipment in the diagnostic imaging department.
- Emergency medicines for resuscitation were stored on dedicated tamper evident resuscitation trolleys, and were available for immediate use.
- Generally, there were effective systems in place regarding the storage and handling of medicines.
- Patient records were maintained and stored in accordance with trust policy.
- Arrangements were in place to safeguard adults and children from abuse.
- Appointments were prioritised according to referral requests from GPs with urgent requests and cancer referrals booked within two weeks. The imaging department prioritised reporting higher risk examinations not seen by other clinicians.
- We found that medical staffing levels and skill mix were planned and reviewed so that patients received safe care and treatment.
- There were adequate numbers of nursing and medical staff to safely manage clinics and that patients' needs were met at the time of the inspection.

# Outpatients and diagnostic imaging

However:

- We found concerns about the fire exit in the fracture clinic. This had been addressed by the unannounced inspection and we found the service had also reviewed all fire exits throughout the service.
- Not all staff were compliant with infection prevention and control measures in the blood taking unit. We raised this with the service, and immediate actions were taken to review infection control precautions to mitigate risk. This had been addressed by the unannounced inspection.
- We found issues with the storage of controlled drugs in the pain relief clinic. However, when we raised this with the service, senior managers took immediate action to address storage of these drugs. This had been addressed by the unannounced inspection.
- Not all staff had had the required frequency of mandatory training, including safeguarding. Plans were in place to address this.

## Incidents

- Staff understood their responsibilities to report incidents and patients were informed when things went wrong. Learning was shared and actions taken to prevent reoccurrence.
- Staff used the trust wide electronic incident reporting system to report incidents. All staff we spoke to confirmed they knew how to escalate and record incidents using this system. Staff in the cardiology outpatient department told us about an incident where a patient was prepared for the wrong procedure. This was reported as an incident, discussed with the patient and at the trust's serious harm group. There was no harm to the patient. Learning from this incident was shared during their team meeting.
- Staff working in the outpatients department told us that learning from incidents was fed back via morning huddles, which were held at the start of each day. These were facilitated by senior nursing staff. The huddles were minuted, as evidence that learning from incidents was cascaded to all staff. Some staff we spoke to were able to describe examples of learning from incidents within their speciality.
- Staff told us they felt fully supported when raising concerns. There was a positive learning culture regarding the management and shared learning of incidents.
- Staff said where they had reported an incident on the electronic reporting system; they were given feedback from the incident.
- There had been no never events reported for outpatient and diagnostic imaging services from May 2016 to July 2017. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- In accordance with the Serious Incident Framework 2015, from May 2016 to April 2017, the trust reported no serious incidents (SIs) in outpatients, which met the reporting criteria set by NHS England.
- In the period from January 2016 to May 2016, the service had reported three incidents where patients received doses "much greater than intended" under the Ionising Radiation (Medical Exposure) Regulations 2000. Since May 2016, the trust had not reported any such incidents. On review of these incidents, it was noted they had been reported on the trust's electronic reporting system.
- There were 115 incidents reported by the outpatients and diagnostic imaging service from July 2016 to June 2017 through the trust's incident reporting system. These covered a range of topics. This showed an effective reporting culture and incidents were documented as per trust policy. We reviewed some incidents and found there was a mixture of different types of incidents, and that these incidents were investigated as appropriate. We saw action was taken immediately after the incident had occurred and action plans put in place.
- The most reported incident theme in diagnostic imaging was about issues with the patient archiving communication system (PACS) and the archiving of images. This category accounted for 20% of the reported incidents. The majority of these were caused by IT issues with the radiology information system (RIS) and PACS. When these incidents occurred, staff escalated it to the IT department, who informed the supplier and they performed repairs.
- The diagnostic imaging department had also picked up a number of referrer errors where the wrong patient had been requested to have an examination. These were all reported as near misses. This showed an effective reporting culture and the ability to pick up to such incidents through internal departmental checks.

# Outpatients and diagnostic imaging

- From November 2014, NHS providers were required to comply with the Duty of Candour Regulation 20 of the Care Quality Commission (Registration) Regulations 2014. 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 staff we spoke with were aware of the Duty of Candour regulation (to be honest and open) ensuring patients always received a timely apology when there had been a defined notifiable safety incident. Staff understood their responsibilities and provided examples of when the Duty of Candour process would be used and were aware of the trust policy and the triggers for when Duty of Candour procedures must be followed. For example, we were told about a patient who was prepared for the wrong procedure. As soon as the mistake was identified, clinical staff openly discussed the incident with the patient and apologised for the distress caused.
- The radiology department had recently implemented Duty of Candour stickers. These stickers were placed into patients' notes following an incident to indicate that Duty of Candour had been followed when required.
- A radiation protection supervisor (RPS) was available for each diagnostic imaging modality as required by IRR99. The purpose of these roles was to ensure that staff followed local rules and adhered to radiation protection procedures in the department. The local rules summarise the key working instructions intended to restrict exposure in radiation areas.
- The radiation protection supervisors provided bi-annual reports covering radiation protection overviews for the areas they cover. These were shared at the Radiation Protection Committee which met quarterly.
- The Ionising Radiation (Medical Exposures) Regulations 2000 is legislation, which provides a framework intended to protect patients from the hazards associated with ionising radiation. During the inspection, some staff were not able to describe or locate key procedures required under this legislation. These members of staff included senior and junior management as well as radiographers working in the clinical areas. We saw the trust's procedures; however, some staff believed these to be of too high a level to be an effective working document. The medical physics team recognised this and this was on the agenda for discussion at the next radiation protection committee.
- When we raised this with senior managers, they stated that in order to understand this issue better, they had met with staff in the radiology department. It was apparent that IR(ME)R regulations were understood and the impression of apparent lack of awareness may have been due to some anxiety on the part of the individuals being interviewed by a CQC inspector together with the terminology used. Whilst the required policy documents were in place, the department used this feedback as an opportunity to review the trust's overarching policy and the other supporting policies and modality protocols. As an immediate action, they informed us that an outline of the standard operational policies for each modality would be put in place within one week. In addition, the functioning of the Radiation Protection Committee was being reviewed with a revised chair in the form of the Divisional Director for Clinical Support services and was due to meet on August 4th. The department leads would also be making visits to other trusts to benchmark their procedures related to IR(ME)R.
- We saw that risk assessments had been carried out on all imaging equipment and staff wore radiation badges to monitor any occupational doses.

## Radiation Protection

- The medical physics department supported diagnostic imaging staff by providing radiation protection services. This team included radiation protection advisors (RPAs, as required under Ionising Radiation Regulations 1999 [IRR99]), medical physics experts (MPEs, as required under Ionising Radiation (Medical Exposures) Regulations 2000 [IR(ME)R]) and radioactive waste advisors (RWAs). The medical physics teams provided scientific support to radiology departments in a number of areas such as monitoring of the specialist radiology equipment, monitoring staff radiation doses, and providing guidance on the various specialists' regulations surrounding the use of imaging equipment.
- The radiology department had a service level agreement with a partner hospital's medical physics team to provide support for the non-ionising radiation equipment such as the Magnetic Resonance Imaging (MRI) and the ultrasound scanners. This agreement provided a safety expert and quality assurance for both MRI and ultrasound scanners.

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## Cleanliness, infection control and hygiene

- Standards of cleanliness and hygiene were generally well maintained. Reliable systems were in place to prevent and protect people from a healthcare associated infection.
- All areas we inspected, including clinical and waiting areas, were visibly clean and tidy. We saw completed cleaning schedules in place, which confirmed areas had been cleaned. Staff told us that domestic staff cleaned the areas daily.
- Cleaning staff were observed using colour coded equipment for different types of areas to minimise risks of cross infection in line with trust guidelines.
- Clinic rooms used for clinical procedures were adequately equipped to maintain safety and infection control standards. Toilets, clinic rooms and clinical areas were clean and well equipped with hand washing gels and paper towels. For example, we inspected 18 consultation rooms across the outpatients department and noted all had gloves, aprons and hand washing facilities available.
- The service held infection prevention operational meetings and actions arising from audits were discussed during this meeting. Matrons from various departments were challenged on what actions they had taken to address any issues identified.
- We looked at January 2017 infection control audit results and saw, the pain relief clinic and ear, nose and throat departments scored 100% on cleaning and decontamination. Hand hygiene audit for doctors and nurses was 100%. The service also carried out regular infection control/cleaning standards audits. In February 2017, the fracture clinic score 99% out of 100% and we saw the one area to be actioned had been addressed. In July 2017, the pain clinic scored 98% out of 100%. Health and safety environmental audits were also carried out including hot water temperatures and legionella flushing processes: for July 2017, for the radiology department no infection control issues had been identified as a concern.
- We observed cleaning of equipment in the integrated surgery outpatient department and patients we spoke with also thought the hospital and department was clean.
- Hand sanitising gel dispensers were available in corridors, waiting areas and clinical rooms. Staff were observed using hand sanitisers and personal protective equipment as appropriate.
- We saw “I am clean” stickers in use across all clinical areas stating the date and time of last cleaning, showing the equipment was clean and ready for use.
- The majority of staff complied with infection prevention and control policies. All clinical staff adhered to the provider’s ‘arms bare below the elbow’ policy to enable good hand washing and reduce the risk of infection. There was access to hand hygiene facilities and a supply of personal protective equipment (PPE), which included gloves and aprons.
- All areas had laminated posters of ‘5 moments of hand hygiene’ displayed in each clinical room.
- In the outpatients’ blood taking unit, we observed poor adherence to infection control precautions as out of five staff observed, three were not changing their aprons between patients and not all staff changed gloves between patients. This was raised with the staff involved and senior staff at the time of our inspection. Following our finding, the unit had undertaken an immediate audit of infection control procedures together with a PPE audit.
- On our unannounced inspection, we found the service had taken immediate actions to address this concern and all staff had had a refresher training session and managers had ensured staff were fully aware of all relevant policies and procedures.
- Staff were required to undergo regular infection control training as part of statutory, mandatory and role specific training in this area. Compliance generally met the trust’s target of 85%.
- In the pain relief clinic, we observed medical staff wearing a surgical gown in a clinic room and this was not in line with infection control guidance. We raised this with staff involved at the time of our inspection.
- We saw clinical rooms had facilities for the disposal of clinical waste and sharps. Waste management was handled appropriately, with separate colour coded arrangements for general waste, clinical waste, and recycling.
- Clinical bins had foot pedal operated lids and were not overfilled. Sharps bins observed were assembled correctly, signed, dated and not overfilled.

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- Staff in the integrated surgery outpatients unit told us patients with known infections would be taken straight into the clinic room and would not be left in the waiting area where possible. The clinic room would be deep cleaned immediately after use.
- We saw children's toys in the blood taking area were on a weekly cleaning rota.
- The imaging department had limited cleanliness, infection control or hygiene audits (with the exception of hand hygiene). Whilst the imaging department was visibly clean and tidy, we found limited audits to ensure standards were maintained.
- In the diagnostic imaging department, we saw from January 2017 to May 2017, 80% of staff audited were compliant with hygiene audits. We raised this with senior managers who took actions to address this.
- The chemotherapy suite had a spillage kit and this was accessible to all staff.

## Environment and equipment

- Generally, the design, maintenance, and use of facilities and premises met patients' needs. The maintenance and use of equipment kept patients safe from avoidable harm. Improvements had been made in some areas in the outpatient environment, which included the expansion of the chemotherapy suite and new equipment in the diagnostic imaging department.
- Clear and bright coloured signage was in place to guide patients visiting the outpatient departments. Outpatient clinics were held within various specialities. Each area had its own reception and waiting area.
- We examined the resuscitation trolleys located throughout the outpatient department and found evidence that regular checks had been completed and documented to ensure the equipment was fit for use. For example, oxygen cylinders were available on the resuscitation trolleys and were all in-date.
- The outpatient areas completed quarterly health and safety inspection checklists. We saw equipment was in working order and working areas were kept clean.
- The maintenance of equipment was completed via either the manufacturers or the trust estates' department. Equipment was assessed annually as safe for use. We saw the maintenance logs for all equipment as part of our inspection.
- Clinicians told us that there was sufficient medical equipment to meet their needs, for the number and

types of patients seen in the outpatient clinics. Both static and mobile equipment was available to ensure patients were seen in a timely manner (for example portable x-ray machines).

- There were systems to maintain and service equipment as required. Equipment had stickers with appropriate dates to show they had been service tested and when the next service was due. Service testing is an examination of electrical appliances and equipment to ensure they are safe to use.
- We observed the equipment within the ear, nose and throat clinic was cleaned appropriately between patients. The scopes were tagged as being dirty and were then transported in trays to the decontamination area within the department. However, we observed a member of staff transporting a dirty scope, which was not placed in a tray. When we challenged this practice, staff said there were shortages of trays. There was a risk of cross contamination due to a potential bodily fluid dripping from the equipment being transported. We raised this with staff who said this was poor practice and was an area for improvement.
- The chemotherapy suite had recently been refurbished with an extra capacity of six chairs to accommodate patients receiving chemotherapy.
- We found concerns about the fire exit in the fracture clinic as we found it had been blocked by chairs on the first day of the inspection. We found concerns about the fire exit in the fracture clinic. When we first visited the department, staff assured us that a narrow door in the staff room was the fire exit, but chairs were blocking this exit. When we returned the next day, this fire exit signs had been removed and painted over. This meant the fracture clinic only had one entrance/exit, presenting a risk to safe egress in case of a fire. We raised this with senior staff at the time of inspection. We raised this as a concern with senior managers. During the unannounced visit, this had been fully addressed and all staff were fully aware of appropriate fire safety precautions and fire exits. Appropriate signage was in place. Staff within the fracture clinic were required to undertake a refreshed fire training to ensure they were aware of fire safety requirements. We also found the service had reviewed all fire exits throughout the service to ensure they were appropriate. A specific table top exercise



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regarding evacuation was organised with the fire safety officer to provide face-to-face training about what to do with ambulatory, non-ambulatory and trolley/bed patients.

- We saw that the last health and safety quarterly inspection was undertaken in quarter two of 2016 in radiology. This showed some minor areas for improvement. Health and safety environmental audits were also carried regularly with the last one in July 2017.
- We saw evidence of daily checks on the dose outputs on the plain film rooms. We heard how medical physics performed checks regularly on the equipment and this was monitored in the radiation protection supervisors report.
- The capital replacement programme was in place within the diagnostic imaging department, the majority of the equipment within the radiology department was new, and all of the equipment that was close to its end of life had plans in place to be replaced in the upcoming period.
- Within the last two years, the department had replaced two of the CT scanners and had an additional third scanner put in for A&E and inpatients examinations. The department had also recently replaced: the nuclear medicine gamma camera, 30 PACs workstations for reporting of images through the radiology consortium, a new fluoroscopy suite, a new interventional suite, four new plain film rooms and a number of ultrasound scanners. The department also had funding to start constructing a new building to house a second MRI scanner.
- In response to the increased demand in the radiology department, CT and MRI scanners had been added to increase the capacity within the department and help to ensure patients receive scans in a timely manner.
- The diagnostic imaging department areas were well lit and free of clutter. The waiting and clinical areas were clean.
- There were clear signage and illuminated radiation warning signs in place to warn people about potential radiation exposure. The MRI scanner was kept secure behind coded doors. Radiographers performed safety questionnaires to ensure anybody entering these areas were kept safe from the high magnetic field.
- The X-ray treatment room in the fracture clinic did not have appropriate ionising radiation warning signs. There was a paper sign stuck to the outside of the door saying "do not enter". There was no fixed sign/red light. When

this was raised with staff, they said this was because it was not a permanent x-ray room. Failure to have clear signage meant that staff, patients and relatives could be exposed if they walked into the room whilst treatment was in progress. The service took action to address this during the inspection.

## Medicines

- Generally, there were effective systems in place regarding the storage and handling of medicines.
- There was an established system for the management and storage of medicines to ensure they were safe to use. Medicines that needed to be kept within a certain temperature were stored in designated refrigerators in the clinical anticoagulation department and the chemotherapy suite.
- There was generally effective compliance with the checking and recording of the ambient and fridge temperatures in line with the trust's policies and procedures. Temperature records we reviewed were completed and contained minimum and maximum fridge temperatures, which alerted staff when they were not within the required range. Staff we spoke to were aware of the procedure to follow when temperatures were not within the required range.
- We found in the chemotherapy suite that medicines were stored securely with secure access limited to nursing staff. Medicines requiring cool storage were stored appropriately in locked medicine refrigerators. However, daily refrigerator temperatures were not always recorded when the clinic was open (on five out of 20 days in June and three out of 17 days in July) which meant it was not always possible to determine if medicines and prepared chemotherapy bags were stored within safe temperature ranges. We raised this with staff who told us this would be raised with all staff and closely monitored. An action plan was available from pharmacy to inform staff what to do if the temperatures were consistently outside the safe range.
- Due to the high volume of patients on the chemotherapy suite, a clinical pharmacist was based on the unit for five days a week. The clinical pharmacist and was fully integrated into the multidisciplinary team and attended the oncology team meetings every three weeks. The pharmacist team were involved in reviewing



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all prescriptions including validating the intravenous chemotherapy prescriptions to ensure accuracy as well as supporting any clinical decision making about patients' individual medicine requirements.

- Patient group directions (PGDs) were used in ENT and ophthalmology to cover the supply and/or administration of eye drops and eye ointments. A PGD is a document signed by a doctor and agreed by a pharmacist, to give direction to a nurse to supply and/or administer specific medicines to a pre-defined group of patients using their own assessment of patient needs, without necessarily referring back to a doctor for an individual prescription. We saw that PGDs had been authorised and signed appropriately.
- The diabetes clinic and maxillofacial outpatient areas used FP10 prescriptions. FP10 prescriptions are the common form on which a prescription is written. They are used for outpatients and can be taken to any pharmacy for the medicines to be dispensed. We observed that FP10 prescription pads were stored securely in locked cupboards. Two members of staff signed out each FP10 that was taken and the prescription form number was logged.
- Prescription pads for dispensing of medicines from the on-site pharmacy were stored securely in the fracture clinic. We saw that systems were in place to monitor prescriptions issued.
- Emergency medicines for resuscitation were stored on dedicated trolleys, which were accessible and available for immediate use.
- All drugs were stored safely behind locked doors and only accessible to appropriate staff. We saw most controlled drugs (CDs) were stored appropriately. Controlled drugs are prescription medicines controlled under the Misuse of Drugs Legislation 2001.
- In the pain relief clinic, we found the CDs storage cupboard contained a variety of non-CDs and that staff spoken with did not fully understand the significance of this incorrect storage. CD cupboards must be solely used for the storage of CDs. We raised this with the trust's pharmacist who said immediate arrangements would be made to remove and relocate all other items. Following our inspection, senior staff informed us that the non-CD medication had been removed from the cupboard and actions taken to ensure that lessons are learnt from this incident. The trust was planning to introduce a trust-wide sticker to go on CD cupboards stating only controlled drugs should be stored

separately. We followed this up during our unannounced visit and saw CDs were stored appropriately and the staff on duty were all fully aware of the trust's procedures regarding CD storage. We also found that the service had reviewed storage of CDs throughout all relevant areas in outpatients to ensure they were being stored correctly.

- Daily checks were in place to ensure emergency medicines were available and safe to be used. This ensured that the Guidance from the Resuscitation Council (November 2016) was followed.
- The plaster room within the fracture clinic contained a cylinder of nitrous oxide and oxygen for patients who required pain relief when they had a plaster cast fitted. This gas is a ready-to-use medical gas made up of half oxygen and half nitrous oxide and is used when patients require a rapid onset and offset pain relief. This gas was only given to patients when a doctor had prescribed it.
- Radiology patients requiring contrast (chemicals that improve pictures of the inside of the body) were screened using safety questionnaires. Risks and potential side effects were also discussed with patients prior to administration.
- Trust doctors prescribed all medicines including contrast media used in CT and MRI. Prescription of such contrast media was documented on the radiology information system (RIS).
- We saw evidence that all contrast media was stored appropriately and warmers were used for the intravenous contrast in CT.

## Records

- Patients had individual care records written and managed in a way that kept them safe from avoidable harm. Patient records were maintained and stored in accordance with trust policy.
- The outpatient department used a combination of paper medical records and an electronic system. Paper records were maintained for each clinic attendance.
- We saw that the records of patients who attended outpatient clinics were stored securely to maintain patient confidentiality. Records viewed were completed accurately and legibly in accordance with trust policy.
- Radiology records were held securely on the radiology information system (RIS) and patient archiving

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communication system (PACS). Staff had access to PACS across the trust and the systems were password protected. Staff received training on these systems as part of the departmental induction.

- Imaging requests were made electronically by doctors and other trained staff across the trust and the local GP community. Paper request forms were still in use for external referrers outside of the trust.
- During our last inspection in 2014, staff within medical records department confirmed that there were regular issues with missing notes and that staff did not always use the tracking system that was available to them. The impact of not having records affected both patients and the clinician seeing the patients as they did not have all the information to inform their decision. During this inspection, we still identified issues with missing notes. Staff in ophthalmology department had started collecting data on missing notes and the audit we saw showed seven patient notes were missing in one day in July 2017. Nursing and medical staff told us across other departments that at least one or two sets of patient records would be unavailable out of ten to 13 booked at each clinic. These were not recorded as incidents. In some cases, the clinician used temporary electronic patient records. However, not all patient records were digitalised and there was a risk that clinicians were treating patients without their full medical history and treatment plan being available. Staff said where patients were booked for a procedure and patient records were unavailable, the procedure would be cancelled.
- In response to our feedback to the trust, senior staff said the trust had been undertaking an improvement project in response to availability of medical notes with a task and finish group led by the divisional manager for clinical support services. This group had completed work at divisional level and were looking into particular issues at directorate and service level. There had been some improvements in recent months.
- The trust undertook monthly audit of medical records availability and this was reported through a divisional performance management process. The overall performance from April 2017 to June 2017 was 98%. Data provided by the trust showed from February 2017 to July 2017 that no procedures or appointments were cancelled because of missing notes.
- Two per cent of patients were therefore seen in outpatients without the availability of a full medical

record. To mitigate this risk, temporary patient records were created in the department to include all the available documents for the patient. Local missing records audits were kept for each area.

- The service risk register identified that missing notes was a concern throughout all directorates. The risk register also recognised that this meant patients could be inadequately assessed and some procedures either delayed or cancelled because of lack of patient medical records.
- We raised this with staff within the medical records department who said there was lack of communication between outpatient departments and the medical records department. The medical records department had a system of checking and making notes readily available up to two days before clinics. Patients were added to the list without direct communication with the medical records department.

## Safeguarding

- Generally, appropriate arrangements were in place to ensure patients were kept safe from potential abuse. The hospital had safeguarding policies and procedures available to staff on the intranet, including out of hours contact details for hospital staff. There were posters displayed with contact details of the hospital's safeguarding team.
- Arrangements were in place to safeguard adults and children from abuse that reflected relevant legislation and local requirements.
- Staff understood their responsibilities and were aware of safeguarding policies and procedures. Staff we spoke with were aware of safeguarding procedures, how to escalate concerns and relevant contact information.
- The trust was in the process of reviewing the appropriate number of staff in the outpatient's service that had the required levels of children's safeguarding training in line with the 'Intercollegiate document on safeguarding children and young people' (March 2014). For example, staff within the integrated surgery department who were involved in the assessment and treatment of children were trained to level two only. Senior nursing staff were trained to level three. Nurses who had direct contact with children said they had been told by safeguarding leads that they required to be trained to level two. Staff said they had access to a level three trained colleague for all clinics.

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- In outpatients, senior managers told us that when staff had a concern about a child or a family in an outpatient clinic, support was obtained from the person in charge. This may be the ward sister or their deputy who had undertaken the appropriate level of training according to the Intercollegiate Document. These safeguarding arrangements were supported by immediate access to a safeguarding professional, available during core working hours (8am to 6pm), who was able to respond to concerns and offer support and advice.
- Training statistics provided by the trust showed that 89% of nursing staff had completed level two safeguarding children and 86% safeguarding adults training level two. We saw 70% of nursing staff had up to date training in safeguarding children level three. The trust's internal target for this training was 85%. The information for doctors showed 68% had safeguarding adults level two training, 72% had safeguarding children's training level two and 64% had safeguarding children level three. We saw that further training dates were being arranged to address this shortfall.
- Senior managers said a discussion was held at the trust's Safeguarding Assurance Meeting in July 2017 to discuss the compliance of level three safeguarding training as it was felt that the trust was attempting to train more staff at this competency level than was required as per the Intercollegiate Document. The associate directors of nursing and the safeguarding team had been tasked to review the safeguarding roles and responsibilities across the trust in line with the Intercollegiate Document to confirm the correct number of staff requiring this training.
- External speakers provided safeguarding level three training in female genital mutilation and domestic abuse three times a year at the trust. In addition, staff requiring level three training were invited to attend the child sexual exploitation forum with a member of the safeguarding team, or alternatively, spend time with the safeguarding children's team, to gain further insight into the complexities of safeguarding children. They were expected to write a reflection in these experiences. This enabled the attainment of greater competencies in safeguarding children whilst ensuring level three compliance.
- Information and relevant contact numbers for safeguarding were seen in public areas in the outpatient and imaging departments.
- Seventy-five per cent of radiologists working within the radiology department had completed mandatory training in safeguarding of children and young people level two and safeguarding of vulnerable adults level two in the past year. This was below the trust's target of 85%. Plans were in place to address this. However, 100% had completed children and young people safeguarding level three where appropriate.
- Seventy-nine per cent of radiographers had completed safeguarding of children and young people level two, 85% vulnerable adults level two, and 100% safeguarding children and young people level three.
- We saw a female genital mutilation poster in the integrated surgery outpatients waiting area with contact details of charities that can provide help and support to patients.

## Mandatory training

- Mandatory training covered a range of topics, including fire, health and safety, basic life support, safeguarding, manual handling, hand hygiene and information governance. Training plans were in place. Mandatory training compliance for nursing staff was 80%, which was lower than the trust's target of 85%. Trust data showed:
  - Equality and diversity training (90%).
  - Manual handling two yearly refresher (70%).
  - Health and safety including risk management (87%).
  - Infection, prevention and control (97%).
- Data provided by the trust showed 65% of medical staff had attended the equality and diversity training and 78% information governance and record keeping. Seventy-four per cent of staff had attended manual handling, 83% for health and safety including risk management, 74% had attended the trust induction and 91% were up-to-date on the infection prevention and practices training. Mandatory training compliance for medical staff overall was 74%, which was lower than the trust's target of 85%. We saw this had been recognised as a risk by the service and plans were in place to improve this compliance with a series of ongoing, rolling training sessions available for staff to attend.
- There was an induction programme for all new staff, and staff who had attended this programme felt it met their needs.
- Training was completed via e-learning modules and/or face-to-face sessions.

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- Senior staff had access to training compliance within the outpatient department and arranged the mandatory face-to-face training sessions for staff. Senior staff were notified of non-attendance via email. Staff in oncology outpatients told us there was a notice board within the department that provided training alert to staff when their mandatory training was due.
- The numbers of radiographers completing mandatory training were generally effective with all training sessions having over 90% attendance; this was above the trust's target of 85%.
- Radiologists were above the trust target for seven out of the nine mandatory training sessions, with only 81% attending trust induction and 75% refresher fire training.

## Assessing and responding to patient risk

- Risks to patients were assessed and their safety monitored and maintained. The nursing team and medical staff assessed and responded well to patient risk through regular assessments.
- Patient appointments were managed through a central electronic booking system (trust wide). Appointments were prioritised according to referral requests from GPs with urgent requests and cancer referrals booked within two weeks.
- There was a clear process in place in outpatients and diagnostic imaging departments to check the identity of the patient by using name, address, and date of birth. We observed staff obtaining this information from patients that attended for appointments within the blood taking unit.
- During our inspection, we observed that clinical waiting areas were constantly staffed. This meant staff had oversight of patients who were waiting to be seen and could respond promptly when needed.
- Risk assessments for patients were comprehensive; covering all health needs (clinical, mental health, physical health, nutrition and hydration needs and social care needs).
- Signs in relation to radiation exposure and pregnancy were seen throughout the imaging department.
- Resuscitation equipment was available in the outpatient and diagnostic areas. Staff in the maxillofacial department used a "grab bag" instead of a resuscitation trolley. This was because there had been two road traffic collisions on the road outside the unit

and staff were unable to take the resuscitation equipment with them. A decision was made to use a portable "grab bag" in order to meet patients' needs in the event of an emergency.

- Staff were aware of what actions they would take if a patient became unwell in the outpatient department. This included a call for urgent medical assistance, which meant that staff holding the emergency bleeps would be alerted to attend the department. Staff gave us examples of when they had appropriately escalated patients who had deteriorated within the department.
- There were emergency call alarms situated in the consulting and treatment rooms in the outpatient department. Staff would use the emergency call alarms to summon urgent assistance as needed, such as when a patient had deteriorated within the department. Emergency call alarms were also situated in the toilets, so that patients could summon urgent assistance as needed.
- Where an outpatient had a suspected cardiac arrest, their patient details would be entered into the emergency call follow up spreadsheet. If the patient had suffered a cardiac arrest their details would be inputted on to the national cardiac arrest audit. The resus team would provide feedback to staff if an incident was raised using the electronic recording system.
- The service carried out harm reviews for patients waiting for 45 weeks and over. Staff held weekly referral to treatment (RTT) performance meetings where all aspects of the patient pathway were discussed, including the validation of all patients waiting over 18 weeks. The service completed a harm form for any patient that was waiting over 45 weeks. This entailed pulling the patient notes along with the attached form and given to the consultant to review. Each directorate also had their own performance meeting to discuss these patients weekly.
- Two medical staff in oncology outpatients reported that sometimes their video conference multidisciplinary team meetings (MDTs) were affected by poor IT connectivity. This led to some MDTs being abandoned and staff having to make decisions about treatment in isolation because they were unable to share vital information about their patients and treatment plans. This could potentially lead to delays in patient treatment. Staff reported these incidents were not being reported through the trust incident reporting system.

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- The issue with poor IT connectivity was fed-back to senior staff during the inspection period. Senior staff said that the IT issues were related to IT connectivity problems from another trust and the local IT team at Northampton General Hospital had checked IT equipment in the oncology meeting rooms and confirmed they were operational.
- The cardiac (heart) centre was used as an escalation area posing risk to patient safety and of deterioration in condition of elective heart centre patients who were cancelled at short notice as a result of the heart centre being used as an escalation area. This was reflected in the service's risk register.
- The hospital joined a radiology consortium with six other NHS Hospitals in the East Midlands in April 2016. A consortium is an association or combination of two or more hospitals. This consortium, which had vanguard status and national funding, was to replace existing picture archiving and communication system (PACS) and radiological information system (RIS) to enable images and reports to be shared across the consortium hospitals. This will eventually allow outsourcing of reporting amongst the hospitals that will support the capacity and cost reduction required to sustain timely radiology reporting. They will also have access to more specialised reporting across the region. At the time of the inspection, the cross-site reporting was not yet available.
- As a result of issues with the PACS and reporting systems when the East Midlands radiology consortium went live, there was a reduction in the reporting performance resulting in delayed reports. In response, the trust changed the way it prioritised the unreported images. Higher risk examinations not seen by other clinicians were prioritised, this included cross sectional imaging. Additional reporting capacity was sought through insourcing (extra reporting sessions using substantive staff) and outsourcing to external reporting services and employment of additional locums.
- As a longer-term solution to reporting backlogs, the department also reviewed its use of reporting radiographers and extension of other roles to reduce radiologists' workloads to allow for concentration on reporting.
- During the period where the backlog was most significant, there was weekly review of the radiology's balance scorecard, which showed reporting performance. Incidents were logged via the trust's incident reporting system and the risk was logged onto the departmental risk register and the risk to patients from a delayed reports was mitigated as best possible by the department. At the time of the inspection, the reporting backlog was around 200, low risk plain films.
- For interventional procedures, staff used the World Health Organisation (WHO) 'Five Steps to safer surgery' (2010) surgical safety checklist. These checklists were used for patients undergoing angiography (procedures involving the injection of contrast into a major vessel) and image guided biopsies and drainages. These had been in use since 2011. These were scanned into RIS.
- The department audited the use of these monthly. In May 2017 an audit showed out of 62 procedures only five checklists had not performed a "check in" which are pre-procedure checks. Areas of non-compliance were fed back to the staff involved. The audit did show that one procedure did not have checklists performed and issue was raised at the daily huddle to remind staff that these checklists must be performed for all required cases.
- The clinical director was looking into the process of writing integrated paperwork incorporating the WHO checklist to cover more minor procedures within radiology.
- Where a radiologist found an unexpected and urgent finding during reporting, there was a procedure in place to ensure that the referrer was informed. The radiologist would phone through to the doctor or fax results to them at the earliest opportunity. This was in accordance with the Royal College of Radiologist guidelines. We heard there were plans in place for an integrated system that would automatically generate these emails as part of the new PACS system and the department was in the process of looking into this.
- Staff working in MRI had emergency plans in place for when patients collapsed or suddenly deteriorated on the table whilst undergoing a scan or after MRI contrast media was delivered. These were practiced during downtimes when the scanner was being tested. These emergency plans differed from that across the hospital due to the high level of magnetism, which prevent normal emergency teams and equipment from entering into the scanning rooms. Emergency resuscitation equipment was also available in all areas.



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- We saw the use of the “pause and check” in the plain film department, however we did not see this in CT. The Society and College of Radiographers produced this resource to reduce the number of radiation incidents occurring within radiology departments.

## Radiology staffing

- The department had avoided junior radiographer vacancies through offering students jobs early on in their third year of training (on the condition of qualification) for when they had completed their degree. These radiographers were initially employed as band 4 while their professional registration was processed. Once registration was achieved they would be appointed as radiographers. Radiology management told us that this process had worked well.
- At the time of the inspection, the radiology department used agency radiographers. We were told the agency staff were initially supernumerary and would only be signed off to work independently when they had completed a local induction. The local induction was very similar to the full induction for new starters and included equipment, procedure and IT competencies.
- Staff sickness was consistently under 3.1% between December 2016 and May 2017, in line with the trust target.
- In plain film, the radiographers were six members of staff above establishment when the current new starters had completed their induction period. These additional members of staff were funded to allow for the introduction of a shift system in plain film.
- Sonographers (specialist radiographers or other health professionals working in ultrasound) were also above establishment; however, this was in preparation for the introduction of Sunday sessions.

## Nursing staffing

- Our observations and interviews with staff confirmed that there were adequate numbers of nursing staff to safely manage clinics and that patients' needs were met at the time of the inspection. There were no national baseline staffing tools used in outpatients department to plan or staffing levels.
- We observed that there were reception and nursing staff available to support all clinics running during the

inspection. At the time of our inspection, actual staffing levels met the planned rota for staff needed per area. The cardiology department and clinic coordinators reported staff shortages.

- In July 2017, the number of whole time equivalent posts for outpatients and elderly care (in the medical and urgent care division) was 85% of a total of 369 whole time equivalent posts.
- The directorate scorecard for outpatient and other medicine specialties showed a bank and agency staff usage of 9.5% for May 2017 and 0% for June 2017. The trust target for this was 7.5%.
- Sickness absence for June 2017 increased slightly from 3.51% to 3.53%, which was below the trust target of 3.8%.
- Nursing staff turnover was 7%, below the trust target of 10%.
- Where additional staffing was required to cover extra clinics, sickness or annual leave, this was covered by bank staff or permanent staff who volunteered to work over and above their contracted hours. The trust employed bank staff on an ad hoc basis.
- The culture of supporting new/ bank staff was evident throughout the outpatient areas we visited. Health care assistants would assist with the management of the clinic lists and offer support to new and bank staff. Staff were provided with mentors and coaches appropriately and regularly worked alongside them to ensure competence.
- New and bank staff were inducted locally using a checklist with an additional competency pack for substantive staff. We saw evidence of local induction for bank and new staff within the blood taking unit.

## Medical staffing

- We found that medical staffing levels and skill mix were planned and reviewed so that patients received safe care and treatment.
- In the outpatient department, medical staffing for clinics was arranged by the individual specialties, such as rheumatology, cardiology, trauma and orthopaedics and ophthalmology.
- Outpatient departments generally had a stable clinic rota and off duties were produced four to six weeks in advance with appropriate staffing levels. Where there was additional demand, bank staff were used. In order to keep up with the demand, additional clinics or weekend working was put on to keep up with demand



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but only when there were suitable and safe staffing levels to accommodate this. Clinic lists were monitored weekly for change and the area managers had close links with the medical secretaries who would discuss any potential changes.

- Doctors and nurses spoken with said they had a good working relationship whereby they could discuss any issues or concerns. This was confirmed by administration staff who said they felt well supported.
- Medical staff undertaking clinics were of all grades; however, we saw that there were usually consultants available to support lower grade staff when clinics were running. For example, in the ophthalmology department, we observed a senior clinician supporting staff of lower grade.
- Reflecting the nationwide shortage of radiologists and difficulty in recruiting, the radiology department also had issues in recruiting consultant radiologists. At the time of inspection, there were seven consultant vacancies, with an establishment of 20.6 whole time equivalent (WTE) many of which were long-term vacancies.
- In response to the vacancies, the trust was looking to do a recruitment drive to help attract radiologists to the trust. The department planned to sponsor the Royal College of Radiologist Annual Scientific Meeting to raise the profile of the department and increase recruitment opportunities. They were also trialling reporting stations at home to attract staff.
- There have been initiatives to mitigate the staffing issues including increasing the skill-mix and role extension of radiographers.
- Consultant radiologists provided on call services after 6pm and the trust outsourced urgent cross sectional reports out of hours to an independent reporting service.

## Major incident awareness and training

- Potential risks to the service were anticipated and planned for in advance.
- There was an effective understanding amongst nursing and medical staff about their roles and responsibilities during a major incident.
- Each area had business continuity plans which contained action cards advising of actions to take in the event of an incident following a wide range of potential scenarios. This included IT failure or theft, loss of staffing or denial of access to an area.

- Staff were able to signpost us to the trust wide policy on major incidents which was located on the trust intranet.
- Staff were aware of fire safety precautions and emergency evacuation procedures.
- We saw a folder in radiology, which contained the steps to take in the event of a major incident. Staff were able to locate this folder.
- The radiology department was affected by the recent cyber-attack. Extra staff were brought in and manual processes were in place to mitigate risk. Following the cyber-attack, there was a debrief and staff were able to make suggestions of ways to manage potential attacks in the future.
- Each department had a fire warden and there were regular fire drills.
- Staff in outpatients worked across four divisions. Fire safety training was provided at division level and we saw 80% of staff were compliant with the fire safety training. This was below the trust target of 85%. We saw that training plans were in place on a rolling basis to improve this compliance level.
- We saw clear fire risk assessments for various outpatient areas. The fire safety policy also showed details of procedure to be followed if a fire was discovered.

## Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

We inspected, but did not rate the service for effectiveness. We found:

- Care and treatment was delivered in line with national guidelines.
- Patient's pain was managed appropriately.
- Staff within the service had the appropriate skills, qualifications, and knowledge to complete their roles safely.
- All teams reported effective multidisciplinary working.
- Staff generally had the information they needed to deliver effective care and treatment to patients.
- Staff understood their roles and responsibility regarding consent and were aware of how to obtain consent from patients.

## Evidence-based care and treatment

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- Patients' needs were assessed on presentation and their care planned in line with best practice and national guidance.
- We saw that specialities within the outpatients services delivered care and treatment in line with the National Institute for Health and Care Excellence (NICE) and national guidelines where appropriate.
- Staff we spoke with demonstrated how to access policies and procedures on the trust intranet.
- National diagnostic reference levels (DRLs) were displayed in the imaging areas. DRLs are typical doses for examinations commonly performed in Radiology departments. They are set at a level so that roughly 75% of examinations will be lower than the relevant DRL. They are not designed to be directly compared to individual doses. However, they can be used as a signpost to indicate to staff when equipment is not operating correctly or when the technique is poor. The radiographers working in CT had an effective working knowledge of the doses, and audits had shown the new scanners had a significantly lower dose than the national DRLs. Interventional radiology also noted their doses are well below the national DRLs.
- The maxillofacial department did local audits to ascertain parent feedback on baby feeding before and after a tongue-tie treatment.
- The radiology department, in partnership with a neighbouring hospital, had produced thorough, evidence based referral guidance for GPs across the county for ultrasound requests. When vetting requests the sonographers recorded reasons why requests would be rejected and this information was audited and fed back to the referral community.
- In plain film, radiographers authorised examinations under guidelines produced by a practitioner. These were readily available for staff to use and the superintendent had produced a quick guide for radiographers to use. These guidelines were produced using up to date evidence based criteria produced by the Royal College of Radiologists (RCR).
- In CT, radiographers were able to authorise head CTs under NICE guidance and all other examinations were justified by a radiologist. The CT department were able to meet targets relating to NICE guideline in relation to head CT scans. All urgent scans were performed within targets for defined clinical reasons. The stroke nurses audited this and results were fed back to the radiology team.

## Pain relief

- Pain of individual patients was assessed and managed appropriately. Staff used a pain score tool to assess and monitor patient's pain levels.
- Analgesic (pain relief) cream was available in the phlebotomy clinic for patients who might experience pain while blood was taken. This was normally used for children but was available for adults if required.
- Patients we spoke with had not required pain relief during their attendance at the outpatient departments.
- The pain relief clinic had access to analgesia. Staff told us that a doctor prescribed any pain relief needed by patients who attended the clinics before it was administered and recorded in the patient's record.
- Patients we spoke with in the oncology department said that their pain was under control and was reviewed during clinics.

## Patient outcomes

- There is no national target for a patient to be seen by a clinician within a specific time once they arrive for an outpatient appointment. The outpatient department did not collect and audit the number of patients who waited over 30 minutes to see a clinician due limitations in the electronic systems used.
- The trust's radiology department actively participated in national and local benchmarking initiatives and submitted data regularly to the annual RCR reporting snapshot survey, national foetal screening audits and NHS benchmarking. Outcomes were in line with trust expectations. The imaging department also had effective relationships with other trusts within their RIS/PACS consortium so are able to share best practice.
- The superintendent sonographer told us of work the team had done in producing audits and contributing to a Public Health England working party. Ultrasound images were subject to robust internal quality assurance checks and peer review. The ultrasound department also actively shared good practice with each other and linked sonographers together to help them develop each other's strengths.
- At the time of inspection, the trust was not participating in the Imaging Services Accreditation Scheme (ISAS), this patient-focused assessment and accreditation programme ensures patients consistently received high quality services, delivered by competent staff working in safe environments. The clinical director was keen to

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start the process since beginning their new role earlier in the year and this formed part of the department's strategy. The department was reviewing the latest standards and was due to start performing a formal gap analysis.

- Discrepancy meetings were held every two months and individual attendance was over 50% as set out in the RCR standards. Radiologists, reporting radiographers and registrars attended these meetings where discrepancies in reports were subject to discussion. Learning points and actions were evidenced. Discrepancies found from outsourced reports were also discussed and these were fed back to the outsourcing company.
- The department had a clinical lead for audit that drove the audit schedule and distributed results. In 2016, the department undertook a number of audits covering a wide range of topics. These included audits in response to RCR surveys, outcomes following interventional radiology procedures, and radiographer reporting discrepancy and report quality.
- We observed re-audits where compliance in previous audits was poor. The aim of these re-audits was to see if compliance had improved following actions being put in place. We saw that a full IR(ME)R compliance audit was completed in October 2015 and that the service was compliant with all 11 standards assessed. There was an audit cycle in place, with the next full IR(ME)R audit due in August 2018.

## Competent staff

- Staff within the outpatient and diagnostic imaging service had the appropriate skills, qualifications, and knowledge to complete their roles safely. Both medical and nursing staff completed trust-wide and local induction programmes on commencement of post. Staff had access to clinical supervision when required.
- Staff we spoke with confirmed they had regular updates on mandatory training and competency assessments. The trust had linked increment payments to mandatory training and therefore staff needed to ensure they had completed all relevant training in order to achieve their yearly increment. A training reminder was sent to the individual and their line manager to ensure that they were aware of the necessity to complete the training within a certain timescale.
- The trust appraisal policy stated that all staff were required to have annual appraisal using the job

description and person specification for their post. Staff that had received an annual appraisal told us it was a useful process for identifying any training and development needs. Overall, staff in the service appraisal rates met the trust target of 85%.

- We spoke with a bank phlebotomist who confirmed they had received an orientation and local induction of the service they were covering. We saw evidence that bank staff had received the appropriate induction to manage and monitor the care and welfare of patients visiting the department.
- New radiography staff underwent a three-month induction programme, during which time competency assessments were completed. The local induction covered a range of topics including equipment training, local policies, procedures, and IT competencies for radiology information system (RIS) and patient archiving communication system (PACS).
- The imaging department made use of role extension of radiographers and nurses to help mitigate the radiologist vacancies. For example, three members of staff were trained to report plain film images, with a further two in training to report chest and abdomen x-rays, some staff were trained to undertake peripherally inserted central catheter (PICC) line insertions, and some contrast studies. The trust was also in the process of advertising a consultant radiographer position with the aim to develop extended roles.
- The imaging department hosted student radiographers. There was a notice board in the plain film viewing area, which clearly explained, for both students and their mentors, what was expected of them and the amount of supervision required. Staff told us they thought students had good experiences whilst training in the department and many chose to stay on working in the department when they qualified
- Appraisal rates in the imaging department were 75% in June 2017. Radiologists told us that their appraisals were regular and were a friendly and helpful process. Plans were in place to meet the trust's target of 85%.
- New radiography staff underwent a three month induction programme, during which time competency assessments were completed. The local induction covered a range of topics including equipment training, local policies, procedures, and IT competencies for RIS and PACS.
- The Nursing and Midwifery Council (NMC) introduced revalidation in April 2016. This ensures all nurses and

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midwives maintain their registration every three years. Line managers were provided with the expiry and revalidation dates for all nurses within the outpatient department.

- The service had monitoring processes in place to ensure that doctors were working within the General Medical Council (GMC) revalidation guidelines and would be able to revalidate in line with the scheduled date. Medical revalidation was introduced in 2012 to ensure that all doctors were up to date and 'fit to practice'. All of the consultants working in the service had either been revalidated or were working towards revalidation in line with the timescale notified to them by the GMC.
- The trust performed a comparison of post-operative outcomes of cataract surgery at the hospital from 2015 to 2016 with national cataract surgery guidelines and benchmarks. It was recommended that cataract surgeons provide supporting information for appraisal once in each five year revalidation cycle and provide an annually updated record of the total number of cataract operations they had performed in the revalidation cycle.

## Multidisciplinary working

- We observed effective working relationships and commitment to care from many different, experienced members of the multidisciplinary team (MDT). All necessary staff were involved with the planning, assessing and delivery of patient care.
- Outpatient and diagnostic teams worked with speciality teams across the trust and external providers to plan and deliver care and treatment.
- We saw that the departments had links with other departments and organisations involved in patient journeys such as GPs, support services and therapies.
- We observed a health care assistant in the outpatient department working closely with a consultant both before and after a patient review.
- Volunteers were available in outpatients and worked closely with reception staff to guide patients to specific clinical areas.
- The radiologists were fully participating in cancer multidisciplinary team meetings (MDT). Two radiologists were allocated to each MDT to provide cover. Each MDT had a dedicated one hour preparation. However, we were told that sometimes this was insufficient time to prepare thoroughly.
- Some MDTs were performed via video conferencing with other surrounding trusts. The new PACS/RIS consortium

had improved the links with PACS images however during the inspection a number of radiologists described the video conferencing as being clumsy and too slow to be useful at times. Plans were in place to address this.

- We saw excellent working relationships between radiologists, radiographers and radiography assistants. Staff told us colleagues were always approachable, utilising each other's expertise and joint working.
- Monthly team meetings were held in the diabetes department with consultants, junior doctors, clinic coordinators, admin staff, nurses, and the directorate manager assistant. Staff discussed clinic waiting times, staff bulletin, clinic availability, and sickness/holiday during these meetings and staff told us they found these extremely helpful

## Seven-day services

- Outpatient clinics were available from 8am to 6pm, Monday to Friday. When the demand for appointments was greater than clinic availability, we were told that further clinics would be created. For example, weekend and evening clinics were arranged to accommodate a backlog of ophthalmology and integrated surgery patients.
- The corporate risk register had identified seven day working as an issue and had an action plan in place to address seven day working across all staff groups and all specialities.
- Almost all diagnostic services had an established seven day working pattern. This enabled patients to be seen at appointments to suit their needs.
- Radiographers participated in an on-call service for some imaging modalities. General radiographers covered plain film examinations, head and neck CTs at all times. We heard that this on call service was currently under review and the department was in the process of introducing a shift system, when staffing numbers allowed, following the induction of the new staff. This was due to the increase in demand of radiology services.
- An on-call CT radiographer covered all other emergency CT scans. There was no MRI out of hours service. Any urgent scan would be performed first thing on the next day's scan list. Urgent scans would be transferred to another trust such as spinal trauma or emergencies, which would be expected anyway as there were no facilities to intervene in such emergencies within the trust.

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- Ultrasound lists were provided five days a week, with Saturday morning appointments offered through overtime. The superintendent told us due to the good feedback from patients on the Saturday service, they were looking to increase the service to Sunday too.
- Interventional radiology offered 24 hour, seven day a week service for emergencies. The calls were made up of both interventional radiologists and a vascular surgeon. Half of the calls were formally covered with the other half informally covered through a local agreement. However, the team was in the process of negotiating a formal agreement with another local trust following an incident where there was no cover for an emergency case, which meant the patient had to be taken to surgery for an open procedure. Radiographers and nurses were also included in the on-call agreement.

## Access to information

- Staff generally had the information they needed to deliver effective care and treatment to people who used services.
- All staff had access to the trust intranet to gain information relating to policies, procedures, NICE guidance, and e-learning.
- Clinic rooms had computer terminals, which enabled staff to access patient information such as x-rays and blood results via the electronic requesting system.
- The diagnostic imaging department held policies, procedures and guidelines in paper form. The department did also make use of a shared drive on their computers. However, this was not easily navigated. Staff were able to locate commonly used documents with ease but were unable to locate documents relating to IR(ME)R procedures or other radiation protection documentation.
- The department looked into ways to improve this and a document management system was in the process of being procured. Such systems would allow documents to be retrieved from any computer within the department much easier.
- During the inspection, we found that many of the processes within the department were “paper-light”. The department utilised the IT systems within the hospital such as PACS, RIS and e-requesting to reduce the amount of wasted paper and increase the amount of information available to the radiologists and radiographers when making decisions.

- During the installation and the months following the change over to the new PACS and RIS, the service experienced severe issues with the stability of PACS image transfers and retrieval and the reporting system. This meant that at times IT systems were unavailable to review at MDTs or report upon images in a timely manner. The trust reported they had lost up to 30% of normal reporting productivity and 40% for plain film reporting which involved a quick turnaround time.
- At the time of the inspection, this had appeared to be largely resolved due to software upgrades carried out by the supplier. However, on discussion with the trust’s radiologists, we were told that the system was still inefficient at times and had multiple technical glitches and reporting productivity was still lower than pre-go-live.
- Staff had low expectations of the system due to problems experienced over the past year and incidents relating to availability of images were reported using the trust’s incident reporting system. Incidents were monitored and raised with the IT department who escalated these to the supplier when appropriate.

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

- Patient’s consent was obtained in line with hospital policy and statutory requirements.
- Staff demonstrated effective knowledge and understanding of obtaining consent, the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). Staff could access these policies from the trust intranet. Overall, the service met the trust’s target for 85% of staff having this training.
- Staff could describe how they supported patients with reduced mental capacity and/or dementia. Staff could name the lead learning disability link nurse within the trust.
- Staff we spoke to were able to describe the relevant consent and decision making requirements relating to MCA and DoLS and understood their responsibilities to ensure patients were protected. Records seen evidenced compliance with trust policies.
- Patients told us that staff explained planned procedures or examinations before they were asked to consent to them being carried out.



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- Doctors discussed treatment options during consultations and where written consent was required; this would be obtained at the time of the outpatient appointment.

## Are outpatient and diagnostic imaging services caring?

Good



Overall, we rated caring as good because:

- We saw that all staff treated patients with caring, compassion, kindness, dignity and respect in all areas visited.
  - Patients were treated with compassion, dignity, and respect.
  - Feedback from patients and those close to them was positive about the way they were treated.
  - Patients we spoke with told us staff had introduced themselves and we saw this happening throughout the service.
  - Patients were involved in their care and decision making processes. Staff spent time talking to patients and those close to them.
  - Staff made patients' appointments according to the needs of the individual. This included moving them to allow work and other appointments to take place.
  - The NHS friends and family test (FFT) from February 2017 to April 2017 showed 93% of patients would recommend the service to their friends and relatives and this was better than the England average of 92%.
  - The trust had a high response rate to the friends and family test with high levels of satisfaction across the clinical areas.
- ### Compassionate care
- We saw that all staff treated patients with caring, compassion, kindness, dignity and respect in all areas visited.
  - During the inspection, we observed staff and volunteers interacting positively and respectfully with patients and their colleagues.
  - We observed reception staff greet patients in a courteous and friendly manner and directed them to the appropriate waiting area.
  - Staff introduced themselves to patients making them aware of their roles and responsibilities.
  - During the inspection, we witnessed staff explaining examinations to patients in a language they understood.
  - We observed a good rapport between patients, reception and nursing staff.
  - All patients spoke positively about their experiences within the departments. Staff were seen to provide support and assistance where needed and patients did not feel rushed. Patients told us that they had attended the same clinic for a number of years and always received good care.
  - We observed staff supporting and treating patients in a kind and caring manner. For example, we saw a child who was frightened to have bloods taken. The phlebotomist talked to the child throughout and encouraged the child to look at character pictures on the wall to reduce the level of fear. This helped to calm the child down.
  - In the pain relief clinic, we observed staff ensured a patient was covered up when assisting them to the toilet.
  - Patient comments included "seen earlier than expected" "fast quick and efficient service" and staff members were "really nice and I felt that they cared".
  - A range of staff had received compliments through the feedback including the administration staff, radiographers, sonographers, and radiologists.
  - The diabetes clinic had volunteers to offer refreshment to patients who were waiting during busy periods.
  - The integrated surgery outpatient had a screened off area which served as an in-patient receiving bay. This provided inpatients with more privacy and dignity, especially if they were wearing a gown.
  - Patients and their relatives we spoke with told us staff had introduced themselves and we saw this happening throughout the service.
  - We saw the NHS Friends and Family Test (FFT) questionnaires throughout outpatient departments with posters, which encouraged patients to leave comments about the service. The NHS launched the FFT in 2013 for all acute trusts. The FFT is a feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to



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provide feedback on their experience. It asks people if they would recommend the services they have used. The feedback gathered was designed so that services can improve patient experience.

- From February 2017 to April 2017, results consistently showed an average 93% of patients would recommend the service to their friends and family. This was better than the national average of 92%.

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

- Patients we spoke with felt well informed about their care and treatment.
- One patient said, "Staff take time to explain my condition and available options to enable me make an informed decision about my care".
- Patients generally understood when they would need to attend the hospital for repeat investigations or when to expect a follow up outpatient appointment.
- Nursing staff reported interpreting services was used more when required.
- Patients we spoke with said they were happy with the information provided by consultants and how they included their family members in their care and treatment options.
- Each patient we spoke with was clear about what appointment they were attending for, what they were to expect and who they were going to see.
- We saw staff in the phlebotomy clinic asking patients which arm they would prefer to have their blood taken from.
- We saw patients' appointments were flexed according to their needs by staff. This included moving them to allow work and other appointments to take place.

## Emotional support

- Staff provided emotional support to patients and staff directed patients to access the hospital multi-faith chaplaincy service and external support services, when required.
- Medical, nursing and administration staff within outpatient departments were actively involved in supporting people's emotional needs. For example, we observed interactions with patients suffering from dementia and saw patients were treated with dignity.
- Volunteers and local advisory groups' staff offered both practical advice and emotional support to both patients and carers.

- Chaperones were available if required, and were available when patients had to undergo intimate examinations.
- Patients told us that they considered their privacy and dignity had been maintained throughout their consultation in outpatients.
- Staff had good awareness of patients with complex needs and those patients who may require additional support should they display anxious or challenging behaviour during their visit to outpatients.
- Staff understood and showed how they would support the emotional and mental health needs of patients and said they were able to access specialist support if necessary.
- Relatives of anxious, distressed or confused patients were able to attend clinics with patients if required.

## Are outpatient and diagnostic imaging services responsive?

Good



Overall, we rated responsive as good because:

- The service worked effectively with a variety of stakeholders and commissioners to plan delivery of care and treatment and was a proactive partner in shaping community provision.
- The service consistently met the referral to treatment standards over time and was better than the England average. Performance in meeting national cancer standards was improving.
- Waiting times for diagnostic procedures was lower than England average.
- The service was generally meeting cancer targets for referral to treatment times.
- The "did not attend" (DNA) rate for the trust from June 2016 to May 2017 was 7% and this was same as the England average of 7%.
- Outpatient specialties ran additional evening and weekend clinic lists to reduce the length of time patients were waiting.
- The radiology department offered a walk in service for all plain film examinations.

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- Services were tailored to meet the needs of individuals and offered flexibility in choice with appointments being flexed across a seven day service within the diagnostic imaging department.
- Generally, the service had an effective process for categorising and handling complaints and concerns.

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

- The service worked effectively with a variety of stakeholders and commissioners to plan delivery of care and treatment and was a proactive partner in shaping community provision. This included local commissioners, GPs, local authorities, charities, other NHS trusts.
- Staff said clinic numbers and waiting times were reviewed weekly and additional clinics were held for specialities with a noted rise in waiting times. This included weekend and evening appointments in addition to normal service.
- The radiology department offered a walk in service for all plain film examinations meaning patients did not need to make appointments to attend.
- The service offered rapid access outpatient services where high risk patients with trans-ischaemic attacks (TIA) were being seen within 24 hours and low risk TIAs were seen within one to two weeks due to reduced consultant capacity.
- Facilities were planned to meet patients' needs. Toilet facilities were available for both patients and visitors in waiting areas across outpatient areas. The disabled toilets were wheelchair accessible with handrails and alarm pull cords.
- Staff were familiar with the needs of people receiving care or treatment and services were planned and delivered to meet patient needs. On attendance, reception staff regularly checked that patient's information including religion and ethnicity. Making appointments via the phone also enabled booking staff to identify specific needs for patients and this allowed appointments to be made which suited individual needs. This included diabetic patients, who would need to fast prior to an appointment. Appointments would be subsequently made to enable these patients to only fast for the minimum time required.

- Transport was provided for eligible patients by the local patient transport service. A telephone number was available for patients to arrange their own transport and staff would assist with this where required.
- There was clear signage to all the outpatient areas and the main receptions were manned during clinic times to assist with directions.
- The outpatient and imaging departments were sign posted from the entrance of the hospital and all areas. Signage around the outpatient and diagnostic imaging department was in English only. We saw staff stopping to ask patients and visitors if they required assistance or directions if they saw them appearing to be lost.
- Five patients and relatives we spoke with said they had to park far away and this was particularly an issue with elderly patients with reduced mobility.
- Service managers held weekly meetings to plan for the weeks ahead. They discussed each clinic taking place, previous performance in terms of appointment utilisation and over runs and highlighted concerns such as patient numbers or cancellations.

## **Access and flow**

- Outpatient clinics for the inpatients specialties directorate were held across several locations onsite at Northampton General Hospital (NGH) and offsite at Danetre hospital. For example, at NGH, respiratory patients were seen in the dedicated chest clinic, cardiology were mainly seen in the Northampton Heart Centre whereas gastroenterology and renal were seen in the main outpatients' department.
- The NHS Constitution states that patients should wait no longer than 18 weeks from GP referral to treatment (RTT). All NHS acute hospitals are required to submit performance data to NHS England, which then publically report how hospitals perform against this standard. The maximum waiting time for non-urgent consultant-led treatments is 18 weeks from the day a patient's appointment is booked through the NHS e-Referral Service, or when the hospital or service receives the referral letter.
- From May 2016 to April 2017, the trust's referral to treatment time (RTT) for non-admitted pathways for patients treated within 18 weeks was 95% and this was better than the England average of 90%. For July 2017, performance was 92%, in line with the England average. The trust has been consistently above the England average and, where the England average had seen a

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gradual decline in performance, the trust had seen a gradual improvement in performance. A total 22,468 patients were waiting for an appointment with half that number of patients waiting less than seven weeks.

- The trust has been consistently above the England average over time. Performances by speciality at the time of inspection was;
  - Neurology: 96%.
  - Ophthalmology: 92%.
  - Cardiology: 95%.
  - General medicine: 94%.
  - ENT: 94%.
  - Dermatology: 96%.
  - Rheumatology: 98%.
  - Neurosurgery: 97%.
- National data showed four specialities were below the England average for non-admitted RTT pathways within 18 weeks;
  - Geriatric medicine: 93%.
  - Trauma and orthopaedics: 87%.
  - Urology: 86%.
  - Cardiothoracic surgery: 63%.
- Referrals were prioritised by clinical urgency; suspected cancer referrals first, then urgent referrals and then routine referrals on a 'next in turn' basis.
- All areas in the service had weekly performance meetings, divisional meetings and board meetings to review their own RTTs. All patients exceeding 18 weeks were reviewed by doctors.
- The percentage of patients seen by a consultant within two weeks and the percentage of patients on the incomplete pathways seen within 18 weeks were consistently better than the England average.
- Suspected cancer and urgent referrals did not always meet the England average but was improving.
- In terms of cancer waiting times standards for quarter one 2017/18 (April 2017 to June 2017), the trust performed:
  - Two week wait for first appointment was 89%, below the England average of 93%.
  - For the cancer standard of first treatment in 31 days of decision to treat, performance was at 98% which was better than the England average of 97%.
  - For the cancer standard for the 62 days GP referral to commencement of treatment, performance was 70%, below the England average of 80%. This was comparable with the previous quarter.
- The service dashboard for June 2017 showed improved performance in all of these standards:
  - The two week wait for first appointment performance standard was 93%, in line with national standard.
  - For the cancer standard of first treatment in 31 days of decision to treat, performance was at 97%, above the standard of 96%.
  - For the cancer standard for the 62 days GP referral to commencement of treatment, performance was 91%, above the national standard of 85%.
- The trust had a cancer recovery action plan which highlighted the need for an intense focus on cancer waiting times. The trust provided a summary of urgent actions which included; review of cancer services workload, cancer pathways, governance arrangements and management of patients in the cancer pathway.
- The risk register reflected the risk of achieving 62 day cancer standard with the risk of patient safety. The trust had implemented a revised cancer action plan which was monitored at the cancer board meeting and linked in with the tumour site specific action plans. In addition, the trust continued to work in collaboration with the local commissioners and NHS Improvement in the forward management of the cancer action plan.
- In April 2017, only 0.5% of patients were waiting over six weeks for a diagnostic test and this was better than the national average of 1.8%. As of June 2017, the service's dashboard showed 100% of patients were seen within six week.
- For June 2017, the proportion of clinics where the patient did not attend was 7% and this was same as the England average of 7%. The service had plans to develop appointment scheduling to include an appointment reminding system which contacts patients in advance by the patients preferred method.
- No excessive waiting times were observed during our inspection and the oncology clinic displayed current waiting times on a noticeboard in the waiting area. Patients were able to see if their clinic was running on time or delayed. Staff said in the event of any delays, they would discuss with patients. Waiting times seen were about 20 to 30 minutes.
- The department had a number of locally set key performance indicators (KPIs) for both access to appointments and length of time for a formal report.
- Appointments for non-plain film examination in diagnostic imaging were made by telephone when

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possible. For outpatient and GP appointments, patients were asked to call the department to arrange an appointment. Letters were only sent when patients did not contact the department. Arranging appointments over the phone meant that patients had better choice of when they could attend the department. This subsequently meant that do not attend (DNA) rates were particularly low. The overall figure for June 2017 showed an overall DNA rate of 2%.

- From May 2016 to April 2017, the percentage of patients waiting more than six weeks to receive an imaging examination was lower than the England average. We heard that the occasions where patients waited more than six weeks was usually due to clinical reasons or patient choice.
- Whilst at the time of the inspection there were no modalities breaching six week targets, the imaging department had highlighted previous concerns surrounding the capacity for CT and MRI and their ability to achieve the two week wait target for cancer imaging.
- The department monitored their activity versus KPIs on a scorecard. This scorecard did not show the number of patients with suspected cancer waits for an imaging examination in relation to the two week wait rule which is used mainly across the country.
- Instead, the department set a local target for all suspected cancer imaging to be imaged and reported within seven days. This target is aspirational for the department and much lower than the national target of two weeks which just covers request to examination. This was acknowledged by the department leads and the aim was to reduce such targets to improve patient waits overall.
- The department's scorecard showed that the local cancer imaging KPI was consistently not met across CT, MRI and ultrasound between April and June 2017. Figures showed that in June 2017 only 12% of CT, 35% of MRI and 59% of ultrasound requests hit the targets.
- In order to tackle issues with capacity in CT and MRI, the department had a number of plans in place or already actioned to improve this.
- The department introduced a new administrative post in 2016, whose aim was to track the reports and appointments for patients waiting for cancer imaging examinations. This role ensured that a constant check was kept on such imaging and waits escalated early to ensure patients were kept waiting as low as reasonably possible. The department had also already installed a third CT scanner to ease pressure on the two existing scanners and the MRI scanner was in the early stages of being built with the expected opening planned for late 2017. Whilst waiting for the new scanner to be installed, the imaging department made use of two mobile MRI vans, supplied and run by an external provider.
- We were told that capacity in ultrasound was limited due to the number of rooms available and the superintendent sonographer was looking into ways to increase the number.
- As a result of issues with the PACS and reporting systems when the East Midlands consortium went live in April 2016, there had been a reduction in the reporting performance resulting in delayed reports. Prior to the trust's "go-live" the radiology's performance against the local key performance indicators was around 95%, however within seven days of the go-live the performance dipped to 56% at its lowest.
- The department defined its backlog as any image unreported for more than seven days.
- At the time of our inspection, the backlog in diagnostic imaging reporting had significantly reduced. We found the longest wait was under 28 days for all modalities. These figures were compared to figures seen across England. We found the amount of images unreported were as follows:
  - CT – 10.4% over 21 days, 14.8% over 14 days, and 36.3% over seven days
  - MRI – 15.5% over 21 days, 17.4% over 14 days, and 22.5% over seven days
  - Nuclear medicine – 13.2% over 21 days, 30.2% over 14 days, and 37.7% over seven days
  - Plain film – 6.9% over 21 days, 9.3% over 14 days, and 27.6% over seven days
- The department stated that their current area of concern remained in plain film reporting where the department had a large amount of images waiting more than seven days to be reported (848) although the backlog over 21 days has reduced significantly (211). The trust reported that they had lost a fair amount of plain film reporting capacity due to radiologists requiring additional reporting capacity for more specialist examinations such as CT and MRI. To ensure that plain film images remain reported in a timely manner, the trust had increased their number of reporting radiographers, with a further two undergoing training.

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- In response to the department's backlog, the trust was looking to increase the amount of images being outsourced to external reporting companies as a short-term solution. However, this had been limited by the external companies' capacity.
- In diagnostic imaging services, porters arranged appointment slots for inpatient scans which in turn ensured flexibility for those requiring scans within clinic appointments. We saw this worked well, with no delays in inpatients receiving scans due to transport delays.
- The maxillofacial department ran additional theatre lists to reduce waiting times for patients.
- The orthopaedic department had a process known as partial booking for all patients who required a follow up appointment in excess of six weeks. For patients requiring a follow up in under six weeks, an appointment was made prior to the patient leaving the clinic and this was based on availability of slots. Lack of appointment slots were escalated to the appropriate administration manager who would discuss options with the consultant.
- Patients requiring an appointment in excess of six weeks were advised they would be contacted with a follow up appointment four weeks prior to the date they needed to be seen. This was to eliminate the need to cancel appointments as a result of consultants booking leave (for which six weeks' notice was required).
- Staff were aware of how to support people living with dementia and had accessed the trust training programme in order to understand the condition and how to be able to help patients experiencing dementia.
- The dementia butterfly scheme was in use within the outpatients department. The system uses a butterfly symbol to help staff identify patients at risk so they can implement measures to address this. For example, ensuring that they are accompanied to their appointments, transport called for them, and assisted to the bathroom if necessary.
- There was no designated area for paediatric patients (children) to wait within the diagnostic imaging department. However, the number of children in radiology areas were low.
- The service offered telephone appointments, which meant specific needs were detected in advance so action could be taken to assist patients if required.
- Translation services were available for those whose first language was not English. Posters advertising this were visible in reception areas.
- We saw a wide range of information leaflets for patients in all areas of outpatients. This included a map of the hospital, general outpatient information and information about personal data confidentiality and coming into hospital.
- The leaflets we saw were in English, with some leaflets were available in other languages on request.
- We saw leaflets with information about scans and tests, drug treatments, and patients guide to X-ray in the radiology department reception area.
- Bariatric equipment could be accessed if required. The MRI scanner was a standard width, however the new scanner was planned to be a wider-bore which would be compatible with bariatric patients.
- We heard receptionists asking when patients would like their appointment to accommodate patient's commitments.
- The outpatient clinics we visited were generally accessible to patients living with physical disabilities and wheelchair users.
- Visitors and patients had access to refreshments from shops and cafes located within the oncology centre with two further cafes, a restaurant and a shop in the hospital.
- The hospital had volunteers to help patients and visitors find the correct departments.

## Meeting people's individual needs

- Services had been planned to take into account the needs of different patients, for example, on the grounds of age, disability, gender, or religion.
- Staff we spoke to had good awareness of patients with complex needs and those patients who may require additional support. Staff told us that patients with dementia or learning difficulty would be prioritised and seen as soon as possible to reduce anxiety during their visit to outpatient areas.
- Patients with a learning disability or those living with dementia were fast-tracked through the maxillofacial clinics and had longer appointments scheduled to enable full explanations and support to be given.
- For patients with complex needs or a learning disability in the maxillofacial department, staff described working closely with carers or family members to provide care or treatment.



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- Patients attending the hospital had access to visitors' car parking. However, this parking was sometimes a long distance from the outpatient departments, some patients said.
- The oncology and pain relief departments did have facilities to make patients hot drinks if required. They also had glucose drinks available for patients with diabetes. Glucose drinks are recommended when a patient has low blood glucose levels and needs to increase their blood glucose levels rapidly.
- The Macmillan cancer support centre in the integrated surgery outpatient department contained lots of information for patients such as food recipes, finance advice and support, and preparing a child for loss information.

## Learning from complaints and concerns

- The service had an effective process for categorising and handling complaints and concerns.
- People were able to raise their concerns with staff or with the patient advice and liaison service (PALS) or make a formal complaint to the trust. Staff were aware of how to support patients and their relatives in making a complaint.
- Information on how to raise a complaint was displayed on notice boards in outpatient and diagnostic test areas. The complaint policy and the procedures were well advertised and there were leaflets and posters available throughout the ward to advise patients, visitors, and family on how to make complaints.
- From February to July 2017, the diagnostic imaging department received nine complaints. Six were related to communication issues, two directly about patient care and one relating to confidentiality. Complaints and compliments in the imaging department were discussed at governance meetings. We saw evidence of a review, which looked at the actions to help ensure such complaints did not happen again. Many of the complaints we saw related to staff attitudes and the department in response dealt with each individual complaint and feed back to staff within the department.
- There were 16 complaints regarding all outpatient areas from April 2017 to June 2017. The directorate score card for inpatient specialties showed only 79% of complaints were responded to within timescales and this was below the trust of 90%. Managers had plans in place to improve this response rate.

## Are outpatient and diagnostic imaging services well-led?

Good



Overall, we rated well-led as good because:

- The service had a challenging and innovative strategy that supported the trust vision. This included redesign of departments, introduction of support systems to improve performance and repatriation of services to improve patient experience.
- Staff had awareness of the trust vision and strategy.
- Staff were aware of the risks within their departments.
- Staff were proud to work at the hospital and passionate about the care they provided.
- The service had leadership, governance and a culture which were used to drive and improve the delivery of quality person-centred care.
- Staff felt that managers were visible, supportive and approachable.
- Specialties were focused on developing services to improve patient care.

## Leadership of service

- The trust did not have a dedicated outpatient department. The outpatients departments were part of the clinical directorates which came under the four clinical divisions in the trust. Each of these was led by a management team comprising of a clinical director, divisional and directorate managers. For example, the diagnostic imaging department sat under the divisional director and the clinical director (CD), who were supported by the head of imaging.
- The service was represented at board level by the chief operating officer.
- Each clinical area had a nominated lead that worked and managed the clinical speciality. For example, in the imaging department each section had a superintendent who was a senior clinician and able to offer support and advise to the team. This ensured that staff had access to clinical experts at all times.



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- The senior team structure in each area was established and understood by staff we interviewed. The outpatient service had newly recruited an outpatients' programme manager who was overseen by the chief operating officer and the deputy chief operating officer.
  - The superintendents for each imaging modality in the diagnostic and imaging service were seen to be present and easily accessible to staff during the inspection. They were all approachable and had several years' of experience working in the hospital and in radiography. However, issues had been raised with managers not having effective communication with staff and departments due to it being a big department with lots of modalities.
  - The superintendent sonographer actively participated in national audits, publications and Public Health England working parties.
  - All staff reported that leadership within the department was very strong, with visible, supportive and approachable managers. All felt that there was a positive working culture and a good sense of teamwork and good staff morale was evident.
  - The nursing staff told us that they felt well supported by the consultants and medical staff. There were senior medical staff present in the outpatient's clinics and so support and advice was able to be obtained quickly.
  - Staff felt that line managers communicated well with them and kept them informed about the day to day running of the departments and were regularly visible in each area.
  - Staff were clear who their managers were and felt they could approach managers with concerns.
- Analysing the number of new appointment slots they had available and looking at how to achieve 100% of new appointment slots.
  - Rolling out a bespoke training programme.
- The trauma and orthopaedic team vision was to provide the best possible care to all patients within a safe, clinically effective and supportive environment whereby staff learned, developed, reflected, and improved their services. Staff aimed to:
    - Make patients feel welcomed on arrival to the outpatient department.
    - Ensure patient details were confirmed and corrected to ensure future communication was appropriate and effective.
    - Ensure patients were seen within 30 minutes of their appointment time.
    - Ensure that patients were booked within an appropriate time and date.
    - Ensure patients were fully informed about the outcome of their consultation.
  - Outpatient areas had engaging leadership and management and staff told us they were kept informed and involved in strategic working and plans for the future.
  - Clinical commissioners and members of the non-executive board attended the outpatient quality meetings to ensure the vision was shared.
  - We saw evidence of a two-year plan for the imaging department for the period 2017 to 2019. This looked at reviewing and implementing integrated services with a neighbouring trust with input from the local commissioners. It also looked at increasing the radiographer reporting workforce and implementing shift patterns and reviewing skill mixes. During our inspection, it was apparent that actions relating to each of these strategies were already in place.
  - During the inspection, we were told of further visions for the imaging department. These include gaining Imaging Services Accreditation Scheme (ISAS) accreditation. The Royal College of Radiologists and the College of Radiographers had developed the ISAS. The department was about to conduct a gap analysis prior to starting this process.

## Vision and strategy for this service

- The various outpatient areas had a strategy that supported the trust vision. All staff we spoke with demonstrated an understanding of plans to develop within specific outpatient areas, across the hospital and what was required to enable the process to be completed.
- In line with the e-referral commissioning for quality improvement (CQUIN), the service was:
  - Reviewing their directory of service.
  - Working with an appointment slot issue (ASI) task group from across the trust.
  - Implementing a system to regularly monitor polling ranges to help reduce ASI's.

## Governance, risk management and quality measurement

# Outpatients and diagnostic imaging

- Governance arrangements were clear. The service was represented at board and trust level and information was shared across the service.
- Senior staff we spoke to felt that outpatients was represented at board level. The chief operating officer was the executive lead for the outpatient quality improvement programme.
- The service had bi-monthly command and control meetings to monitor and improve progress against the quality improvements initiated by the trust for the outpatient department. Cancer waiting times were overseen within the division and were picked up as part of the service improvement project.
- Clinical governance meetings were held in different specialities within the outpatient division. We looked at minutes from the elderly and stroke, surgery, ENT (ear, nose and throat) and maxillofacial departments and saw incidents, mandatory training, appraisals and the risk register were discussed during the meetings.
- The outpatients department had a number of locally set key performance indicators for both access to appointments and length of time for a formal report. This was monitored monthly on a scorecard which was presented at the department's operational meeting along with other performance information.
- We looked at minutes of clinical governance committee meetings held across various outpatient specialties. We saw the governance meetings covered a range of topics including patient experience, complaints, incidents, and the clinical effectiveness and service quality.
- There was also an introduction of a more formal risk meeting, whose key agenda was to look at the risk register. The meetings where these were discussed were minuted. The diagnostic imaging risk register reflected the risks in the department and we saw that it had been reviewed regularly.
- The minutes of outpatient, elderly and stroke governance meeting held in June 2017 showed that the service had 33 open incidents had been reviewed and specific learning from the incidents reported was disseminated at huddles and meetings.
- Staff said they were confident to report incidents. Learning from incidents was given feedback by team briefings and local meetings. These were facilitated by senior nursing staff in various specialties.
- The maxillofacial department had recently introduced a safety huddle which took place every morning. Staff discussed the incidents reported, feedback from incidents, equipment issues, resuscitation checks and staffing issues. Staff had to sign to say they had attended the huddle.
- There was evidence that some outpatient departments had audited the number of notes unavailable for clinic appointments. Minutes from the oncology and haematology governance group held in May 2017 showed missing notes were being audited. The trust provided data that the availability of notes had been audited from January 2017 to July 2017. Following our inspection, the medical records service and the divisional managers held a meeting to explore ways of addressing issues with missing notes.
- The imaging department held a number of meetings each month to look at the operation, governance and risk within the service. These fed into the divisional meeting and subsequently into the clinical quality and effectiveness group and into the quality governance committee.
- We saw evidence of an effective response to the increasing imaging backlog caused by the IT issues experienced in 2016. The risk was quickly identified and appropriately assessed, escalated and managed.
- The radiation protection committee (RPC) sat quarterly. This committee fed into the health and safety committee and subsequently into the quality governance committee. This allowed opportunity for any issues relating to radiation protection discussed at the RPC to be escalated to the board when appropriate.
- The committee's function was to have oversight of compliance against a number of radiation protection legislations. Each area within the trust produced six-monthly assurance reports on areas such as staff dosimetry, training, nuclear medicine waste disposal, and radiation risk assessments. The radiation protection supervisor for each area produced these.
- IR(ME)R requires a number of procedures to be in place within every department that uses ionising radiation. These cover a wide range of patient safety features such as patient ID, checking pregnancy and dose recording. During the inspection, we found that some staff had limited understanding of the regulations themselves and five members of staff we spoke to were unable to locate where the employers procedures were kept. This was escalated to the trust. The senior management and medical physics team were aware of this concern and

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this was due to be raised at the next radiation protection committee. Once we raised this as a concern, the trust provided evidence of immediate and also ongoing actions to address this in a prompt manner.

- Following our inspection, feedback about the concerns found within the outpatient areas was given to the trust. In response to our feedback, the trust acted immediately to rectify the issues and put systems in place to mitigate risks. For example, concerns identified with storage of controlled drugs, fire exit and poor infection control practices was immediately rectified. By the unannounced inspection, the service had also audited all other areas to ensure all areas were following trust policies to keep patients safe from avoidable harm.

## Culture within the service

- Staff described an open culture where they could raise concerns without fear of reprisal and seek advice from colleagues from other disciplines.
- Radiographers and sonographers were extremely positive about the department, and were keen to show off their good work. Staff told us they felt respected, valued and were treated fairly, with equal opportunities for training, development and career progression.
- Many of the radiologists, senior radiographer and other members of staff had worked in the department for many years. We were told by several members of staff that this was due to the good working environment and close relationships within the department. We also heard how members of staff had returned from retirement because they loved working in the ultrasound department.
- Staff we spoke to during the focus group reported an open and honest culture within the outpatient and diagnostic imaging department. Staff felt confident to escalate concerns and report incidents.
- Multidisciplinary teams worked collaboratively and were focused on improving patient care and service provision.
- Both senior and junior staff were proud to work at the hospital. They were passionate about their patients and felt that they did a good job. For example, senior staff said during the recent cyber-attack, staff voluntarily stayed beyond their working time and would go an extra mile to ensure patient safety.

- Staff felt respected and valued. Staff told us they felt there was a culture of staff development and support for each other.
- Staff recognised that the outpatient area was the first and sometimes the only point of contact patients had within the hospital. They felt it was their responsibility to make patients feel welcome and experience good care and treatment.

## Public engagement

- We saw the NHS Friends and Family Test (FTT) questionnaires throughout outpatient departments with posters, which encouraged patients to leave comments about the service.
- Feedback was sought from patients, those close to them and their representatives by the NHS Friends and Family Test questionnaires which were available in various departments via paper form or through an iPad. We saw posters displayed, which encouraged patients to leave comments about the service.
- We saw evidence that the managers of the imaging service wanted to reinstate the patient experience group meetings to gain more feedback on their service.
- All patients and relatives we spoke with were positive about the service and the care received by the clinical teams.

## Staff engagement

- Minutes of a governance meeting within the diagnostic imaging department showed some staff felt there was not efficient communication within the department. In response, the managers looked into a newsletter and setting up a communication group. At the time of our inspection, we saw evidence of a radiology briefing which included information on patient satisfaction, staff development, and general information about changes and the operations within the department. They were also looking to conduct more regular staff meetings.
- The department, in partnership with a neighbouring hospital and the local commissioners, had produced thorough, evidence based referral guidance for GPs across the county for ultrasound requests. When vetting requests the sonographers recorded reasons why requests would be rejected and this information was audited and fed back to the referral community.
- Extended scope of practice for non-medical staff was effective within the department. We heard of several areas where training of existing staff had been

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supported to develop roles such as reporting radiographers and other non-gynaecological sonographers, radiographer led fluoroscopic contrast studies and radiographer/nurse led line insertions.

- The trust newsletter was distributed throughout the hospital to update staff on current issues and future plans.
- A weekly blog was completed by the chief executive officer and was available on the intranet for all staff in the department. Staff spoken to said they valued this information.

## Innovation, improvement and sustainability

- Despite transition issues to the new imaging reporting system as part of the East Midlands Radiology Consortium (EMRAD), diagnostic imaging staff had a positive approach to reporting and maintained the delays due to transitioning the reporting systems to a minimum.
- The division leads and outpatients programme manager told us of development plans relating to clinic utilisation, equipment replacement and extended clinic hours and had an action plan in place on how this could be managed.
- Medical outpatient departments held multidisciplinary huddles with representatives from all service users to promote cohesive working.
- Obstetric (pregnant) patients known to be epileptic were seen jointly at obstetric review to enable close monitoring of epilepsy without using up additional epilepsy clinic slots.
- A transformation programme had been introduced and a newly recruited project manager oversaw the service improvement changes across outpatient areas. They engaged with clinic coordinators, discussed concerns with them and feedback to leaders.
- A project team looked at improving the administration and booking process in the medical outpatient department. The medical outpatients department provided over 70 outpatient clinics a week, for over 1000 patients a week, coordinating seven different specialities and many clinicians. Outcomes of this work resulted in removed inequality in the booking process for gastroenterology patients and the wait for patients to receive an appointment had been reduced from between three and 27 days to three and six days to receive their appointment.
- A 'Making Quality Count' project in cardiology commenced in April 2017 to reduce the average number of letters waiting to be processed per fortnight by 50% with a timescale for delivering this change later in autumn 2017.
- We saw a business case had been prepared for the introduction of a band 7 clinical nurse specialist in ophthalmology to work autonomously to free up clinician's time to work in main outpatients by holding two additional clinics rather than perform the injections. The role was also to be instrumental in the development of future services, succession planning and training of juniors within the department, leading on audit and research to ensure best practice pathways were developed, embedded and followed.
- In urology, a project team established through process mapping with the team a greater understanding of the booking process, how this worked across a care pathway and highlighted where there was deviation from the trust's access policy. Staff established a visual management process to understand clinic utilisation and support managers and clinic coordinators. A team huddle was introduced to improve communication together with introducing a standard operating procedure that was being also being implemented across the trust. Staff developed an easy to read guide on the DNA policy; this had also been introduced to other parts of the trust.
- A virtual fracture clinic was introduced in May 2017. The aim of this Clinic was to ensure patients who needed to attend a face to face clinic were offered appropriate appointments at appropriate times with the correct consultant relating to the limb affected. The virtual fracture clinic had a dedicated line to call patients who had been discharged. The clinician would look at the X-ray and form a management plan. The nurse would ring the patient to inform them about their treatment plan. A letter to the GP and patient was also produced. This improved patient experience and satisfaction as they were seen at the right time, in the right place by the right person. It also improved clinic efficiency and reduces DNAs as patients who did not need to be seen were appropriately discharged and not offered face to face appointments.
- Project work was underway in the gynaecology outpatient's clinic with the aim of reducing patient waiting time and improve the flow in the clinic.

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- The musculoskeletal team had won multiple service awards due to excellence in their service to patients as well as members of the team being regional leads with peer organisations.
- In radiology services, the introduction of a new Magnetic Resonance (MR) Imaging suite due to open in November 2017 was expected to increase capacity within diagnostic imaging services without the use of mobile vans.
- The diagnostic imaging service was working towards gaining ISAS (imaging service accreditation scheme) accreditation and was conducting a gap analysis prior to starting the process.
- Role extension and skill mix was very positive and training was supported to develop radiographers, sonographers and nurses to undertake tasks to relieve the pressure of the vacancies in radiology.
- The service was proactive in training staff to meet the demands of the service, developing additional skills that would benefit patient flow through the trust. This included changes within the laboratories, clinics, and diagnostic departments.
- The service started a community project with the local commissioners and a partner trust in June 2017. This enabled GPs who had special interest in dermatology to attend the department. There were nurse-led clinics every four month and monthly consultant led clinics.

# Outstanding practice and areas for improvement

## Outstanding practice

- The 'Chit Chat' group was set up by the maternity service in 2016 to facilitate antenatal education, parenting advice and peer support for women with additional needs, including learning disabilities or anxiety. Staff said these meetings were two weekly and very well attended. This group meeting initiative had been nominated for two national awards and had won one at the time of the inspection.
- The maternity service reviewed and evaluated the provision of multi-disciplinary training when the service was chosen as one of the 10 pilot sites for enhancing patient safety. As part of the pilot, the service chose to concentrate on the fetal monitoring and team working and skills drills sections with the outcome that the service was able to deliver these training programmes completely internally (including Practical Obstetrics Multi-professional Training (PROMPT)).
- Gosset ward will be the first neonatal unit in the country to receive Bliss Accreditation on 12 September 2017. This means the ward has undertaken exceptional work through the involvement of parents to encourage bonding with these very special babies which has helped to build the evidence for Bliss accreditation.
- Staff had developed an assessment tool to improve the monitoring and assessment of baby's skin on Gosset ward. The ward was working with neonatal services from across the world (Canada and Turkey) to further develop the tool.
- The recruitment of 1.7 WTE advanced neonatal nurse practitioners (ANNP) onto the medical neonatal rota was helping to address recruitment issues in relation to junior doctors.
- The superintendent sonographer was very passionate about their service and had developed an excellent team which provided image quality assurance and peer review. They were able to detect team members' weaknesses and pair them with other sonographers to help them develop. The ultrasound department conducted many audits and feed these back to ultrasound community in England.

## Areas for improvement

### Action the hospital SHOULD take to improve

- Review pharmacy provision to meet the needs of the critical care service and be in line with national guidance.
- Continue to review and monitor over eight hour delayed discharges in critical care and report incidents and mixed sex breaches using the electronic reporting system.
- Monitor staff mandatory training to ensure compliance with the trust's target including annual refresher training for safeguarding adults at level two and safeguarding children level two and three.
- Review multidisciplinary support to critical care services to ensure national best practice is following, in relation to therapy support.
- To monitor allergy testing ampoules are used within their recommended expiry dates.
- The trust should consider improving the facilities for parents to stay overnight on paediatric wards.
- Continue to monitor and review the impact of patients admitted to paediatric wards with mental health issues.
- Continue to monitor and review the effect on children's services due to the limited availability of psychologist support, particularly for children with long term conditions.
- Continue to monitor controlled drugs are effectively stored in outpatient areas.
- Continue to monitor fire exits are accessible at all times.
- Continue to monitor caesarean rates and perinatal mortality rates in the maternity and gynaecology service.