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

Urgent and emergency services	Good
Medical care (including older people's care)	Good
Surgery	Good
End of life care	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 18 critical care beds. The hospital employs 4,157 staff, including 496 doctors, 1,074 nursing staff and 2,587 other staff.

We carried out this inspection as part of our routine focused inspection programme. We announced the inspection on the 24 January 2017. We completed a short notice focused inspection on the 7, 8 and 9 February 2017. We carried out unannounced inspections on 30 January and 17 February 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 in January 2014, when the overall rating was requires improvement. In this inspection, we inspected four core services: urgent and emergency care, medical care, surgery and end of life care.

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. This was notable in all four core services that we inspected with an inclusive, positive and compassionate whole team focus on the drive for improvements in the quality and safety of care and treatment being delivered by all staff, at every level.

We rated all four core services we inspected as good overall. 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.
- 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.
- Medicines were stored and handled in line with the hospital's medicines management policy.
- There were 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 and nurse staffing levels met patients' needs at the time of the inspection.
- 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.
- The emergency department (ED) had a recovery plan to improve performance to meet the national standard for patients being seen by a doctor within four hours following arrival, which had been agreed with local commissioners and other stakeholders. Performance had declined and was below the national average.
- In December 2016, the hospital's referral to treatment time (RTT) for admitted pathways for medical services was 97%, which was better than the England average of 90%.
- Between January 2016 and December 2016, the hospital's referral to treatment time (RTT) for admitted pathways for surgical services was about the same as the England overall performance.
- From October 2015 to September 2016, the number of patients whose operation was cancelled on the day of surgery was 4%, below the England average of 8%.

Summary of findings

- Due to ongoing bed capacity issues in the hospital, the trust had implemented safety driven bed escalation and management process to address patient flow concerns in the hospital. This kept patients safe, even at times of significant pressure on bed capacity.
- Despite very high bed occupancy over time and on the days of the inspection, the commitment to the safety and quality of care and treatment for patients was clearly demonstrated by all staff at all levels.
- The hospital had a well-defined process for the management of medically outlying patients.
- The hospital's discharge team supported staff with complex discharge arrangements and senior managers were continually working to improve patient flow out of hospital.
- Staff we spoke with had an effective awareness of patients with complex needs and those patients who required additional support. The adjustments made by staff and facilities provided met patients' needs effectively.
- The overall time from arrival to initial assessment for patients arriving by ambulance at this ED was consistently worse than the England average from December 2015 to November 2016 and ranged between 11 and 30 minutes, whilst the England average was consistently less than ten minutes. An action plan was in place to improve this.
- During our inspection, the average time to initial clinical assessment for all patients was between 19 and 22 minutes. From information provided by the trust for the six months to the end of February 2017, the average time to initial clinical assessment for all patients was 15 minutes. An action plan had been developed for three specific areas that the emergency department had identified as areas for improvement.
- The hospital did not have a system in place to de-nature liquid controlled medications. The hospital immediately rectified this during the inspection.
- Not all patients' records were stored appropriately but the trust took immediate action to address this concern.
- There were 300 patients in trauma and orthopaedics and 180 patients in ophthalmology who waited over 18 weeks for surgery. Some patients waited over 35 weeks for surgery. These patients had been risk assessed to check if their condition had deteriorated whilst waiting.
- The 24 hour reviews of venous thromboembolism assessments were not always recorded. We raised this on inspection and the trust rectified this immediately.
- Whilst the hospital did collect information on the numbers of patients who were rapidly discharged (from regional data), however, it was not systematically used within the whole SPCT to drive improvements.
- There was not always a clear record of discussions about do not attempt cardiopulmonary resuscitation (DNAPCR) with patients who had capacity. Mental capacity assessments were not always clearly recorded to underpin decisions about 'do not attempt cardio-pulmonary resuscitation' DNACPR.

We saw several areas of outstanding practice including:

- The geriatric emergency medicine service (GEMS) was outstanding in terms of providing awareness of and responding to the needs of patients within this group and developing a service that provided a multi-agency approach at the front door.
- Physician associate programmes were being developed to provide a larger group of decision-making clinicians and provide developmental opportunities for staff.
- The emergency department (ED) worked with external organisations to develop an on-site psychiatric liaison service within the ED, 24 hours a day, seven days a week.
- The ED was actively working with local educational institutions to develop courses that were specific to areas that were difficult to recruit to such as geriatric and paediatric emergency medicine and the ED had a robust leadership development programme in place.
- In the Sentinel Stroke National Audit Programme (SSNAP) the hospital was rated as band A overall (A being the best and E the worst), in the April to June 2016 audit, which indicated a world-class stroke service.
- We visited patients being cared for in two out of the three care homes that the hospital used to place patients that were fit for discharge and awaiting their return back to the community. There was a weekly consultant led ward round once a week for these patients and a hospital doctor also visited both homes on three other days of the week. We saw in all there was excellent level of clinical oversight and detailed records of all input from the service's doctors.

Summary of findings

- Staff were focused on continually improving the quality of care and the patient experience. For example, we saw evidence that the service was committed to improving the care of elderly patients, such as those living with dementia. Colour-coded bays were evident on some of the wards we visited and finger food boxes had been introduced, which made it easier for patients to eat when they wanted and helped them to maintain independence. Directorate leads told us of plans that were being developed in collaboration with primary care and community services to support the care of elderly patients at home.
- The end of life care service had piloted, evaluated and fully implemented an end of life companion volunteer scheme for dying patients who may not have any visitors. The service had support from the local community in caring for patients at the end of their life.
- The ED had developed an end of life care room that was situated adjacent to the resuscitation area. There was a specific pathway and guidance for managing these situations when the patient was a child or young person. The ED had developed a specific continuation of care record for patients who were in the end of life care room; this included ensuring that they had received consultation and timely review for symptom control.
- 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.

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

- Ensure that mental capacity assessments underpinning decisions about cardiopulmonary resuscitation are being evidenced in patients' records for end of life care decisions.

The trust should:

- Continue to work to improve performance in meeting the national four-hour performance measure.
- Review the planned daily consultant cover in ED as it was below national recommendations of 16 hours per day at 14 hours.
- Monitor the security and ensure access to medical care entrances are secured to reduce the risk of unauthorised access and vulnerable patients leaving unaccompanied.
- Monitor compliance with guidelines for documenting monitoring of invasive devices including peripheral vascular devices and urinary catheters.
- Monitor the number of cancelled patient procedures in cardiology.
- Review systems so that patients have their venous thromboembolism (VTE) re-assessment 24 hours after admission.
- Review systems so that patients with hip fracture have a perioperative medical assessment within 72 hours of admission.
- Review systems so that patients whose operations are cancelled on the day of surgery are rebooked to be treated within 28 days.
- Monitor that medication is stored at the correct temperature in all rooms and fridges.
- Monitor the systems for denaturing controlled drugs.
- Continue to monitor the time to initial clinical assessment in the emergency department so patients receive this assessment within 15 minutes.
- Consider sharing outcomes of national audits with all surgical staff to improve patient outcomes.
- Review the provision of information leaflets for the most commonly used languages in the area.
- Review the facilities in the chapel so it is inclusive to those of other faiths.
- Review systems for collecting information on the percentage of patients who are discharged to their preferred place of death and how many are discharged to their preferred place within 24 hours.
- Monitor that records are stored securely preventing unauthorised people accessing patient records.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	Good 	We rated the emergency department as good overall and outstanding for the well-led key question. There was a strong, team-centred approach to ensuring all patients were provided with safe care and treatment. The culture and drive for improvement within the staff team was positive, coupled with a focus on providing evidence based care and benchmarking from national audits to drive improvements in the service.
Medical care (including older people's care)	Good 	We rated the medical care service as good overall. Despite significant bed capacity and patient flow pressures, staff worked positively and effectively to minimise the risk and discomfort for patients. Patient outcomes were generally better than the national average, notably the service's performance for stroke care. Staffing levels met patients' needs including in the escalation areas used. Senior managers had clear oversight of the pressures and risks in the service and were taking actions to improve all aspects of patient care and treatment.
Surgery	Good 	We rated the service as good overall. Many patient outcomes were better than the national average and a strong safety culture was prevalent in wards and theatres. Staff delivered safe, effective care and treatment with compassion and respect.
End of life care	Good 	We rated the service as good overall. Many improvements had been made to raise the profile for the end of life care service in the trust and this had led to improvements in the way patients received safe, compassionate care in their last days. However, more work was required to collect performance information about the service and ensure that mental capacity assessments underpinning decisions about cardiopulmonary resuscitation were being evidenced in patients' records.

Northampton General Hospital

Detailed findings

Services we looked at

Urgent and emergency services; Medical care (including older people's care); Surgery and End of life care.

Detailed findings

Contents

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 18 critical care beds. The trust employs 4,157 staff, including 496 doctors, 1,074 nursing staff and 2,587 other staff.

It has an income of approximately £250 million and a workforce of around 4,300 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 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 service 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 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.

- Urgent and emergency care
- Medical care (including older people)
- Surgical care
- End of life care

We did not inspect critical care, children and young people, maternity and gynaecology or outpatient and diagnostic imaging services.

Detailed findings

Our inspection team

Our inspection team was led by:

Chair: Carole Panteli, Former Director of Nursing.

Head of Hospital Inspections: Bernadette Hanney, Care Quality Commission (CQC)

The team included seven CQC inspectors, one assistant inspector, one CQC pharmacist inspector and a variety of specialists including an emergency department consultant, a theatre nurse, medical doctor, medical nurse, surgical doctor, and an expert by experience who had experience of using services.

How we carried out this inspection

To get to the heart of patients experiences of care, we 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. We announced the inspection on the 24 January 2017. We completed a short notice focused inspection on the 7, 8 and 9 February 2017. We carried out unannounced inspections on 30 January and 17 February 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 4,307 full time equivalent staff as of December 2016.

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

The trust provides hospital care for a population of 341,270. 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.

Urgent and emergency services

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

Information about the service

The Emergency Department (ED) at Northampton General Hospital NHS Trust provides a 24 hour, seven day a week service for a population of approximately 380,000 people across Northampton.

The ED has a streaming system whereby patients are allocated to different flows according to their needs. Within Northampton General Hospital, the ED consisted of 25 majors' bays, which included five dedicated geriatric emergency medicine bays for frail and elderly patients and ten dedicated first intervention and treatment (FIT) bays where patients are rapidly assessed and receive immediate intervention and treatment for life-threatening conditions such as sepsis. There are four minors' bays, 10 resuscitation bays and an emergency clinical observation area with space for up to six trolleys. The department also has a dedicated GP service which started 1 February 2017 (prior to this date the GP provision was from an external provider which we did not inspect as part of this inspection).

The department has its own children's ED, which is open 24 hours, seven days a week. The children's ED has its own separate waiting area, three cubicles, and a dedicated resuscitation bay in the main resuscitation area.

Patients present to the department either by walking into the reception area or arriving by ambulance via a dedicated ambulance-only entrance. Patients who transport themselves to the department report to the reception area where they are assessed and streamed to either minors, majors or the GP service (GP service was available 9am to 11pm, seven days a week).

From April 2015 to March 2016, there were 114,075 ED attendances: 22,434 of these attendances were children aged 0 to 17 years (about 20%).

We conducted an unannounced inspection on 30 January 2017 and an announced inspection on 7 and 8 February 2017. During our inspection, we spoke with 23 staff, five patients and looked at 13 sets of patient records.

Urgent and emergency services

Summary of findings

We rated this service as good because:

- There was a positive culture towards reporting incidents and learning from these to improve patient safety.
- 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.
- Medicines were stored and handled in line with the hospital's medicines management policy. Patients' individual care records were well managed and stored appropriately.
- There were effective processes in place to ensure that adults and children in vulnerable circumstances were safeguarded from abuse. Staff at all levels in the ED 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.
- Nurse staffing met patients' needs at the time of the inspection.
- Evidence-based guidance was used to develop how care and treatment was delivered throughout the ED. Patient outcomes were better than the national average in all the national audits undertaken. Effective multidisciplinary working was clearly evident throughout the department.
- Patient's consent was obtained in line with trust policy and statutory requirements.
- Staff were friendly, professional, compassionate and helpful to patients in all interactions that we observed.
- Staff in the ED had arranged for volunteers to attend the department and provide support and information for patients who may have social needs.
- The ED 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.
- A consultant in ED had started developing the geriatric emergency medicine service (GEMS) in 2014 to make the ED 'frail friendly' and to improve staffs' skills in geriatric emergency medicine. The GEMS was outstanding in terms of providing awareness of and responding to the needs of patients within this group and developing a service that provided a multi-agency approach at the front door.
- From November 2015 to October 2016, the monthly percentage of patients waiting between four and 12 hours from the decision to admit until being admitted for this trust was better than the England average ranging between 4% and 14% whilst the England average was consistently above 10%. No patients waited more than 12 hours from the decision to admit until being admitted.
- The ED 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.
- The leadership team in ED was 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 department and were proud of the organisation and its culture.
- Governance and performance arrangements were proactively reviewed and adapted to take into account national best practice. Risks in the ED were assessed and reviewed frequently and clear mitigating actions and timescales for action were in place.
- There was a clear focus on patient safety at all times from all staff during the inspection, even when the ED was under considerable pressure due to the increased number of attendances. Staff in the ED had a proactive approach to seeing out new and more sustainable models of care while maintaining high quality and delivery of safe care.

However:

- The ED had a recovery plan to improve performance to meet the national target for patients to be admitted transferred or discharged within four hours following arrival, which had been agreed with local commissioners and other stakeholders. From April 2016 to August 2016, the ED met and exceeded their

Urgent and emergency services

planned trajectory for improvement in four-hour performance. However, the increased number of attendances in September to December 2016 had meant performance to this measure had declined and was below the national average.

- The overall time from arrival to initial assessment for patients arriving by ambulance at this ED was consistently worse than the England average and ranged between 11 and 30 minutes, whilst the England average was consistently less than ten minutes. An action plan was in place to improve this.
- During our inspection, the average time to initial clinical assessment for all patients was between 19 and 22 minutes. From information provided by the trust for the six months to the end of February 2017, the average time to initial clinical assessment for all patients was 15 minutes. An action plan had been developed for three specific areas that the ED had identified as areas for improvement that included developing a more robust rapid assessment process for children to ensure that they received an initial assessment by an appropriate healthcare professional within 15 minutes.
- There were plans in place to increase the number of cubicles in the children's ED, which did not meet national guidance at the time of the inspection.
- Whilst patients' needs were met at the time of the inspection, the planned daily consultant cover in the emergency department was below national recommendations of 16 hours per day at 14 hours.

Are urgent and emergency services safe?

Good

We rated safe as good because:

- There was a positive culture towards reporting incidents and learning from these to improve patient safety. There was clear evidence that learning from incidents was embedded across all staff groups.
- 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 generally met all patients' needs. There were systems and processes in place to ensure that the maintenance and use of equipment kept people safe.
- Medicines were stored and handled in line with the hospital's medicines management policy.
- Patients' individual care records were well managed and stored appropriately.
- There were effective processes in place to ensure that adults and children in vulnerable circumstances were safeguarded from abuse.
- Staff at all levels in the ED 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.
- Nurse staffing met patients' needs at the time of the inspection.
- Effective systems were in place for managing major incidents.

However:

- During our inspection, the average time to initial clinical assessment for all patients was between 19 and 22 minutes. From information provided by the trust for the six months to the end of February 2017, the average time to initial clinical assessment for all patients was 15 minutes. An action plan had been developed for three specific areas that the ED had identified as areas for improvement.
- The overall time from arrival to initial assessment for patients arriving by ambulance at this ED was consistently worse than the England average from

December 2015 to November 2016 and ranged between 11 and 30 minutes, whilst the England average was consistently less than ten minutes. An action plan was in place to improve this.

- Whilst patients' needs were met at the time of the inspection, the planned daily consultant cover in the emergency department was below national recommendations of 16 hours per day at 14 hours. Medical staffing for middle grade and junior doctors met the needs of patients at the time of the inspection.

Incidents

- The emergency department (ED) had systems in place to monitor an appropriate range of safety and quality information.
- 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 December 2015 to November 2016. 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'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 December 2015 to November 2016, there were two incidents categorised as serious incidents that were attributed to the ED.
- All serious incidents were 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. All staff we spoke with described how some incidents resulted in changes to the way that they prioritised patients for treatment. For example, the ED had made changes to the prioritisation of patients who presented to the ED (either via ambulance or self-presenting) aged 50 and over with back pains and had symptoms indicative of a potential ruptured abdominal aortic aneurysm (AAA). AAA is a localised enlargement of the abdominal aorta, the main blood vessel that leads away from the heart, down through the abdomen to the rest of the body. It usually causes no indications unless ruptured when symptoms can include abdominal pain, low blood pressure, back pain or loss of consciousness and can sometimes result in death. These patients were highlighted on the electronic patient record system as being 'high risk' and were given priority to receive an initial clinical assessment within 15 minutes. We saw that there were 10 other conditions that had been added to the 'high risk' group as a result of learning from incidents, this included patients who were receiving cancer therapy and were at risk of developing neutropenic sepsis (a potentially fatal complication of anticancer treatment).
- From December 2015 to November 2016, there were 742 incidents reported for ED. All incidents were graded from 'no harm' to 'death' in line with the trust's incident management policy and national guidelines. The majority of incidents (76%) were categorised as no harm and related to incidents such as patients who arrived at the ED with pressure ulcers and verbal aggression towards staff. Of the remaining incidents, 22% had been categorised as low harm, 1% as moderate harm and less than 1% were categorised as severe or resulting in death. We saw that staff had recorded any incidence of fluid therapy mismanagement as incidents in line with National Institute for Health and Care Excellence (NICE) clinical guideline (NICE CG174- intravenous fluid therapy in adults in hospital, 2014).
- Mortality and morbidity meetings were conducted monthly and there was an effective process in place to disseminate information to staff at all levels. For example, the department had started conducting simulation exercises to learn from incidents. Staff at all

levels were invited to attend and relevant information was available on the dedicated ED intranet page, and hard copies were stored in a folder in the staff communal room.

- 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.
- All staff were aware of their responsibility to be open, transparent and honest and gave examples of when they had offered patients and relatives an apology. Staff were aware of the organisation's policy and their requirement to apply Duty of Candour for any incident that was investigated and categorised as moderate or above. Our observation of records showed that when things went wrong patients, their loved ones were offered a verbal and written apology and complied with Duty of Candour processes. This also included arranging local meetings and support for patients and relatives.

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 guidelines (NICE Quality Standard Infection prevention and control, QS61, 2014). For example, patients received care from staff who had decontaminated their hands immediately before and after every episode of direct contact or care.
- The ED was visibly clean and there was a dedicated team of domestic staff responsible for ensuring that all areas of the ED were kept clean.
- 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 August 2016 to January 2017, the ED scored between 92% and 100% for compliance to hand hygiene protocols: this included adherence by medical, nursing 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.
- The hospital had policies and processes in place to ensure that patients who needed a urinary catheter or vascular device inserted had their risk of infection minimised by the completion of specified procedures in line with national guidance (NICE, 2014). This included policies relating to catheter insertion and removal and monthly audits. From November 2015 to November 2016, there were zero cases of catheter urinary tract infection reported for the ED.
- In addition to the hospital-wide audits, domestic supervisors conducted monthly infection control audits for all areas in ED and these results were included in the departmental quality dashboard. Each audit had an action plan attached with a clear indication of who was responsible for the action and when it was to be completed. For example, in the audit of the majors' area (which was conducted in September 2016) it was identified that the sealing around the base of public toilets was not intact: the action plan showed that the work had been reported to the estates' department and works completed within the same month.
- There were two dedicated isolation rooms in the ED where patients with suspected infectious diseases (such as chickenpox or measles) could be cared for to minimise the risk of spreading infection.
- 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 trollies 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 ED, including public areas. There was sufficient hand sanitising gel dispensers throughout the department including at the entrances.

- From December 2015 to November 2016, there were no cases of MRSA or Clostridium Difficile reported for the ED.
- 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.

Environment and equipment

- The design, maintenance and use of facilities and premises generally met all patients' needs. There were systems and processes in place to ensure that the maintenance and use of equipment kept people safe.
- The department had commenced an expansion plan in 2014. Staff told us that this had given them the opportunity to develop some areas of the department in line with department of health guidelines for EDs (Health Building Note 15-01: Accident & Emergency departments, April 2013). For example, the dedicated geriatric emergency medicine service (GEMS) which was five rooms situated within the ED had been located in the quietest area of the ED, at the end of a corridor, which was not a thoroughfare. The resuscitation area had been increased from six bays to 10, which included a dedicated trauma room that was fully equipped with provision for adults and children. The department was adjacent to the ambulatory care unit, and located close to the fracture clinic and hyper-acute stroke unit. Our discussions with staff at all levels confirmed that the planning for the design and layout of the department was based on a patient-centred and whole system approach to providing care at the 'front door', which was in line with the guidance.
- The ED was located next to the radiology department, which meant that they had direct access to the magnetic resonance imaging (MRI) and computerised tomography (CT). A health care assistant (HCA), porter or transfer nurse escorted patients to the radiology department.
- The children's ED had a dedicated waiting area that was audio and visually separated from the adult's section in line with guidance. Children and young people who attended ED via ambulance or walked in were automatically sent to the children's ED. Authorised staff were able to access the children's ED using personal electronic swipe cards, parents and visiting professionals were given access via an intercom system.
- Staff in reception sat behind screened windows and had access to panic buttons, which alerted security staff if a patient or visitor displayed aggressive or challenging behaviour. This system alerted security staff and other staff within the ED when necessary.
- The department had a dedicated mental health room that met the Royal College of Emergency Medicine guidelines (RCEM, 2009). The room was situated in the First Intervention and Treatment (FIT) area, which was a part of the majors' area and accessible via the dedicated ambulance entrance and swipe door access. The FIT area had ten dedicated bays where patients were rapidly assessed and receive immediate intervention and treatment for life-threatening conditions such as sepsis. The room, in line with RCEM guidelines had two doors that opened both ways, immovable furniture, panic strips around the walls and no ligature points.
- There was resuscitation equipment for adults and children readily available throughout the ED. Records showed that the resuscitation equipment had been checked on a daily and weekly basis based according to the hospital's policy. All staff we spoke with, including reception staff, had been trained in basic life support and the use of an automated electronic defibrillator.
- The ED had a dedicated trauma storeroom that was located near to the resuscitation area. There was an appropriate range of equipment to treat adults and children of all ages. There was a dedicated trauma resuscitation room and staff had access to a portable trauma equipment stacking system that was regularly checked and could be transported to other areas of the ED if necessary.
- The department used a dedicated porter or transfer nurse to escort patients to other wards and for tests.
- The ED had clear processes in place to manage clinical and domestic waste. Regular audits were undertaken to ensure that waste was classified, segregated, stored, labelled handled and, where appropriate, treated and disposed of appropriately.

Medicines

- Medicines were stored and handled in line with the hospital's medicines management policy.

- For example, fridge and room temperatures were regularly checked and temperatures recorded.
- Controlled drugs (CDs) (a medicine that is controlled under the Misuse of Drugs legislation 2001 (and subsequent amendments) were kept in locked cupboards and stored in areas that required swipe card access. The nurse in charge held the keys to CD cupboards. We saw that almost 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.
- We reviewed 13 sets of patient records and found that allergies had been clearly documented in patient's records. All prescribing charts showed when medicines (including oxygen therapy) had been requested and who had requested them, the charts showed when the medication had been given and by whom.
- We observed nursing staff preparing and administering intravenous fluids in line with guidance.
- Patient group directives (PGDs) allow some registered health professionals (such as nurses) to give specified medicines (such as painkillers) to a predefined group of patients without them having to see a doctor. Our observations of records and discussions with staff confirmed that there were effective processes in place to ensure that these were up to date and used by authorised personnel only.
- The urgent care directorate had a dedicated pharmacist who conducted monthly audits of drug storage and compliance to statutory requirements.
- During our inspection, we saw one instance in the resuscitation area where records showed that there was an amount of controlled drugs used for anaesthesia, procedural sedation and severe agitation was missing. We highlighted this to a senior nurse who immediately informed the pharmacist who attended the ED to investigate the discrepancy. It was quickly identified that the drug was not missing but had been stored in a locked box in another drug cupboard that was located in the children's resuscitation area and was not secure; staff told us that this was for easy access. This was not in line with trust policy or statutory requirements. The trust immediately put in actions to address this issue; this included ensuring that the cupboard was locked with a key that had to be obtained from the lead nurse and returned after use.

Records

- Patients' individual care records were well managed and stored appropriately. Records seen were accurate, complete, legible and up to date.
- Records used in the ED were a mixture of electronic and paper-based. All paper-based records were scanned to the electronic system. Requests for tests and diagnostics were made via the electronic system.
- We found that paper records were stored securely in locked trollies throughout the ED.
- The ED had developed continuation of care records that were paper-based and used to evidence that all risk assessments and observations had been completed and that the details had been entered onto the electronic records. It was a checklist which nursing staff completed on a two hourly basis to ensure that a patient's observations, pain score, pressure area care, personal care needs and nutrition and hydration had been checked and recorded.
- We found that risk assessments had been completed in line with national guidance for patients at risk of falls, venous thrombolytic embolism (VTE) and pressure ulcers.
- 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 dashboard.

Safeguarding

- There were effective processes in place to ensure that adults and children in vulnerable circumstances were safeguarded from abuse.
- 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 ED had an electronic child protection information sharing system that allowed them to share and receive information regarding children who were identified as at risk of potential abuse. A health visitor attended the ED three times a week to review all child attendances.
- 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, staff told us 77% of nursing staff and 71% of medical staff had completed safeguarding level three training against a target of 85%. The ED had an on-going action plan to deliver safeguarding level three training in line with guidance.
- There was information relating to female genital mutilation (FGM) on the trust's intranet and dedicated ED learning page. 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. Specific training in regards to FGM awareness was planned to be delivered for the 2017/18 training year.
- Flow charts were on display in staff areas of the ED directing staff to information about who to contact in suspected cases of domestic violence and abuse.
- 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 EDs 2017/18 training action plan.
- Staff told us that the hospital safeguarding team delivered bespoke training for staff in the ED and directed us to information on their dedicated intranet page regarding topics such as child sexual exploitation. Staff said the safeguarding team were very visible in the department and were always available to give advice.
- All staff were clear about their responsibilities and were able to tell us the indications of suspected abuse, for both adults and children.
- The children's ED had flow charts at the nurse's station and on the dedicated intranet page to assess the risk of physical abuse in children presenting with suspicious injuries.
- The hospital's safeguarding team reviewed all new attendances by children to the ED within 24 hours and informed the relevant authorities and GPs when required.

Mandatory training

- Mandatory training for medical nursing staff in the ED consisted of statutory training modules such as information governance, health and safety, equality and diversity and fire safety. There was also mandatory training that was role specific such as advanced trauma nursing care for all band 6 nurses.
- Staff said training was accessible, met their needs and they were given time to attend when required.
- The trust's target for mandatory training completion was 85%. At the time of our inspection, mandatory training completion for nursing, medical and administrative/clerical staff was 87% overall.
- All staff we spoke with told us that they were up to date with their mandatory training.
- The dedicated practice and development educator facilitator worked with the nursing 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

- Comprehensive risk assessments were carried out for patients and risk management plans were developed in line with national guidance. Staff at all levels in the ED 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.
- The ED had developed effective processes to continuously monitor the safety of the patients who attended the department. This included a two hourly 'safety round' of the whole department which was conducted by the clinical lead doctor and nurse in charge and included a review of patients with the highest acuity level and those that had been waiting the longest in the department.
- The department had developed their own electronic 'safety thermometer' which was updated from the evidence gathered in the safety round and included information regarding the status of neighbouring emergency departments. Staff told us that the safety round and thermometer allowed them to have a holistic view of the levels of safety within the department. All staff we spoke with demonstrated a clear focus on patient safety in the ED at all times.
- There was a clear system of streaming (streaming is the process of allocating patients to specific groups and/or physical areas of a department) and triage for all patients who presented to the ED.

- For all patients who self-presented to ED, dedicated non-clinical reception staff took the patient's details and a brief description of their symptoms. Staff in reception had been trained to recognise patients with 'red flag' symptoms as defined by the Royal College of Emergency Medicine (RCEM, 'Triage position statement', 2011) such as chest pains and difficulty breathing. These patients were immediately sent to the FIT waiting area to be seen by a triage nurse. All reception staff had received training in basic life support and had immediate access to nursing staff in the FIT area if they had any concerns about a patient's condition. All other patients waited in the main waiting area as a part of the streaming process to receive triage/initial clinical assessment by the streaming practitioner (between the hours of 8am and 10pm) and a registered nurse (band 6 or above) outside of these hours. The streaming practitioner conducting the triage for all patients who self-presented was situated adjacent to the main waiting area and had a clear view of all patients waiting to be either triaged or seen by a doctor.
- The FIT area had been developed in 2016 with the expansion of the department. The area provided the ED with a rapid assessment process that allowed senior clinicians and nursing staff to start treatment for patients with immediately life threatening conditions such as heart attacks and sepsis. Patients who were seen in the FIT area were initially triaged using a rapid assessment and prioritisation tool called the Manchester Triage System. An initial assessment tool (IAT) was then applied, the IAT was mapped to 31 presenting complaints for the major's area, and these included acute kidney injury (AKI), gastrointestinal bleeding and abdominal pain. The IAT provided medical staff with a list of tests for each presenting symptom to rule out or confirm a life-threatening diagnosis. IATs were developed from evidence-based guidelines and updated on a regular basis.
- All children were immediately sent to the children's ED waiting area where they received an initial clinical assessment within 15 minutes, and then waited to see an ENP in minors, the GP or a doctor. From information provided by the trust for the six months to the end of February 2017, the average time to initial clinical assessment for children and young people was 13 minutes.
- The ED aimed for all patients to receive an initial clinical assessment within 15 minutes of arrival in line with national guidance such as the Royal College of Paediatric Child Health 'Intercollegiate standards for children and young people in emergency care settings' (RCPCH, 2012). This included observation and recording of vital signs, pain score, brief patient history and immediate care plan.
- Senior staff told us that the standard for initial clinical assessment was also applied to all self-presenting adult patients to ensure that patients without 'red flag' symptoms were safe to wait and they were seeing their sickest patients first.
- During our inspection, the average time to initial clinical assessment for all patients was between 19 and 22 minutes. From information provided by the trust for the six months to the end of February 2017, the average time to initial clinical assessment for all patients was 15 minutes. The department had taken part in an external patient safety culture survey along with seven other emergency departments in the east midlands area in July 2016 and had received the results in November 2016. An action plan had been developed for three specific areas that the ED had identified as areas for improvement that included developing a more robust rapid assessment process for children to ensure that they received an initial assessment by an appropriate healthcare professional within 15 minutes.
- All patients who arrived by ambulance were taken to the FIT area where a handover of patients took place between the ambulance and ED staff. The FIT area had ten bays where patients could receive a rapid assessment and start of treatment for time sensitive conditions such as sepsis.
- The Department of Health recommends that ambulance handovers be completed within 15 minutes of arrival at the ED to ensure that an initial clinical assessment is carried out in a timely manner. From December 2015 to November 2016, the overall time from arrival to initial assessment for patients arriving by ambulance at this ED was consistently worse than the England average and ranged between 11 and 30 minutes, whilst the England average was consistently less than ten minutes. The department had an action plan in place to improve performance in this area; this included the introduction of the FIT area and developing ways to improve flow throughout the ED by improving urgent care facilities/ provision. Performance against this standard showed a

trend of improvement from March 2016 and the department was achieving between 11 and 15 minutes from June 2016; however, they were still below the England average.

- From April 2016 to December 2016, there were 2,883 ambulance handovers of over 30 minutes and less than 60 minutes.
- A 'black breach' occurs when a patient waits over an hour from ambulance arrival at the emergency department until they are handed over to the emergency department staff. From April 2016 to December 2016, there were 781 'black breaches' recorded for this trust. There were clear action plans in place to improve performance in this area and the trust had seen a decrease in ambulance handover times with the introduction of the FIT area from June 2016 (250 black breaches in May 2016, 130 in June 2016 and 47 in July, this figure was 11 in September 2016) .
- A colour-coded early warning system (EWS) was used for adults in ED and a paediatric early warning system (PEWS) was used in line with NICE clinical guidance (Acute ill adults in hospital: recognising and responding to the deterioration, CQ50, 2007). We reviewed 15 sets of records and found that the EWS or PEWS score had been recorded and appropriate escalation was made when required.
- All frail patients or those with a suspected fracture were placed on a special air mattress for comfort and to minimise the risk of them acquiring pressure ulcers. All patients who were in the department for longer than four hours were transferred onto hospital beds.
- Staff had access to acute paediatric support for the investigation of sudden, unexpected deaths in infancy and childhood. Staff had access to contact details for the hospital's children's liaison team if they needed support.
- First initial assessment proformas were used to conduct clinical assessments for all patients and contained a modified screening tool for sepsis. The ED used the Sepsis Six pathway for adults and children. The Sepsis Six is the name given to a bundle of medical therapies designed to reduce the mortality of patients with sepsis. The Sepsis Six consists of three diagnostic and three therapeutic steps – all to be delivered within one hour of the initial diagnosis). Sepsis is the presence of harmful bacteria and their toxins in the body. Patients with suspected sepsis were flagged on the electronic system and a sepsis sticker placed on their paper based assessments.
- There were clear processes in place to provide care and treatment for adults and children who were experiencing acute mental health illness. This included risk assessments and a mental health care room that was compliant with RCEM standards. The on-site psychiatric liaison team was based in the ED and was able to arrange assessments for patients 14 years old and over. There were pathways in place to arrange Child Adolescent Mental Health services (CAMHS) for all children and young people.
- The hospital had a hyper acute stroke unit (HASU) where patients who had been diagnosed with a stroke could receive time sensitive thrombolytic treatment. The ED had a dedicated 'stroke' bay where treatment could be started by trained staff if necessary. Staff told us that if the patient was in the bay a member of the staff from the HASU could attend ED and start the treatment there before transferring the patient.
- The ED had a process in place for reception staff to arrange a GP appointment for patients who had received triage and were referred to a GP by the ENP or streaming nurse.
- Staff told us that VTE assessments were conducted for all patients with lower limb immobilisation and other patients including those who had suffered other traumatic injuries in line with national guidance (NICE Venous thromboembolism: reducing the risk for patients in hospital, CG92, 2010). The urgent care dashboard showed from October 2016 to December 2016 the average compliance to conducting VTE risk assessments was 93% against a target of 95%. There was an on-going programme of reminding staff and auditing compliance to protocol.

Nursing staffing

- We observed in adults and children's ED during the unannounced and announced inspections that there was a good skill mix and level of nurse staffing to meet the needs of patients based on National Institute of Health and Care Excellence (NICE) guidance.
- Nursing staffing was planned up to 12 weeks in advance and reviewed regularly including on a daily basis to allow senior staff the opportunity to allocate staff to different areas depending on skill mix.

- The overall lead for adults and children's ED was the ED matron: the department was in the process of developing the leadership in this area by introducing a band 7 nurse position for a paediatric-trained nurse/ practitioner who could help to develop staff in the department.
- There were no junior staff working without supervision and senior nursing staff were visible and available at all times.
- Daily staffing was planned to have 16 registered nurses (RN) and five HCAs from 7.15am to 7.45pm. This rose by two RNs and one HCA who were rostered to work 4pm to midnight. There were two transfer nurses planned for 10am to 6pm and 4pm to midnight daily, who could escort admitted patients to wards and those who may be transferred to other hospitals for specific care.
- During the nights, the planned rota was 18 RNs from 7.15pm to 8.30pm and this went down to 14 RNs from 8.30pm to 7.15am, with three HCAs from 7.15pm to 7.45am. During our inspection, we saw that actual staffing met the planned levels.
- The daily staffing numbers included two RNs (children's branch) for children's ED from 7.15am to 7.45pm and an HCA and one RN (children's branch) from 7.45pm to 7.15am.
- At the time of our inspection, there were 113 whole time equivalent (WTE) nursing staff in post against a budget of 120WTE (this figure was for RNs and HCAs). There was an ongoing campaign of recruitment at the hospital and we saw that there were effective arrangements in place to cover vacancies with bank and agency staff. The hospital had started a campaign to encourage their own workforce to join the in-house bank staff to reduce agency spend and have greater consistency of care. The campaign included providing bank staff with opportunities to develop through free clinical skills training and support with revalidation. Senior nursing staff told us that this had reduced their agency spend for ED and the opportunities for development had led to some bank staff joining the ED on a permanent basis. By the end of February 2017, there were forecasted to be no vacancies for nursing staff against the budgeted establishment. Senior staff told us that they were developing a list of applicants that wished to be considered for posts in the future.
- There were comprehensive induction processes in place for bank and agency staff that included orientation to the department, access to IT systems, information governance and safeguarding for adults and children. We saw that induction records were kept for bank staff that highlighted the areas that they were competent to work in; these records were audited and checked by the ED matron on a monthly basis. From April 2015 to January 2017, the ED average percentage of shifts filled by bank and agency staff was reported as 12%.
- Nursing staffing levels in ED were discussed at regular intervals throughout the day at departmental and hospital-wide bed management, twice-daily safety huddles and capacity meetings. There was an effective staffing escalation protocol in place and senior managers and clinical site supervisors monitored the ED's staffing levels throughout the day and night.
- We observed nursing handovers that were structured and conducted in small teams and individually. The nurses in charge of ED conducted verbal and written handovers and discussed the acuity levels of patients and capacity.

Medical staffing

- The proportion of consultant staff working at the hospital was about the same as the England average and the proportion of junior (foundation year 1-2) staff was lower than the England average.
- The RCEM recommends that EDs seeing 80,000 plus patients annually should provide 16 hours of on-site consultant cover per day (RCEM, 2010). The ED had on-site consultant cover Monday to Friday from 8am to 10pm (14 hours per day) and six hours per day on weekends and bank holidays (this was planned based on demand). There was a middle grade doctor (ST4 or equivalent) available on site 24 hours a day and on-call consultant cover at all other hours. Consultants were required to be able to return to the hospital within 45 minutes if required.
- At the time of our inspection, the ED had funding for 10.8 WTE consultants and there were seven substantive members of staff in post and three long-term locums. The department had plans to fill the remaining three posts in 2017/18 and to increase the provision of consultant cover to meet RCEM guidelines. At times of high demand or for short notice cover consultants covered extra hours as part of their job plans (programmed activities as part of the NHS contract) and worked for up to four hours over their contracted shift times. Senior staff told us that they recognised that this was not sustainable and could affect staff well-being

and they adjusted rotas to compensate for extra hours worked. Medical staffing for middle grade and junior doctors met the needs of patients at the time of the inspection. There was a designated consultant in charge on a daily basis.

- The department had introduced physician associates in 2016 and had five advanced associate practitioners who worked seven days a week from 8am to 10pm. An advanced associate practitioners works with doctors in the treatment and management of patients they receive specific medical training including taking histories, analysing specific test results and diagnosing illnesses under direct supervision of a doctor.
- We observed effective medical handovers which were conducted in a group 'safety huddle' and for each area of the ED. Medical staff discussed the acuity levels of patients, safety alerts and briefings, updates on protocols, issues with staffing and levels of demand.
- There were clear processes in place for the induction of temporary medical staff. This included a corporate and local induction for locums, which included statutory and mandatory training checks and local orientation. From April 2015 to March 2016, the trust reported the average percentage of medical bank and agency use was 23%.
- At the time of our inspection, the department did not have a consultant who specialised in paediatric emergency medicine in line with guidance (RCPCH, 2012). All medical staff were trained in advanced paediatric life support, European paediatric life support or paediatric intermediate life support. Senior staff told us that it had been challenging recruiting a consultant with sub-speciality in paediatric emergency care and they had been working with a local educational institute to develop a training programme that incorporated paediatric and geriatric emergency medicine to meet the need in the future.

Major incident awareness and training

- There ED had a major incident plan with clear guidance and action cards for individual roles in the event of specific incidents. There were clear diagrams strategically placed throughout the department directing staff of immediate actions required in the event of a major incident.
- All staff we spoke with were aware of where to locate the major incident equipment if they were required to and knew where to find information on the intranet and within the department.
- Major incident training formed a part of the ED mandatory training programme: staff were required to undertake training every two years, and when the plan was updated.
- There were regular bespoke training sessions arranged four times a year: this included major incident simulation exercises, we saw that these were published on the ED training plan and staff at all levels were able to book onto the sessions.
- The department had clear processes in place to manage patients who may have been exposed to chemical, biological, radiological or nuclear (CBRN) hazards. This included a dedicated decontamination room that was located next to the resuscitation area and was accessible from the ambulance entrance to minimise the risk of cross contamination.
- There were business continuity plans in place to manage the ED in the result of adverse weather, loss of power or disruption to staffing.
- During our inspection, we saw that there was an adequate level of security personnel presence to keep people safe. Staff on reception had access to panic buttons at their desks and all staff told us that their requests for assistance from security were always responded to in a timely manner.
- There was a system in place to enable security and senior staff to 'lock down' the ED and restrict access to authorised personnel only.
- Overall, 90% of staff had completed health and safety training that included risk management and 79% of staff had completed refresher fire safety training as part of the mandatory programme.

Are urgent and emergency services effective?

(for example, treatment is effective)

Good

We rated effective as good because:

- Evidence-based guidance was used to develop how care and treatment was delivered throughout the ED.

- The ED took part in all relevant national audits to measure patient outcomes and developed clear action plans for areas identified for improvement.
- Patients' pain relief was appropriately assessed and managed.
- Patients' dietary and hydration needs were being met 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 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:

- The ED un-planned re-attendance rate did not meet the national standard of 5%.
- Not all doctors had had an appraisal in line with the trust's target of 85%.

Evidence-based care and treatment

- Evidence-based guidance was used to develop how care and treatment was delivered throughout the ED. All policies were up to date, reflected national guidance and staff said they were accessible via the trust's intranet.
- There was a clear programme of audits conducted in regards to compliance to organisational standards and protocols. There was a lead consultant and senior nurse responsible for managing the department's annual audit calendar.
- The ED had developed a comprehensive falls' bundle that was based on a combination of National Institute of Health and Care Excellence (NICE Head injury: Triage, investigation and early management of head injury in infants, children and adults, CG56, 2007) and best practice guidelines for patients who have fallen from a standing height.
- The department had developed electronic initial assessment tools (IATs) based on NICE guidelines and Royal College of Emergency Medicine (RCEM) clinical standards (RCEM, 2014). The IATs were mapped to each presenting symptom to the ED and contained guidance on tests that were required for specific symptoms and what conditions symptoms could be related to. A senior consultant was responsible for developing and maintaining the IAT database, staff told us that initially it was designed as a training tool to support staff who were under supervision; however, it had been developed to be used as an information portal and checklist for all staff.
- There was a consultant lead for clinical audits and senior nursing staff had developed a system of auditing protocols and changes to practice to monitor and improve patient care. For example, when the department introduced the continuation care records they started a series of audits to monitor compliance and made changes when necessary.
- The department used the 'sepsis six' care bundle and active cancer sepsis care bundle pathways in line with RCEM guidelines and the UK Sepsis Trust (2014) for adults and children. These pathways are to aid those delivering care with the rapid recognition and treatment of severe sepsis. There were proformas in place for staff to record their actions within defined guidelines and the department had a dedicated clinical lead for sepsis.
- A sepsis audit conducted in September 2016 showed that 63% of eligible patients were being appropriately screened for sepsis. The department had carried out a number of actions to improve this, which included random audits of initial assessment forms and educating staff. Audits were conducted monthly from September 2016 to January 2017 and the performance in this area had improved to 90% compliance.
- The ED had developed their fractured neck of femur pathway to include a fascia iliac block (this is an interventional radiological procedure that allows medical staff to give pain relief into a specific nerve) as standard. This had been audited and the department had received an internal award for introducing the process and improving the timeliness of pain relief for patients.
- The ED had introduced a paediatric vacuum mattress to be used for children who were going to have a computerised tomography (CT) performed. This process had been developed in October 2016 after a consultant led study and audit, which had started in December 2015, showed that there was a reduction for children requiring sedation to keep them still during this

procedure in order to obtain a useable image. The process had been adopted in the paediatric department and was used to develop the geriatric emergency medicine service.

- The department met most of the standards set out in the intercollegiate document 'Standards for children and young people in emergency care settings' (Royal College of Paediatric Child Health, 2012). For example, they had sufficient registered nurses (children's branch) employed to provide a minimum of one per shift, training plans to provide adult nurses with paediatric competencies and had systems in place to identify children and young people in vulnerable circumstances. However, they did not meet some of the standards including ensuring that there were age appropriate distractions for children and young people of all ages.
- The department conducted venous thrombolytic embolism (VTE – blood clots) risk assessments for all patients with lower limb immobilisation in line with RCEM guidance. There were processes in place to conduct VTE risk assessments for all patients in line with national guidance (NICE Venous thromboembolism in adults: reducing the risk in hospital, QS3, Statement five, 2010 and NICE CG92 updated June 2015).
- The ED had processes in place to ensure that adults receiving intravenous fluids were cared for by staff who were competent to do so in line with national guidance (NICE Intravenous therapy in adults in hospital, QS66, statement two, 2014).

Pain relief

- Patients' pain relief was appropriately assessed and managed. All patients that we spoke with told us that they had been offered pain relief and felt that their pain was being managed.
- Pain scores had been recorded in all patient records that we reviewed and analgesia administered in a timely manner. Pain scores were recorded on initial assessment and the ED used a pain-scoring tool for adults that were based on the World Health Organisation's (WHO) 'pain ladder' on a scale from one to 10.
- The children's ED used a visual aid as a pain-scoring tool that was a selection of five faces that the child would point to show how they were feeling. Pain scores were checked on the continuation of care records at regular intervals after the initial assessment.
- The department conducted monthly documentation audits which included documentation of pain score for adults and children. Records showed that in May 2016, 73% of pain scores for children had been documented and 92% in January 2017. For adults, there were two standards applied, the percentage of patients who had their pain score recorded and the percentage of patients who had documented pain re-assessment in line with guidance. Records showed that 84% of adults had their pain score documented in July 2016 and 100% in January 2017. The audit for adults showed that 10% of patients had their pain re-assessment documented in July 2016 and 90% in January 2017. There was a marked increase in the second standard for adults from September 2016 (17%) and October 2016 (52%) when the department introduced continuation of care records.
- The trust had recently established a nurse-led pain group with a specialist interest in pain in the ED. The group included representatives from adults and paediatrics and were responsible for setting up local audits and link meetings.
- The ED did not audit the effectiveness of pain management for children in line with RCEM guidance (RCEM, 2013 Management of pain in children). Senior staff told us that there were plans to participate in the RCEM annual audit.
- The ED had not yet formally implemented the Faculty of Pain Medicine's core standards for pain management (2015); however, the continuation of care records, which were completed on a two hourly basis for every patient, required the nursing staff to complete a pain assessment. The department had developed specific continuation of care records for patients on end of life care pathways that included a regular review of symptom control measures including pain relief.
- In the CQC A&E Survey (published in December 2014), the trust scored 5.3 out of 10 (which was the same as the average for other trusts) for the question "How many minutes after you requested pain relief medication did it take before you got it? This was about the same as other trusts. The trust scored 7.5 out of 10 for the question "Do you think the hospital staff did everything they could to help control your pain?" This was about the same as other trusts.

Nutrition and hydration

- Patients' dietary and hydration needs were being met appropriately.
- Patients we spoke with told us that they had been offered food and drink whilst they were in department.
- Nutrition and hydration needs were checked as part of the nursing continuation of care records on a two hourly basis.
- Fluid and food intake was monitored effectively using the national Malnutrition Universal Screening Tool (MUST) which is a five-step screening tool to identify adults who are malnourished or at risk of malnutrition.

Patient outcomes

- Patient outcomes were monitored regularly, the department took part in national audits and made improvements and changes to practice as a result of audits.
- The Royal College of Emergency Medicine (RCEM) invites emergency departments to take part in national clinical audits annually that evaluate care based against agreed standards. We saw that the ED participated in relevant audits annually, which allowed them to benchmark their performance against national performance.
- In the 2013/14 RCEM audit for asthma in children, the trust performed better compared to other trusts for three of the ten measures relating to initial observations and treatment was similar to the national average.
- In the 2013/14 RCEM audit for paracetamol overdose, the trust performed better compared to other trusts for one of the four measures related to treatment within a specified time and was worse than the national average for three of the four measures.
- In the 2013/14 RCEM audit for severe sepsis and septic shock, the trust performed better compared to other trusts for three of the 12 measures related to treatment within a specified time and was worse compared to other trusts for two of the 12 measures related to recording vital signs in patient's records.
- In the 2014/15 RCEM audit for assessing cognitive impairment in older people, the trust performed better compared to other trusts for three of the six measures related to recording early warning scores and communicating findings with other relevant services, carers and GPs which was similar to the national average.
- In the 2014/15 RCEM audit for initial management of the fitting child, the trust performed better compared to other trusts for one of the six measures related to recording all clinical information and was in the between the upper and lower percentages for two of the six measures.
- In the 2014/15 RCEM audit for mental health in the ED, the trust performed worse compared to other trusts for four of the six measures and was between the upper and lower quartiles for one of the six measures. Of the two fundamental standards included in the audit, the trust did not meet the fundamental standard of having a documented risk assessment taken. The trust did not meet the fundamental standard of dedicated assessment room for mental health patients. However, the hospital had actioned both these issues following the audit outcomes.
- In the 2015/16 RCEM audit paediatric vital signs. The department had developed an action plan to improve performance in the areas identified as not meeting the standards. This included a re-audit of cases meeting the criteria and updating the paediatric initial assessment forms to include a space to record the exit observations. This was audited on a regular basis as a part of the department's documentation audit process.
- In the 2015/16 RCEM audit VTE risk in lower limb immobilisation, the trust performed better compared to other trusts in two of the standards related to completion of risk assessment. They performed better compared to other trusts for the standard related to evidence that information was given to the patient. The action plan included ensuring staff recorded that patient's had received verbal and written advice and updating the flow chart which was placed in the ED. VTE assessments were audited on a regular basis.
- In the 2015/16 RCEM audit procedural sedation in adults, the trust performed better compared to other trusts in one of the standards. The action plan included improving staff awareness of sedation procedures and developing a trust sedation committee and training package.
- From December 2015 to November 2016, the trust's unplanned re-attendance rate to ED within seven days was consistently worse than the national standard of 5% and ranged between seven and eight per cent. This was generally worse than the England average by less than 1%.

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.
- New staff in the nursing team were supervised by a more experienced member of the team at the start of their career for a period of no less than six weeks.
- The ED had a dedicated practice educator who was a member of the senior nursing team. The practice educator had introduced development grids for each level of adults and children's nursing staff up to and including band 7 nurses. The development grid consisted of minimum core standards required for each nursing grade and a structured plan of development to progress to the next grade. For example, core standards for a new band 5 staff nurse included mandatory training, attendance at clinical skills week, corporate induction and local induction.
- The practice educator worked with the ED senior nursing team to provide bespoke training sessions for nursing staff in the ED to complete their development grids. There were annual plans for training sessions that all ED nursing staff could access via their dedicated intranet page.
- The practice educator undertook two clinical days per month and used this time to conduct clinical supervision for nursing staff. There was a preceptorship programme in place for senior nursing staff to take on clinical supervisory duties for junior nursing staff.
- Nursing staff in ED had received sepsis management training from the hospital's sepsis consultant lead.
- At the time of our inspection, 92% of nursing staff and all administrative and clerical staff had up to date appraisals against a trust target of 85%. Nursing staff we spoke with told us that their appraisals gave them an opportunity to discuss their individual training needs and the requirements of the department.
- There was a recently appointed lead emergency nurse practitioner (ENP) who was responsible for ensuring that ENPs were competent in areas such as specific paediatric related care.
- The ED had five members of staff who had achieved advanced associate practitioner (a physician's assistant role has been developed to work alongside doctors and GPs to independently assess and treat patients with doctor's supervision). The department clinical leads had developed a programme to further develop these and three of the advanced associate practitioners were being supported to learn new competencies in areas such as ultrasound radiology and diagnostics such as lumbar punctures to work towards becoming senior physicians associates.
- Medical revalidation is the process that all medical staff have to undergo in line with General Medical Council (GMC) requirements to maintain their registration. As at February 2017, all medical staff had up to date revalidation and 72% of medical staff had up to date appraisals against a target of 85%.
- Revalidation is the process introduced in April 2016 that all nurses and midwives in the UK need to follow to maintain their registration with the Nursing and Midwifery Council (NMC) and allow them to continue practising. The practice educator had developed a process to support staff with their revalidation, which was available on the dedicated intranet page. Staff were given a list of subjects that could be included as a part of their revalidation and offered training through online workbooks, reflective practice and study days.

Multidisciplinary working

- Effective multidisciplinary working was clearly evident throughout the department.
- There were effective systems in place to ensure that all teams required to deliver care and treatment were involved in planning and assessing the needs of individual patients.
- The department worked closely with the hospital's integrated care team to co-ordinate care in the community and discharge planning for patients with complex medical conditions. This included working with physiotherapists, occupational therapists, and social workers.
- The ED had dedicated staff called 'trackers' who worked within the department to assist with the co-ordination of beds for patients waiting to be admitted. We observed effective communication between the trackers and the medical and nursing staff to ensure that the right patient was being sent to the right ward.
- The ED had developed a service with another local trust to provide a 24 hour dedicated psychiatric liaison team that was located within the ED clinical observations area.

- We saw medical and nursing staff from different specialities such as cardiology and surgery liaising with staff in the ED to admit patients and develop treatment plans.
- The ED was a part of the East Midlands Trauma Network and was a designated trauma unit. We saw that they had developed pathways with external providers to coordinate care for patients who had suffered major trauma.
- The ED had developed 'special care plans' with other providers for patients who frequently attended the ED and could be cared for in the community without admission. The care plans were flagged on the electronic patient system and had contact details for services that the patient could be referred to, such as alcohol misuse liaison teams.
- There was clear evidence that the ED worked with other specialities to co-ordinate care for patients. The ED had worked with the trust's end of life care and palliative nurse care specialists to develop pathways for patients with a terminal illness. There was effective communication between ED and staff in the hyper-acute stroke unit, ambulatory care unit and emergency assessment unit.
- The ED had a positive working relationship with the paediatric department who provided support to the children's ED and the departments had worked together to develop processes and protocols for children.

Seven-day services

- The adults and children's ED was open 24 hours a day seven days a week. Our observations of patient records, discussions with staff and review of policies confirmed that the service met NHS England's seven-day services priority standards two (all emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible and within 14 hours of arrival at the hospital), five (hospital inpatients must have scheduled seven-day access to diagnostic services such as x-ray, ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, bronchoscopy and pathology) and six (hospital inpatients must have timely 24 hour access, seven days a week, to consultant-directed interventions that meet relevant speciality guidelines either on-site or through formally agreed networks).
- The ED had access to diagnostics and imaging 24 hours a day, this included magnetic resonance imaging (MRI) and CT scanning.
- The pharmacy department was 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 department had access to an on-call pharmacist outside of these hours.
- The ED had access to an emergency and trauma theatre as per national guidance 24 hours a day, seven days a week.

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.
- When patients moved between teams or wards, the appropriate information was shared.
- Staff accessed the trust's electronic patient record system and received test results electronically.
- Staff were able to look at patients' notes from previous attendances on the electronic system, including allergy statuses.
- A summary of care was sent to GPs electronically when a patient was discharged.
- The department had been discussing sharing the whole patient record with GPs for continuation of care; this was not yet implemented at the time of our inspection but plans were being considered as to how to implement this.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- 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).
- All staff we spoke with were able to describe instances when they would use 'best interest decisions' in line with legislation if the patient lacked capacity.
- We looked at one set of records which had a do not attempt cardio pulmonary resuscitation (DNACPR) order attached and found that there was appropriate documentation of the patient's consent and mental capacity to make the decision.

- 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.
- Staff spoken with in adult and children's ED demonstrated how Gillick competence and Fraser guidelines related to the consent process in their practice.
- Gillick competency and Fraser guidelines refers 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.

Are urgent and emergency services caring?

Good

We rated caring as good because:

- 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.
- Staff spoke about their patients in a caring and compassionate manner and respected patients' dignity at all times, even when the ED was very busy.
- Staff communicated with patients and their loved ones in ways to help them understand their care and treatment.
- Staff in the ED had arranged for volunteers to attend the department and provide support and information for patients who may have social needs.
- Staff were aware of the impact that a patient' care, treatment or condition could have on their wellbeing and on those close to them both emotionally and socially.

Compassionate care

- Staff were friendly, professional and helpful to patients. Staff used humour when it was appropriate and were respectful of all patient's individual preferences, habits, culture, faith and background.
- 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.
- Staff spoke about their patients in a caring and compassionate manner and respected patients' dignity at all times, even when the ED was very busy.
- We observed staff treating children with patience and compassion to put them at ease.
- Receptionists were warm and friendly when assisting all patients during the booking in process.
- Patients and those accompanying them were treated with respect, including when receiving personal care.
- We saw an outstanding example of staff understanding the personal and social needs of their patients. A patient living with dementia had attended the ED and was in the geriatric emergency medicine service (GEMS) area. The patient's partner had also had an accident and needed treatment. Staff felt that both the patients would appreciate being together whilst they waited for doctors and test results so they converted a room to accommodate both patients on trolleys.
- The hospital's Urgent and Emergency Care Friends and Family Test performance was about the same as the England average from January 2016 to December 2016 and ranged from 84% to 88% of patients recommending at as a place of care. The ED was involved in the hospital-wide action plan to develop ways of receiving feedback from patients. The response rate for ED had improved from an average of eight to ten per cent in August 2016 to 17% in December 2016.
- We observed nursing and medical staff offering appropriate comfort to patients who were distressed.

Understanding and involvement of patients and those close to them

- Patients told us that they had felt involved in their care and treatment. We saw that patients were kept informed about the treatment plans at all times.
- Patients generally knew which doctor was looking after them and what diagnostic tests were being carried out.
- Staff spoke about the importance of keeping patients informed of waiting times and plans for care and treatment.
- Staff communicated with patients and their loved ones in ways to help them understand their care and treatment. This included adjusting the pace of their speech and recognising when patients may need extra support to communicate such as translation services.
- Staff in the ED had arranged for volunteers to attend the department and provide support and information for patients who may have social needs.

- Relatives were kept informed of plans for patients' admission or discharge as appropriate.

Emotional support

- Staff told us that they would take the time to support patients and their loved ones if they were faced with distressing news.
- Staff were aware of the impact that a patient' care, treatment or condition could have on their wellbeing and on those close to them both emotionally and socially.
- Staff were fully aware of how to make referrals to adult and children's mental health services when required.
- Staff working with children and young people were aware of the support that parents needed when children attended the ED.
- Staff referred patients and their loved ones to bereavement counselling services and support networks for carers and dependents.
- 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 urgent and emergency services responsive to people's needs?

(for example, to feedback?)

Good

We rated responsive as good because:

- The ED 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 ED had recently appointed a GP to work within the ED and develop their urgent care 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.
- The ED had clear systems and processes in place to meet the needs of patients with complex conditions such as those living with dementia or a learning disability.
- A consultant in ED had started developing the geriatric emergency medicine service (GEMS) in 2014 to make the ED 'frail friendly' and to improve staffs' skills in geriatric emergency medicine. The GEMS was outstanding in terms of providing awareness of and responding to the needs of patients within this group and developing a service that provided a multi-agency approach at the front door.
- From November 2015 to October 2016, the monthly percentage of patients waiting between four and 12 hours from the decision to admit until being admitted for this trust was better than the England average and no patients waited more than 12 hours from the decision to admit until being admitted.
- The ED 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.

However:

- The ED had a recovery plan to improve performance to meet the national target for patients to be admitted, discharged or transferred within four hours following arrival, which had been agreed with local commissioners and other stakeholders. From April 2016 to August 2016, the ED met and exceeded their planned trajectory for improvement in four-hour performance. However, the increased number of attendances in September to December 2016 had meant performance to this measure had declined and was below the national average and the planned trajectory.
- There were plans in place to increase the number of cubicles in the children's ED, which did not meet national guidance at the time of the inspection.

Service planning and delivery to meet the needs of local people

- The ED worked with a variety of stakeholders and commissioners to plan delivery of care and treatment. This included local commissioners, GPs, local authorities, charities, other NHS trusts, local police and other external bodies. There was a focus in providing integrated pathways of care, particularly for patients

with multiple or complex needs. This was in line with Royal College of Emergency Medicine (RCEM) recommendations in their report 'How to achieve, safe, sustainable care in our Emergency Departments' (RCEM, 2013).

- We saw that 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 expand urgent care facilities as a part of the overall strategy to reduce admissions via ED.
- The department had undergone a re-design and expansion programme, which started in 2014 and was based on the increasing levels of activity and attendances to the ED. The increase in capacity meant that the ED was able to form a dedicated area within majors for frail elderly patients. This area was called the geriatric emergency medicine service (GEMS) and consisted of five rooms within close proximity to a toilet that was accessible and adapted for patients with physical disabilities.
- There was adequate seating space in the main waiting area and the children's ED waiting area.
- Until the 30 January 2017, the department had an arrangement with an external provider for GP services: this was replaced by an internal GP arrangement as of 1 February 2017. The ED had appointed a GP to work within the ED and develop their urgent care provision by having a GP service that was a part of the ED. The service was working with other GPs in the area to develop new ways of working to deliver care in line with the 'Five year forward view' (NHS England, 2013). This included developing rotational programmes for GPs to work in ED as part of their training. This was in line with the service's overall strategy to improve urgent care facilities and plans to develop a standalone urgent care facility adjacent to the ED.
- The ED had worked closely with a local charity to secure premises adjacent to the hospital to develop an urgent care facility that could also accommodate patients that were medically fit to discharge and waiting for external arrangements to be put in place to support their care in the community.
- The ED had worked with an external provider to develop their Child Adolescent Mental Health Service (CAMHS) provision by developing pathways of care with the on-site psychiatric liaison team for young people aged 14 to 15 years.
- The new design of the ED enabled patients to access services effectively. There was evidence of proactive programmes and service adaptations, which were aimed at meeting the needs of people in vulnerable circumstances.
- The children's ED did not meet some of the recommendations in the intercollegiate document 'Standards for children and young people in emergency care settings' published by the Royal College of Paediatrics and Child Health (RCPCH, 2012). This guidance states that EDs should have a dedicated clinical cubicle or trolley for children per 5,000 annual child attendances. This ED had just under 25,000 attendances a year and had three dedicated cubicles for children in the dedicated children's ED and one dedicated children's cubicle in the resuscitation area. Staff told us that there was on-going work in the children's area and there was an action plan in place to increase cubicle space. The children's ED was adjacent to the majors' area and they had access to a majors' cubicle that could be converted to use for children and access restricted to entry via the children's secure ED entrance.
- Whilst the ED did not employ a designated play specialist for peak times, they did have access to a play specialist service in line with the intercollegiate guidance (RCPCH, 2012).

Meeting people's individual needs

- Services had been planned to take into account the needs of different people, for example, on the grounds of age, disability, gender or religion.
- The ED had clear systems and processes in place to meet the needs of patients with complex conditions such as those living with dementia or a learning disability.
- A consultant in ED had started developing the geriatric emergency medicine service (GEMS) in 2014 to make the ED 'frail friendly' and to improve staffs' skills in geriatric emergency medicine. This included introducing bespoke training for staff in the ED and improving the provision of facilities. The GEMS was innovative in terms of providing awareness of and responding to the needs of patients within this group and developing a service that provided a multi-agency approach at the front door.
- At the time of our inspection, the GEMS had developed to incorporate four rooms in the majors' area that had

been designed for frail elderly patients and cognitive impairments in line with national guidance (Alzheimer's Society UK, 2013). This included walls being decorated with calming colours and paintings. The area was also located in the quietest area of the ED with the least amount of traffic.

- The ED 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 were a number of distraction items in the ED for patients with a learning disability and those living with dementia. These included 'twiddle muffs' and 'twiddle bags' (these are made from soft materials with different textures to keep patients active) there were also specially designed jigsaw puzzles.
- The hospital's dementia awareness team delivered bespoke training to staff in the ED and worked with them to help develop the service for frail elderly patients and those living with dementia.
- The department worked with Age Concern UK to provide support for elderly patients and a volunteer visited the ED on a daily basis to provide advice and support regarding social matters.
- The ED had access to translation services and leaflets with information could be printed off for patients in languages other than English.
- There was a portable hearing induction loop and speech amplifier that was kept in the GEMS area and could be used in any area of the ED for patients with auditory impairments. Patients with auditory impairments had access to a portable hearing induction loop and speech amplifiers when visiting the GEMS area.
- The ED had developed an end of life care room that was situated adjacent to the resuscitation area. The ED had developed a specific continuation of care record for patients who were in the end of life care room; this included ensuring that they had received consultation and timely review for symptom control.
- The ED had dedicated hostess staff who assisted with providing food and drink for patients. The hostesses conducted continuous rounds of the areas to check if patients needed refreshments.
- Patients waiting in the main waiting area of the ED had access to a vending machine. In the CQC 2014 A&E Survey, the trust scored 5.92 out of 10 for the question "Were you able to get suitable food or drinks when you were in the A&E Department?". This was about the same as in other trusts.
- There was a chaplaincy booklet available in the ED that had contact numbers for chaplaincy 24 hours a day and an on-site multi-faith chapel that was open at all times.

Access and flow

- The Department of Health's standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the ED. The hospital failed to meet this target from January 2016 to December 2016 and was below the England average for eight out of the 12 months. Overall, for that period the ED achieved 87% against an England average of 90%.
- Performance against the four-hour indicator was a part of the urgent care overall improvement plan and was discussed at board level. It was recognised that performance against this target was affected by other factors in the trust and the wider care network, such as delayed transfers of care and patients that were 'stranded' in inpatient areas whilst they waited for appropriate care to be arranged in the community.
- The ED had a recovery plan to improve performance to this target, which had been agreed with local commissioners and other stakeholders. From April 2016 to August 2016, the ED met and exceeded their planned trajectory for improvement in four-hour performance. From September 2016 to December 2016, they did not meet their planned trajectory and performance against this metric was below the England national average. In the same period the ED performance ranged between 83% and 90% whilst the England average was between 86% and 90%. Senior staff told us that there were a number of contributing factors to the failure to meet the target, which included an increase in attendances and other trust wide issues.
- From November 2015 to October 2016, the monthly percentage of patients waiting between four and 12 hours from the decision to admit until being admitted for this trust was better than the England average ranging between 4% and 14% whilst the England average was consistently above 10%. No patients waited more than 12 hours from the decision to admit until being admitted.

- The ED had a dedicated clinical observations area that was used for a specific group of patients who were likely to be discharged after receiving results of specific tests or investigations performed in ED. There were specific criteria for patients admitted to the area and all admissions had to be accepted by the senior clinician in ED. No patients who were waiting to be admitted to a speciality were accepted to the clinical observations area unless authorised by the clinical director for urgent care or deputy chief operating officer.
- The clinical observation area had six bays and space for up to six chairs, there were separate shower and toilet facilities for men and women. One of the bays was in a room that could be used as a psychiatric liaison/ assessment room (this was separate to the designated mental health room and not for patients who were suffering acute mental health illness). We saw that this area was strictly monitored and the standard operating policy for the area stipulated that it was not to be used as a means to meet ED targets.
- From October 2015 to September 2016, the percentage of patients leaving the hospital's urgent and emergency care services before being seen for treatment was between 2% and 3%. This was consistently better than the England average, which was between 5% and 4%.
- From October 2015 to September 2016, the average total time in ED for admitted patients was 151 minutes and higher than the England average of 147 minutes. Performance against this metric showed a trend of improvement between March 2016 and September 2016.
- There was a clear escalation policy and staff at all levels were able to articulate the triggers for implementation of the different levels.
- The ED had clear pathways to admit patients to the ambulatory care unit or emergency assessment unit for specific conditions such as suspected pulmonary embolisms (PE) or deep vein thrombosis (DVT).
- As part of the ED escalation process, an area of the corridor was sometimes used to nurse patients who had arrived by ambulance, received an initial assessment and were waiting to be seen by a doctor. The ED had clear guidance on the number of patients who were to be cared for in the corridor and a nurse or HCA was designated to look after up to four patients at a time. The area was close to the main nurse's station and there were screens put up to allow patients to be cared for with some privacy.
- There was an electronic screen in the main ED waiting area that advised patients of the waiting time to see a clinician. Staff told us that during safety rounds the team would check on patients who had been waiting and explain delays.

Learning from complaints and concerns

- The ED 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 the ED 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 final response within 28 days. The trust's quality account for 2015/16 showed that the hospital had improved their response times to complaints from 81% in 2014/15 to 90% in 2015/16. At the time of our inspection, the ED had seven complaints under investigation; each complaint had been allocated to a senior member of nursing or medical staff and was within the specified period for responding to complaints.
- We saw clear evidence that opportunities for learning from complaints were identified and changes made when necessary. For example, a complaint had been raised regarding a patient with complex needs who had a special care plan in place that had not been implemented and not flagged on the electronic system. Because of this complaint, a note was placed on ED whiteboards reminding staff to check if a patient had a special care plan in place in case it was not flagged on the system.
- Complainants and those who supported them found the department to be open and transparent at all stages of the process for raising concerns and complaints.

Are urgent and emergency services well-led?

Outstanding ☆

We rated well-led as outstanding because:

- The leadership team in ED was 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 department and was proud of the organisation and its culture.
- The ED had a strategic plan that set out defined realistic objectives for the future development and sustainability of the department and was in line with the hospital's overall strategy.
- Governance and performance arrangements were proactively reviewed and adapted to take into account national best practice.
- Risks in the ED were assessed and reviewed frequently and clear mitigating actions and timescales for action were in place.
- We saw a clear focus on patient safety at all times from all staff during the inspection, even when the ED was under considerable pressure due to the increased number of attendances.
- Staff in the ED had a proactive approach to seeing out new and more sustainable models of care while maintaining high quality and delivery of safe care.

Leadership of service

- The leadership team in ED was cohesive and inclusive and were focused on delivering safe, high quality care and treatment for all patients.
- The ED formed a part of the medicine and urgent care division that was led by a divisional director and divisional manager. At a local level, the ED had a clinical director who was supported by a directorate manager and the ED matron. Two nursing managers acted in a supernumerary position in the ED on a daily basis and designated senior consultant leads supported the clinical director and ED matron.
- The leadership team were established and experienced members of staff. The divisional manager was relatively new to the organisation (having been in post for six months prior to our inspection) and described the leadership team as cohesive and inclusive.
- Our discussions with leaders of this service confirmed that they understood the challenges to providing safe patient care. They were taking actions to address these challenges such as developing services to meet the needs of different patient groups.
- The leaders of the service told us that their main aim was to keep patients safe and provide the best care and treatment possible. They told us that they recognised the importance of achieving the four-hour arrival to discharge target and they were working towards it whilst ensuring that patient safety remained the focus for staff at all levels.
- Staff spoke positively about their leaders at all levels and referred to the chief executive officer (CEO) by their first name and said that they saw the CEO and other members of the executive team in the department on a regular basis.
- Leaders of this service were visible and approachable and staff told us that they felt supported by their management team to do their jobs. During our inspection, the department was experiencing high levels of attendance and we saw leaders supporting staff to manage demand.
- We saw that leaders of this service 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. This meant there were comprehensive and leadership development strategies in place to ensure the delivery and development of a positive culture within the department.
  - Due to positive safety outcomes as measured by an internationally recognised patient safety analytics system, leaders in ED had supported other trusts in the East Midlands region on work to improve their safety culture, both by visits from other teams and developing and chairing an A&E network meeting.

Vision and strategy for this service

- All staff we spoke with were aware of the hospital vision and values and the strategy for the service.
- The hospital vision was 'To provide the best possible care for all our patients' and the values were to '…put patient safety above else…aspire to excellence…reflect, learn and improve…respect and support each other'. Staff told us that the trust's values were important to ensure that the patient was at the centre of everything they did.

- The ED had a strategic plan that set out defined realistic objectives for the future development and sustainability of the department and was in line with the hospital's overall strategy. There was a coherent strategy for engaging with key partners.
- The plan had been developed through staff engagement exercises and consultation meetings. All staff we spoke with were aware of the strategy and their role in achieving it; this included having the opportunity to feedback and contribute to plans.
- Staff told us about the immediate plans to develop the urgent care facilities through external partnership working and the long-term plans for developing staff and existing services. Staff spoke positively about the recent appointment of a GP and the potential impact that would have in terms of opportunities for shared learning and governance arrangements.
- Each objective had defined work streams with designated leads and individual action plans. For example, a key area was refining the streaming process to ensure that patients were being seen by the most appropriate service including referrals to external services. This was in line with NHS England Sustainability and Transformation Programmes and the Keogh report 'Transforming urgent and emergency services in England' published in November 2013.
- Progress against the strategy was monitored and discussed at divisional meetings with updates disseminated via departmental meetings and the dedicated ED intranet page.
- Senior staff attended trust wide multi-disciplinary meetings that fed through to executive level and the trust's board.

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 robust 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 department.
- The department had a senior consultant who acted as the governance lead and they were in the process of recruiting a senior nurse to assist with the governance role for the urgent care division.
- There were 11 risks on the departmental risk register: two were related to lack of medical and nursing staffing. Other risks identified related to lack of discharge capacity affecting the ED ability to reach the four hour performance target, mandatory and safeguarding training levels not meeting the trust target, storage of oxygen cylinders, IT infrastructure and reducing the risk of pressure ulcers. The risks present on the register reflected the views of the staff we spoke to at all levels. Risks were reviewed frequently and had clear mitigating actions and timescales for action.
- The ED had a systematic programme of clinical and internal audits to monitor quality and processes to identify areas for improvement and best practice.
- The ED matron used a quality dashboard to help inform audits and areas for improvement with clear links to the governance framework and risk register.
- The hospital was in the process of reviewing the safety checklist they used for invasive procedures. The checklist in place at the time of our inspection was a modified version of the World Health Organisation (WHO) 'Five Steps to Safer Surgery' checklist. We saw that the hospital was developing the checklist in line with National Safety Standards for Invasive Procedures (NatSSIPs, NHS England, 2015). The NatSSIPs bring together national and local learning from the analysis of never events, serious incidents and near misses through a set of recommendations that will help provide safer care for patients undergoing invasive procedures.
- The ED had recently ended their contract with an external provider for the provision of GP services and employed a GP to work within the ED. Staff told us that this would allow them to have a more streamlined governance process for urgent care provision. We saw that prior to this change; the performance of the external provider had been monitored through service level agreements.
- In ED, the service worked with the trust Improving Quality and Efficiency (IQE) team on a project relating to frail elderly patients (GEM) and patient safety. This project was one example of the joint working between the IQE, trust Quality Improvement team and ED team to further support the safety improvements made by the service.

Urgent and emergency services

Culture within the service

- 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 department and was proud of the organisation and its culture.
- We found the culture of the department open and inclusive and fully focused on patient safety. Staff that we spoke to felt that they were valued and respected by their peers and leaders.
- Staff were confident and felt they were accountable for their role within the ED. The department had clear guidance and decisions, which they clearly communicated to staff, public and patients.
- The culture of the ED was centred around 'patient safety first' and staff felt that they were not under pressure to achieve targets at the detriment of patient care. Staff told us that when the ED was experiencing high levels of demand it was seen as a hospital wide issue and staff from other specialities worked within ED to keep the doors open for patients. We saw this clear focus on patient safety by all staff at all times during the inspection, even when the ED was under considerable pressure due to the increased number of attendances.
- All staff were aware of the duty of candour regulation and how being open, honest and transparent related to improving patient safety and learning. There was information available on the ED dedicated intranet page related to duty of candour and the governance lead had started including duty of candour incidents in simulation training exercises so staff could relate the principles to situations in the ED.
- There was an emphasis on 'shared learning' and staff with extra skills were encouraged to share their knowledge at team meetings. For example, we saw that a member of the nursing team who had come from a background of critical and intensive care nursing had been given the opportunity to talk at a team meeting about looking after patients who required assisted ventilation (for example patients with acute respiratory failure).
- There was a departmental 'Good egg' award that was given out bi-monthly and annually. Staff told us that it was a way that they could let their colleagues know that they appreciated what they were doing in their daily jobs. For example, the hostess staff had received the internal award for their contributions to the patient's experience.
- There were systems and processes in place to support the well-being of staff in the ED. Staff told us that they encouraged each other not to work too many hours as this could lead to 'burnout' and impact on individual health and patient safety. The ED had a supportive sickness management process in place which was managed by a senior member of the nursing team.
- Staff had access to support networks and counselling services through the occupational health department.

Public engagement

- There was a hospital-wide plan to develop and improve pathways to receive patient feedback.
- The department welcomed constructive challenges from patients. Innovative approaches were used to gather feedback from patients, those close to them, the public and local patient and community groups.
- The trust's public website invited the local community and patients to provide feedback on the strategy and plans for the future and their experience at the trust.
- The hospital had arranged trust wide events to give patients and the public the opportunity to provide feedback and learn more about the trust and the services provided. The ED matron had attended an afternoon event and spoken to members of the public about the ED and its function.

Staff engagement

- In June 2016, the department had undertaken an internal survey of the safety culture in the ED along with seven other trusts and had a high rate of staff engagement amongst the group with 92 out of 168 eligible staff completing the survey. The survey was a part of a four-year plan to improve safety processes in the ED.
- The results of the ED staff survey showed that:
  - 95% of staff said they liked their job.
  - 91% of staff felt that patient care errors were handled appropriately.
  - 90% of staff felt that they could ask questions easily when they did not understand.
  - 88% of staff felt they worked well as a team.
  - 85% felt they were supported by their colleagues to deliver care for patients.

  - 84% said they would feel safe to be treated there as a patient.
- The bottom five results were:
  - 60% of staff feeling supported by executive managers on a daily basis.
  - 41% of staff said they did not worry about errors being kept on their staff files.
  - 37% of staff said they didn't feel 'used up' at the end of their shift.
  - 51% of staff felt that patient safety was sacrificed to get work done.
  - 40% felt that there were patient safety problems in ED.
- As a result of the staff survey, the department had developed an action plan with separate work streams including work culture, rapid assessment processes for children and improving the use of the clinical observations area.
- The department had a closed social media page where they could arrange team social events.
- The ED matron sent all members of the team a fortnightly bulletin, which included requests for feedback on items of interest or plans for future developments.

Innovation, improvement and sustainability

- The department had a proactive approach to seeing out new and more sustainable models of care while maintaining high quality and delivery of safe care.
- The geriatric emergency medicine service had been introduced in 2014 and had been developed to meet the needs of patients with complex needs and also provided a learning platform for staff.
- Physician associate programmes were being developed to provide a larger group of decision-making clinicians and provide developmental opportunities for staff.
- The appointment of an ED GP and development of urgent care facilities had been implemented in line with national recommendations to improve access and flow in EDs.
- Senior staff actively encouraged staff development to provide future nursing and medical staff to help maintain staffing levels.
- The department's strategy was aligned to the trust wide strategy and the Sustainable Transformation Programme and new models of care.
- The department was actively working with local educational institutions to develop courses that were specific to areas that were difficult to recruit to such as geriatric and paediatric emergency medicine.
- The service was a regional leader in using an internationally recognised patient safety analytics systems to measure and improve safety in the ED.

Medical care (including older people's care)

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

Information about the service

Northampton General Hospital NHS Trust provides general acute medical services to people living in Northampton and the surrounding areas. It also provides hyper-acute stroke, vascular and renal services to people living throughout the whole of Northamptonshire. Medical service provisions include general medicine, cardiology, respiratory, stroke, renal, oncology and haematology.

The trust provides medical services from the main hospital site and three other locations, which are situated in close proximity to the main hospital. The trust is only responsible for providing the medical care at these three locations. All other aspects of care, such as nursing care, are the responsibility of two other providers. The trust has 615 general and acute beds situated on the main hospital site and a further 77 beds across the three other locations.

Medical care services are part of the medicine and urgent care division, which is led by a divisional director and divisional manager. Medical care services are split into two directorates: inpatient specialities and outpatients, elderly and stroke services. The current leadership structure for both directorates includes a clinical director and directorate managers. Assistant directorate managers and matrons support the teams.

The medical service had 43,778 admissions from April 2015 to March 2016, which consisted of approximately 47% emergency admissions, 52% day case admissions and 1% elective admissions. General medicine had the most admissions (54%), followed by oncology (16%) and haematology (11%).

The service had previously been inspected in January 2014 and was rated requires improvement for safe, effective, responsive and well-led, and good for caring.

We carried out an announced focused inspection on 7 to 9 and 17 February 2017. We visited all areas where inpatient and day case medical care was provided, including:

- Ambulatory care unit
- Allebone ward – stroke rehabilitation
- Althorpe ward- surgical ward
- Becket ward – respiratory
- Benham ward – male medical assessment unit
- Brampton ward – short stay admissions ward for the elderly
- Collingtree ward – gastroenterology
- Compton ward – care of the elderly re-enablement / rehabilitation
- Creaton ward – general medicine
- Discharge lounge
- Dryden ward – cardiology
- Eleanor hyperacute stroke unit
- Emergency assessment unit – female medical assessment unit
- Endoscopy
- Finedon ward – renal
- Heart centre
- Holcot ward – care of the elderly / care of patients with dementia

Medical care (including older people's care)

- Knightley ward – general medicine
- Talbot Butler ward – oncology and haematology
- Victoria ward – care of the elderly

We spoke with 65 members of staff including nurses, doctors, pharmacists, therapists, administrators and housekeepers. We spoke with 34 patients and relatives. We observed interactions between patients and staff, considered the environment and looked at 45 patient care records. We also reviewed the hospital's medical care performance data.

Summary of findings

We rated this service as good because:

- Patient safety was monitored and incidents were investigated to assist learning and improve care.
- Standards of cleanliness and hygiene were well maintained in all wards visited. Generally, the premises and equipment met patients' needs. Appropriate systems for the handling and storage for medicines were in place.
- There were arrangements in place to safeguard people from abuse that reflected relevant legislation and local requirements. Staff compliance with mandatory training was generally above the hospital's target. Staff understood the importance of consent and mental capacity and delivered care in accordance with legislation.
- Appropriate systems were in place to assess risk and to recognise and respond to deteriorating patients.
- Actual nurse staffing levels met planned rotas during our inspection, and patients' needs were met. Medical staffing was appropriate and there was an effective level of cover to meet patients' needs.
- The medical oversight of the 'fit for discharge' patients in local care homes used by the trust was excellent.
- Patient's care and treatment was planned and delivered in line with evidence-based guidelines. Patients' pain, nutrition and hydration needs were generally assessed and met.
- In the Sentinel Stroke National Audit Programme (SSNAP) the hospital was rated as band A overall (A being the best and E the worst), in the April to June 2016 audit, which indicated a world-class stroke service.
- The service performed well in a number of other national audits, including the Myocardial Ischaemia National Audit and the National Lung Cancer Audit. We saw improved performance on previous audit results. The endoscopy unit had achieved the accreditation standards set by the Joint Advisory Group on Gastrointestinal Endoscopy.

Medical care (including older people's care)

- Staff had the clinical skills, knowledge and experience they needed to carry out their roles effectively. There was effective multidisciplinary working and we saw positive collaborative working to improve patient care and service provision.
- The service was working towards delivering sustainable seven-day services in line with its clinical strategy, with a focus on compliance with the key clinical standards.
- During our inspection, we observed care being delivered by nursing, medical, therapy and auxiliary staff, who interacted with patients in a positive caring manner. Staff were focused on ensuring patients received the best possible care.
- In December 2016, the hospital's referral to treatment time (RTT) for admitted pathways for medical services was 97%, which was better than the England average of 90%.
- Due to ongoing bed capacity issues in the hospital, the service had implemented safety driven bed escalation and management processes to address patient flow concerns in the hospital. This kept patients safe, even at times of significant pressure on bed capacity.
- Despite high bed occupancy over time and on the days of the inspection, the commitment to the safety and quality of care and treatment for patients was clearly demonstrated by all staff at all levels.
- The hospital had a well-defined process for the management of medically outlying patients.
- The hospital's discharge team supported staff with complex discharge arrangements and senior managers were continually working to improve patient flow out of hospital.
- Staff we spoke with had an effective awareness of patients with complex needs and those patients who required additional support. The adjustments made by staff and facilities provided met patients' needs effectively.
- Staff felt that leadership was strong, with visible, supportive and approachable managers. The service was focused on providing quality care and had a defined strategy, which was aligned to the trust vision and values, organisational aims and wider healthcare economy goals. There was an effective governance and risk management framework in place.
- Staff and public engagement was valued. Feedback was encouraged from patients, relatives and staff, and was used to inform service improvements.

However:

- Not all patients' healthcare records were stored securely. Once we raised this as a concern, the hospital took urgent action to address this concern.
- The service was not compliant with the National Institute for Health and Care Excellence standard regarding reassessment of patients' venous thromboembolism (VTE) risk at 24 hours following admission. The hospital was taking urgent action to address this.
- We found that ward entrances were unsecured. This meant that there was a potential risk of unauthorised access and vulnerable patients leaving wards. Staff told us the risk had been mitigated by having one staff member to oversee a small group of such patients in a bay (called 'cohorting') when required.
- There were some issues regarding medicines management including storage of medicines at correct ambient temperatures and morning medicine rounds in the Heart Centre. Immediate actions were taken by the hospital to address this once we had raised this as a concern.
- Some guidelines were out-of-date, which meant there was a potential risk that staff were not following the most current guidance. The service had a working group in place to address this.
- Some patient's cardiology procedures were cancelled during our inspection, due to being used as an escalation area for inpatients. However, the hospital had procedures in place to ensure high priority patients were not cancelled.

Medical care (including older people's care)

Are medical care services safe?

Good

We rated safe as good because:

- Patient safety was monitored and incidents were investigated to assist learning and improve care.
- Staff had awareness of the importance of the Duty of Candour regulation and we saw evidence that staff were open and honest when things went wrong.
- Standards of cleanliness and hygiene were well maintained in all wards visited. Generally, the premises and equipment met patients' needs.
- Appropriate systems for the handling and storage for medicines were in place.
- There were arrangements in place to safeguard people from abuse that reflected relevant legislation and local requirements. Staff compliance with mandatory training was generally above the hospital's target.
- Generally, appropriate systems were in place to assess risk and to recognise and respond to deteriorating patients.
- Patients were monitored and early warning scoring through an electronic observation system and escalated for review if clinically deteriorated.
- Overall, actual nurse staffing levels met planned rotas during our inspection, and patients' needs were met.
- Medical staffing was appropriate and there was an effective level of cover to meet patients' needs at the time of the inspection.
- The medical oversight of the 'fit for discharge' patients in local care homes used by the trust was excellent.

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Incidents

- Patients were protected from abuse and avoidable harm, as staff were confident to report incidents and told us that they reported incidents where required. There were processes in place to learn from incidents and implement good practice. There was an open culture to encourage focus on patient safety and risk management.
- Clinical staff were aware of the reporting process for incidents, near misses and never events. The trust used an electronic incident reporting tool to report incidents. Staff were encouraged to report incidents and learn from them. Examples given included debriefing sessions following serious incidents. Staff told us that learning from incidents was shared at the hospital's daily safety huddle meetings, for example. We saw evidence of this during our inspection.
- There had been no never events reported for the medical care service from December 2015 to November 2016. 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.
- There were six serious incidents (SIs) reported through the Strategic Executive Information System (STEIS) in the medical care service from December 2015 to November 2016. Three of the SIs (50%) were classified as sub-optimal care of the deteriorating patient. Two (33%) were classified as slips, trips and/or falls meeting SI criteria and one (17%) was classified as pressure ulcer meeting SI criteria. We reviewed two serious incident investigation reports and found they were detailed, showed appropriate involvement of specialist staff and focussed on the root cause in order to prevent future incidents.

Medical care (including older people's care)

- Staff reported 4,299 incidents in medical care services from February 2016 to January 2017. Of these 55 were classed as resulting in moderate harm and six resulting in death. The remaining incidents were classed as low or no harm incidents. Actions taken as a result of incidents were documented on the electronic system.
- Staff on Allebone ward described learning and changes to practice following two serious incidents related to safe transfer of patients to other hospitals. There was now a transfer checklist completed that included pre-transfer patient observations.
- Staff on Dryden ward had new observation monitors installed which allowed retrospective status reviews following recommendations from an incident investigation.
- Staff on Eleanor ward described learning from a medicine incident. We saw evidence that the incident was discussed at a multidisciplinary team teaching session. A consultant had carried out a teaching session for staff on medicines used on stroke patients to make the blood less sticky or runny. Staff told us they found this teaching session informative.
- 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 we spoke with were aware of their responsibilities regarding the duty of candour. Staff explained how families had been involved in the process following reporting of incidents and staff knew the thresholds for application of duty of candour processes, in accordance with trust policy.
- We observed the use of duty of candour stickers in patient's notes on Holcot ward. The sticker was used to evidence when the duty of candour had been applied. In this instance, we saw that an apology had been given to the patient and their family due to a recent outbreak of flu on the ward. Visiting had been restricted to once a day to prevent the spread of infection.
- Mortality and morbidity meetings took place in each speciality regularly to review cases and share learning. The frequency of the meetings was different for each speciality. However, this was generally every couple of months. The minutes showed good attendance numbers and generation of actions and recommendations. The stroke team's minutes also included the terms of reference, which would guide the meeting regarding quorate and the process for escalating concerns. Some specialities such as nephrology used mortality case note review templates. This was used to structure the mortality assessment and also prompted the reviewer to consider the quality of the patient's care, by asking 'was the care given suitable for a member of your own family?'

Safety thermometer

- Each ward participated in the NHS Safety Thermometer, which is a national improvement tool, designed to support and measure local improvements to patient care. It allows frontline teams to take a monthly 'temperature check' on harm and records the number of patients that are 'harm free' from pressure ulcers, falls, catheter associated urine tract infections and venous thromboembolism (VTE, a potentially life-threatening condition where a blood clot forms in a vein). Medical wards collected data monthly and the results were publically displayed.
- The NHS Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination. Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of the suggested data collection date.
- Data from the NHS Safety Thermometer for medicine reported 91 pressure ulcers, 18 falls with harm, and 9 catheter urinary tract infections (CUTIs) between January 2016 and January 2017. The prevalence rate fluctuated throughout the period for both falls and CUTIs. The rate of pressure ulcers had generally fallen from March 2016 until December 2016; however the rate increased in January 2017. Pressure ulcer prevention was included on the risk register for medical care services.
- We saw that action was taken to address any areas of concern. For example, staff on Holcot ward told us they had changed staffing ratio's, increased the number of

healthcare assistants, and introduced bay working, whereby nurse stations were positioned by the bays so that patients could be constantly seen by staff, in order to reduce the number of falls and pressure ulcers.

Cleanliness, infection control and hygiene

- Standards of cleanliness and hygiene were well maintained in all wards visited. The service had systems in place to reduce the risk of healthcare associated infection. All wards we visited were visibly clean and tidy.
- Wards had link nurses for specialist areas, which included infection prevention and control. They attended meetings to learn and then share best practice with ward teams. They also collected audit data such as 'saving lives', an evidence-based approach that relates to key clinical procedures or care processes that can reduce the risk of infection if performed appropriately.
- The wards displayed clear instructions and signage to encourage staff and visitors to wash their hands on entering the ward. We found hand cleansing gels available in all areas we visited. These were found at the entrances to clinical areas and at each patient's bed space.
- We observed that staff complied with infection control and prevention policies such as 'arms bare below the elbow' and wore personal protective equipment appropriately. For example, we observed staff wearing gloves and aprons when assisting patients with using a bedpan.
- We observed staff carrying out hand washing prior to and after patient contact.
- Waste management was handled appropriately with separate colour coded arrangements for general waste and clinical waste. Bins were not overfilled. We saw all clinical areas had appropriate facilities for the disposal of clinical waste and sharps. All sharps bins we observed were clean, dated, not overfilled, and temporary closures were in place. Temporary closures are recommended to prevent accidental spillage of sharps if the bin is knocked over and to minimise the risk of needle stick injury.
- We saw that stickers were generally placed on items of equipment stating when they had last been cleaned. The equipment we saw during our inspection was clean and ready to use. For example, we saw commodes on Holcot ward had stickers placed on them to indicate the time and date they had been cleaned.
- The Heart Centre was a unit usually used for cardiology patients undergoing day case procedures. During the inspection, this area was being used for inpatients due to bed pressures at the hospital. There was a policy to guide staff regarding suitable patients for this area. This excluded patients with potential infections such as MRSA or with diarrhoea and vomiting. This was important due to the type of procedures being undertaken. Staff advised that rarely, patients with unknown infections had been admitted to the area. When this was discovered it was reported as an incident, the patient was moved to another ward, procedure lists were stopped and the unit remained closed until it had been deep cleaned. Actions had been taken to prevent cross infection.
- The endoscopy unit had effective processes in place to ensure the cleanliness of equipment and to prevent contamination. This included separate dirty and clean rooms.
- Patients attending endoscopy appointments identified as having suspected communicable infections were placed at the end of treatment lists to allow additional cleaning time between patients. Equipment used underwent a longer decontamination process.
- The hospital participated in patient-led assessments of the care environment (PLACE). Each year members of the public undertake unannounced visits to assess how the environment supports; cleanliness, general building maintenance, patient's privacy, dignity and wellbeing, food, dementia and disability. The PLACE audit results for 2016 showed the trust scored better than the England average for cleanliness. The trust scored an average of 100%, while the England average was 98%.
- Patients we spoke with said they found the wards were clean. One patient told us the cleanliness of Benham ward was "excellent".
- The hospital's infection prevention and control team (IPCT) conducted a monthly audit to monitor compliance to the Department of Health (2009) SIGHT guidance for patients that had acquired C. difficile infection post-admission. Results were presented and discussed at monthly Infection Prevention Operational Group meetings and Infection Prevention Steering Group meetings, and we saw an appropriate range of actions detailed in the minutes of these meetings. For example, in December 2016 there were 11 patients with a newly identified MRSA colonisation, 10 of which were identified through routine admission screening and one

of which was a post admission colonisation of a wound. Of these 11 patients, 5 were discharged before the positive result was received by the IPCT. Of the remaining 6 patients, 100% were prescribed and administered the topical decolonisation treatment and rescreened afterwards as per the trust MRSA Policy.

- In January 2017, the IPCT audited the water outlets that were not frequently used across the hospital to ensure that they are being flushed twice weekly to reduce the risk of water contamination from legionella or pseudomonas. There were 11 wards and 13 departments that were identified as having water outlets that were not used frequently and therefore required flushing twice weekly and a flushing regime to be completed. Of the 24 clinical areas audited, all had the water flushing log sheet in place and the necessary checks had been carried out.
- From August 2016 to January 2017, there had been no reported cases of MRSA bacteraemia or Clostridium Difficile on the medical wards.
- The hospital carried out monthly hand hygiene audits and all surgical wards and clinical areas showed 100% compliance in December 2016.
- Staff training compliance was at 80% below the trust target of 85% as of February 2017: further training dates had been arranged.

Environment and equipment

- Generally, the premises and equipment met patients' needs. Wards we visited were well maintained and tidy. However, some wards lacked storage space given the age and design of the building. We found that on some wards, rarely used areas such as shower rooms, were being used to store bulky equipment. The lack of storage for Allebone and Eleanor wards was included on the medical service's risk register.
- The majority of the departments we visited during the inspection did not have secured doors to the entrance. On some wards, the doors were kept open and there was no challenge to people entering the units. We also found that the security code to access Victoria ward was displayed on the door. We raised this with the ward manager at the time of our inspection who took action to address this. Senior staff told us that vulnerable patients were supervised by a dedicated member of staff (wards 'cohorted' patients in a bay with a member of staff present at all times) to mitigate the risk. We noted that 26 instances of patients leaving ward areas within medical care services had been reported from February 2016 to January 2017. The exception to this was the Heart Centre, which had staff pass access and security camera linked to a monitor at the workstation. The security of Holcot ward was described on the risk register. Keypad access had been installed and the cost of swipe access was being explored.
- Equipment that we checked during our inspection, had been appliance safety tested and maintained appropriately. Staff told us they had access to equipment required to provide safe care and treatment including patient handling equipment such as hoists and pressure relieving aids.
- Clinical rooms were found to be locked or keypad access.
- We found that on Knightly ward there were some issues related to estates. These included dirty celling light fittings, torn ceiling tile and a broken storage cupboard. We raised these with the nurse in charge of the ward who reported the issues to the estates department. Some of the issues had been reported previously but were waiting to be addressed.
- Fire exits were found to be clear to allow use in an emergency.
- We found that items were locked in cupboards in line with Control of Substances Hazardous to Health (COSHH) regulations in the areas we inspected.
- Wards had access to resuscitation trolleys containing equipment required in an emergency. These had tamper evident seals in place and had records completed showing that they were checked regularly.
- The PLACE audit for 2016 showed the trust scored better than the England average for condition, appearance and building maintenance. The trust scored an average of 97%, while the England average was 93%.

Medicines

- Generally, appropriate systems for the handling and storage for medicines were in place. Medicines, including intravenous fluids and gases, were appropriately stored and access was restricted to authorised staff.
- We found that controlled drugs (CD) 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.

- Wards had arrangements for safe handling of the CD keys. The CD keys were kept separately from other keys. Not all wards kept a record or log of who held the keys for example, Beckett ward.
- Staff on Benham and Victoria ward told us that pharmacy staff would come to the ward and denature (render irretrievable) patient's own CDs if they were no longer needed with a denaturing kit. This was in line with Home Office advice.
- FP10 prescription pads were stored securely on Benham ward. We saw that monitoring systems were in place to ensure that all prescriptions were accounted for.
- Wards had appropriate areas for storage of medical gases. Medical gases were found to be within expiration dates.
- Medicines and intravenous fluids we checked during the inspection were found to be in date. Patients' own medicines were locked in patient's bedside lockers in accordance with trust policy.
- We saw staff used 'do not disturb' tabards during administration rounds to avoid medicine errors. The performance dashboard for medical services showed that from October to December 2016, there were no reported medicine incidents resulting in significant patient harm.
- We found that fridge temperatures were generally being checked and recorded on a daily basis. However, we reviewed the records for Holcot ward and found eight occasions from 1 January to 7 February 2017, when fridge temperatures had not been recorded daily. We also found six occasions when temperatures had not been recorded daily on Victoria ward, for the same period. Staff understood what action to take if fridge or ambient room temperatures were out of the required range. However, on Knightley ward we found that in the previous seven days, the ambient temperature of the store room had been higher than 25 degrees for four days. There was no record of actions taken. We raised this with the nurse in charge who informed the estates department to take prompt action.
- Some wards had electronic medicines storage system installed, which used fingerprint access. Most of the wards used an electronic prescribing system. Some still used paper prescription charts. The hospital's aim was to change all prescribing over to the electronic system. We checked six prescription charts during the inspection and found that prescriptions were signed, included the patient's allergy status and any missed doses had documented explanations. However, three charts did not include the patient's weight.
- We saw evidence of medicine reconciliation undertaken by pharmacists documented in patient's prescription charts. We saw that patients were prescribed and received VTE prophylaxis.
- The Heart Centre was a unit usually used for cardiology patients undergoing day case procedures. During the inspection, this area was being used for inpatients due to bed pressures at the hospital. On display on the unit were the set expectations for overnight staff. This included having administered all patients' medicines before the day staff came on at 7am. This was requested because the day team's role was to prepare patients for the cardiology procedures taking place that day. This meant that patients were being woken early to have their medicines. We raised this issue with senior managers during our inspection. In response, the trust advised that the director of nursing, midwifery and patient services had taken immediate action in respect to this and the 6am drug round in the Heart Centre had ceased. They also advised they would be undertaking a review of incidents and the outcomes from patient feedback mechanisms to ensure that there were no safety or patient experience issues that needed further investigation.

Records

- We found that not all patient records were not kept secure on all wards we visited. This meant there was a risk that patient records could be removed or viewed by unauthorised persons and staff would be unaware. We also observed that whiteboards on wards, which contained confidential patient information such as patient's full name, were visible to visitors and staff. We were told that patients were asked their permission for this as part of the ward admission checklist. We raised our concerns with senior staff following our inspection and they provided assurance of immediate actions they had taken to address our concerns. Keypad lockable notes trollies were purchased for all areas, Staff were also told to ensure all patient notes were stored securely behind nursing stations or in locked rooms.

Furthermore, full patient names had been removed from whiteboards and were replaced with the patient initial and surname. On the unannounced inspection, we found all patients' notes were securely stored.
- Healthcare records that we checked during our inspection contained risk assessments, records of care and treatment and were legible and signed and dated.
- Many professionals used stamps in the healthcare records, which included name and professional body registered number. This would help to identify who had made entries.

Safeguarding

- Staff we spoke with were aware of their responsibilities regarding safeguarding people from abuse and were aware of policies and procedures and who to contact for advice. Safeguarding training included female genital mutilation (FGM).
- We saw that computer screen savers throughout the departments were used to highlight certain topics. For example, we saw that the international FGM awareness day was displayed during our inspection.
- Staff could describe types of abuse including financial and neglect and the actions they would take if they had any concerns. Staff knew how to follow the trust's safeguarding polices, which were up to date and reflected local and national guidance.
- Staff undertook mandatory training for safeguarding children and adults. Records for February 2017 showed that for medical wards and departments training met compliance target of 85%, with safeguarding children (level one) at 91% and adults (level one) at 89%.
- Staff we spoke with were aware of safeguarding procedures and knew how to escalate concerns. Staff could give us examples of when they had made safeguarding referrals.
- Staff told us they could access the trust safeguarding team for advice on any safeguarding matters.

Mandatory training

- Mandatory training covered a range of topics, which included health and safety, manual handling, infection prevention control, fire safety, equality and diversity and basic life support (BLS). All staff within the medical service were aware of the need to attend mandatory training.
- The trust target for mandatory training compliance was 85%. Records for February 2017 show that for medical wards and departments the overall met this compliance target. Areas that did not meet this target were fire training at 78% and infection prevention at 80%.
- Staff we spoke with told us that they were up-to-date with mandatory training. They said that they would receive electronic reminders for when training needed to be updated.

Assessing and responding to patient risk

- Generally, appropriate systems were in place to assess risk and to recognise and respond to deteriorating patients. Assessments for patients were comprehensive and covered all health and social care needs, including clinical health, physical health, and nutrition and hydration requirements. Actions had been taken as learning serious incidents.
- Staff arranged the wards to maximise the supervision and observation of patients in order to reduce risk of harm for example through falls. On Holcot and Knightley wards there were small desks set up outside the bays to facilitate this approach. There was a falls' coordinator available at the trust who could be called for advice.
- Clock faces were used on some wards to indicate when the next time the patient required assistance with changing position in order to prevent pressure damage.
- Risk assessments seen were completed appropriately including falls risk, dementia, pressure ulcer development and use of bed rails.
- An electronic observation system was used to record observations such as temperature, heart rate and respiratory rate. The National Early Warning Score (NEWS) was incorporated into this system and teams such as the critical care outreach team could see patients when they triggered the early warning score. We reviewed 33 electronic NEWS charts and found these were completed appropriately. Appropriate escalation for medical review was evidenced. The electronic system meant that a doctor could view a patients' NEWS charts from anywhere in the hospital.
- We saw the response to patient's deterioration in case notes we reviewed during the inspection. For example, we saw that a patient's observations had triggered the early warning system and this was documented in the patient's records. The patient was reviewed by the doctor within an hour of the request and a treatment plan was recorded.

- Staff knew how to contact support such as the critical care outreach team should a patient deteriorate.
- We saw that some patients had treatment escalation plans that documented consideration of the patient suitability to receive certain treatments, such as ventilation and other critical care interventions. This meant that there were clear pathways in place for patients should their condition deteriorate.
- We saw that patients on Eleanor ward who were at high risk of falls were nursed using falls alarms, which would alert staff to occasions when the patient was getting off their bed or chair. This enabled staff to attend the patient immediately to prevent any harm from falling. We observed staff attend patients immediately when the falls alarms were triggered. Patients at high risk of falls also had low beds and crash mats placed beside their bed to help prevent injury should they fall.
- We saw that at each patient's bed space and in cubicles in the ambulatory care area, staff had access to call buttons to use in an emergency to summon help.

- The service followed the hospital policy for the screening and management of sepsis (a life-threatening condition that arises when the body's response to infection injures its own tissues and organs), which was based on national recommendations from the UK Sepsis Trust. The care pathway could be implemented if sepsis was suspected. The majority of wards we visited had "sepsis boxes" available, which contained equipment required to initiate the care pathway, such as blood culture bottles, oxygen mask, needles, syringes, and gloves. Appropriate antibiotics were available when required to facilitate immediate antibiotic treatment for patients with suspected sepsis.
- The hospital's sepsis pathway prompted staff to inform the consultant when sepsis was suspected. The critical care outreach team would be contacted if a patient remained clinically unstable despite initial treatment and management. During our inspection, we observed prompts on all medical wards, reminding staff to escalate any deteriorating patients to the medical team.
- We observed the handover with the hospital at night team during the inspection. We saw that there was good use of the electronic observation system. This allowed the team to discuss patients that were currently triggering a high NEWS assessment score and ensured that plans were in place for them. There was a member of the critical care outreach team on duty for the night. They advised and supported ward areas with care of the critically ill patient.
- We found eight cannula and four catheter care assessments on the electronic system were overdue on Collingtree and Holcot wards. We also reviewed the corresponding paper patient records and could find no evidence that these assessments were carried out. One patient on Collingtree ward told us their cannula had been removed on 7 February 2017, but there was no documentation in the paper medical records or electronic system as to when the cannula had been removed. Furthermore, according to the electronic record for this patient the cannula was due to be removed on 1 February 2017. The trust had a policy to guide staff regarding the management of invasive devices. This clearly stated that patients with devices such as peripheral venous cannula and urinary catheters should be assessed for signs of infection and the electronic observation system updated accordingly each shift. We brought this to the attention of senior staff on the wards, who took actions to address this.
- There were some records completed electronically and some paper based. For example, we found that the VTE risk assessments, which used to be completed in paper records, were changed over to the electronic system in December 2016. This had resulted in non-compliance with the reassessment of patients' VTE risks at 24 hours following admission. We reviewed 23 VTE assessments on the electronic system on Collingtree and Holcot wards and found 16 occasions when the VTE assessment was overdue. These overdue assessments ranged from one day to 59 days. Senior managers were aware of this issue and took immediate actions to address this. They responded to our concerns in a timely way by accelerating their progress with implementing the new electronic system, reviewing policies and protocols and having senior medical staff conduct spot audits.
- Staff on Creaton ward told us they carried out weekly documentation and risk assessment audits. This included falls audits. Any issues found as a result of the audit were addressed with staff, such as updating care plans.
- Glucose gel and tablets were available for patients with diabetes when needed, in all wards we visited. Glucose preparations were stored in hypoglycaemic boxes on

the emergency trolleys. Glucose preparations are recommended when a patient has a 'hypo' and needs to increase their blood glucose levels rapidly (a 'hypo' is commonly used to describe hypoglycaemia, which is where the blood glucose level of a patient with diabetes falls below the normal range).

- Non-invasive ventilation (NIV) was provided on the respiratory (Beckett) ward and emergency assessment units.
- Between September 2015 and August 2016, 64% of patients did not move wards during their admission, and 36% moved once or more.

Nursing staffing

- We found that planned met actual nursing staffing on the wards during our inspection, and that patients' needs were met.
- Staffing of ward areas was monitored on a daily basis through a clinical safety huddle, which we attended. Staffing levels of areas were assessed against criteria, in line with National Institute for Health and Care Excellence (NICE) guidance.
- The medical wards staffing status for December 2016 showed that they achieved a fill rate of above the trust target of 80% for day and night shifts, including registered nurses and care staff. The exception was Talbot Butler ward, with a fill rate of 71% for registered nurses at night. The trust explained that they were actively recruiting staff currently and had increased the number of care staff as an interim measure.
- We found that planned met actual nursing staffing on Benham, Collingtree, Finedon, Holcot and Victoria wards. However, on Knightley ward we found that a healthcare assistant had been sent to help out on another ward. This meant they had two instead of three healthcare assistants on duty. On Beckett ward a qualified nurse was not on duty due to illness. This meant that there were four qualified nurses instead of the planned five. The ward sister was supporting the ward. On Talbot Butler ward, there were 10 qualified nurses on duty instead of the 13 planned. The ward was calm, well organised and no immediate impact to patient care was observed. The trust explained that they were actively recruiting staff currently to this team.
- The hospital had effective staffing escalation plans in place and we saw from the daily safety huddle in the morning and the from bed management meetings held throughout the day, that safe staffing levels in all areas was a key priority for all senior staff. We saw that consideration was given to staff being flexed across wards to mitigate any staffing shortfalls.
- The ambulatory care unit was a busy unit, which had recently increased their service to seven days a week. Staff told us that they often worked without proper breaks on 13 hour shifts. The ward sister informed us that a business case for increased staffing for the unit had been submitted.
- As at 31 December 2016, the hospital reported a vacancy rate of 10% in medical care.
- Between February 2016 and January 2017, the service reported a bank and agency usage rate of 21% in medical care wards.
- From January 2016 to December 2016, the trust reported a turnover rate of 6% and a sickness rate of 5% in medical care wards.
- Agency nurses were employed to cover gaps in planned staffing numbers. The trust had their own nurse bank for temporary staffing. We found that when required due to clinical needs, wards were able to complete risk assessment forms to request enhanced staffing cover, over their planned numbers. For example, on Allebone ward eight shifts in January 2017 were filled by qualified agency nursing staff.
- Ward staff completed induction checklists with temporary (bank and agency) staff and ensured they were familiar with the ward layout, call bell systems, fire procedures, and ward protocols, for example, before they provided patient care.
- The emergency assessment unit employed a care practitioner, in a new role as a trial. This involved coordinating the unit's admissions and discharges. The role had been positively received regarding communication with areas such as the emergency department.
- Agency nursing staff were also required to staff escalation areas such as the Heart Centre. The Heart Centre was a unit usually used for cardiology patients undergoing day case procedures. During the inspection, this area was being used for inpatients due to bed pressures at the hospital. The unit was not routinely staffed overnight and over weekends and this had to be arranged for each shift. This meant that there was a risk that temporary staff may not be sourced leaving the area without sufficient nursing cover.

- The risk of lack of sufficient nursing staff was entered on the risk register for medical services and actions related to recruitment and retention were documented.

Medical staffing

- Medical staffing was appropriate and there was an effective level of cover to meet patients' needs at the time of the inspection.
- As at 31 December 2016, the trust reported a vacancy rate of 30% in medical care. Leaders of the medical service explained that they were aware of this and were actively recruiting and looking to create more attractive posts to reduce the vacancy rate. The risks related to medical staffing was entered on the risk register for medical services and actions related to recruitment and retention were documented.
- The number of consultants was in line with the England average: 35% of medical staff were consultants, compared with 36% for the England average. The percentage of middle grade doctors was 4%, which was slightly lower than the England average of 6%. Middle grade doctors had at least three years' experience at senior house level or a higher grade within their chosen speciality. The percentage of medical staff at registrar level was 44%, which is higher than the England average of 38%. The percentage of junior doctors (who have one to two years' experience) was 17%, which was lower than the England average of 20%.
- From January 2016 to December 2016, the trust reported a medical staff turnover rate of 8% in medical services.
- The trust reported a sickness rate of less than 1% for medical staff working for medical services (January 2016 to December 2016).
- From April 2015 to March 2016, the trust reported a temporary medical staff (bank and locum) usage rate of 7% in medical services.
- We observed the handover with the hospital at night team during the inspection. This was attended by the on-call medical consultant, the medical registrar and other junior medical staff. This handover was mutli-speciality and the hospital had an electronic list of potentially deteriorating patients in line with the Royal College of Physicians (RCP) guidance. The toolkit for handovers was used (RCP 'Acute care toolkit 1: Handover' September 2015)
- We saw evidence in records that patients were reviewed by a medical care consultant within 12 hours of admission to the medical care service in accordance with the hospital's policy.
- There were consultant ward rounds on the wards Monday to Friday. However, weekend cover and out of hours was generally through on-call medical staff (including consultants).
- We visited patients being cared for in two out of the three care homes that the hospital used to place patients that were fit for discharge and awaiting their return back to the community. There was a consultant led ward round once a week for these patients and a hospital doctor also visited both homes on three other days of the week. We reviewed 10 patients' records and saw in all there was excellent level of clinical oversight and detailed records of input from the service's doctors. Care home staff said there was positive relationships with the hospital doctors.
- We noted that on Althorpe ward there were two patients' records that showed evidence of delay of medical staff attending the ward. One patient had required their regular medicines prescribing and another required medical review of treatment. The staff reported the incidents and the nurse in charge was in the process of investigating them at the time of the inspection.
- The endoscopy team had an effective process in place to manage patients requiring an urgent endoscopy with on call provision out of normal working hours.
- We saw that patients were reviewed by doctors in a timely manner in the ambulatory care unit. During our inspection, we checked three patients' records and found that they had been seen by a doctor following arrival at the unit within 12, 26 and 55 minutes respectively.

Major incident awareness and training

- The trust had appropriate policies in place with regard to business continuity and major incident planning.
- On the emergency assessment unit, staff were allocated roles for a clinical emergency so responsibilities were clear. These were on display on the unit.
- Service managers and senior staff considered seasonal demands when planning medical beds within the trust. For example, the hospital scheduled more elective day case procedures during the winter months to reduce the number of patients who required beds.

Medical care (including older people's care)

- Some wards had rescue mats available for patient evacuation in the event of a major incident such as fire.
- The hospital had a simulation suite where staff could practise emergency scenarios. Staff on Collingtree ward told us the team practised emergency scenarios, such as patient sepsis and head injury, on a regular basis. This meant skills needed in a clinical emergency were maintained and improved where needed.
- Staff fire safety training was above the trust target of 85%.

Are medical care services effective?

Good

We rated this service good for effective because:

- Patient's care and treatment was planned and delivered in line with evidence-based guidelines.
- Pain was assessed and managed on an individual basis and was regularly monitored by nursing staff.
- Patients' nutrition and hydration needs were generally assessed and met.
- In the Sentinel Stroke National Audit Program (SSNAP) the hospital was rated as band A overall (A being the best and E the worst), in the April to June 2016 audit, which indicated a world-class stroke service.
- The service performed well in a number of other national audits, including the Myocardial Ischaemia National Audit and the National Lung Cancer Audit. We saw improved performance on previous audit results.
- The endoscopy unit had achieved the accreditation standards set by the Joint Advisory Group on Gastrointestinal Endoscopy.
- The service was actively involved in local and national audit activity. Staff reflected on audit outcomes and there was evidence of action plan development and changes in practice.
- Staff had the clinical skills, knowledge and experience they needed to carry out their roles effectively. Staff were supported to maintain and further develop their professional skills and knowledge.
- There was effective multidisciplinary working and we saw positive collaborative working to improve patient care and service provision.
- The service was working towards delivering sustainable seven-day services in line with its clinical strategy, with a focus on compliance with the key clinical standards.
- Staff understood the importance of consent and mental capacity and delivered care in accordance with legislation.

However:

- We found some guidelines were out-of-date, which meant there was a potential risk that staff were not following the most current guidance. The service had a working group in place to address this.
- The risk of readmission for emergency and non-emergency patients was higher than the England average.
- The trust target for the number of staff who had received an annual performance appraisal had not been met.

Evidence-based care and treatment

- Patient's care and treatment was planned and delivered in line with evidence-based guidelines. Staff referred to evidence-based guidance, standards, best practice and legislation, such as the National Institute for Health and Care Excellence (NICE) and Royal College of Physicians, to support the provision of care and treatment.
- The trust intranet and e-mail systems were available to staff, which enabled them to keep pace with changes and developments elsewhere in the trust and access guidelines, policies and procedures to assist them in their specific role. Local policies were accessible on the trust intranet and were based on national guidance, where appropriate. Staff we spoke with demonstrated how to access policies and procedures on the trust intranet.
- The hospital had a clinical guidelines group, which was responsible for ensuring all guidelines were reviewed regularly and reflected current evidence-based practice. However, we sampled seven guidelines from the trust intranet and found three were out-of-date. For example, the trust's Thromboprophylaxis Guideline for Adult Patients was due to have been reviewed in February 2012, yet we found this version was still active on the intranet. This meant we were not assured that robust processes were in place to ensure staff were accessing the most up-to-date guidance. We raised this with the medical director and were told the trust was in the process of developing an electronic information resource, where current evidence-based guidance

would be available for staff to access. Appropriate members of staff, such as consultants, would have administration access to the electronic information resource so that guidance could be updated to reflect national recommendations as needed. The clinical guidelines group would oversee this process. The trust planned to launch this electronic information resource shortly, but no date had been set at the time of our inspection.

- The clinical guidelines group, terms of reference were in the process of being updated at the time of our inspection. Draft copies of this were provided by the trust.
- Hospital policies were assessed to ensure guidance did not discriminate because of race, ethnic origin, nationality, gender, culture, religion or belief, sexual orientation and/or age.
- The service was actively involved in local and national audit programmes, and collated evidence to monitor and improve care and treatment. The hospital had an audit forward plan 2016/17, which detailed a range of completed and ongoing evidence-based reviews.
- In accordance with NICE and other national bodies, such as the British Thoracic Society, Royal College of Physicians and National Cardiovascular Outcomes Research, the service was involved in data collection for numerous national audits. This included chronic obstructive pulmonary rehabilitation, rheumatoid and early inflammatory arthritis, cardiac rhythm management, cardiac arrest, heart failure, Parkinson's, falls and fragility fracture (including hip fractures), and renal replacement therapy. We saw evidence that audit findings and recommendations were shared within the clinical specialities and changes to local practice were made, when indicated.
- The service had developed a number of evidence-based, condition-specific care pathways to standardise and improve patient care and service flow. In stroke services, for example, there were care pathways for patients who were thrombolysed (a treatment to dissolve dangerous clots in blood vessels, improve blood flow, and prevent damage to tissues and organs) and patients who were not thrombolysed. In cardiology, we saw integrated care pathways for patients who underwent elective short stay invasive cardiology and pacemaker implantation.
- The service followed the hospital policy for the screening and management of sepsis (a life-threatening condition that arises when the body's response to infection injures its own tissues and organs), which was based on national recommendations from the UK Sepsis Trust. The care pathway could be implemented if sepsis was suspected.
- Endoscopic procedures were carried out in line with national guidance and best practice. The Joint Advisory Group on Gastrointestinal Endoscopy (JAG) found that endoscopy services met the accreditation standards, which include policies, practices and procedures. JAG accreditation is the formal recognition that an endoscopy service has demonstrated that it has the competence to deliver against the measures in the Global Rating Scale (GRS) standards.

Pain relief

- Pain was assessed and managed on an individual basis and was regularly monitored by nursing staff.
- We observed nursing staff monitoring pain levels of patients, recording the information, and taking appropriate action to control patient's pain. Pain levels were routinely assessed during the completion of patient observations and were recorded on the patient's National Early Warning Score (NEWS) charts. We observed nursing staff ask patients if they were in pain, and to identify the intensity and location of the pain. Nursing staff reviewed medicine charts and administered prescribed pain relief when needed.
- Nursing staff told us that patients could be referred to the specialist pain management team, if pain was difficult to control. This service was available Monday to Friday, 9am to 5pm. The on-call medical team was available to manage pain control outside of these hours. Palliative care specialists were also used to assist with the management of palliative care patients and symptom control.
- Patients we spoke with told us they had access to regular pain relief and stated that their pain had been managed effectively
- Pain management was audited monthly for compliance, as part of the nursing quality and performance dashboard. According to the dashboard for December 2016, all medical wards met the trust target for pain management, with an average of 99% compliance against a trust target of 90%.
- Pain relief was available for patients who underwent endoscopic procedures and included 'gas and air' (a

ready-to-use medical gas made up of half oxygen and half nitrous oxide, which is used when pain relief that works quickly and is excreted from the body quickly is required) and sedation.

Nutrition and hydration

- The service recognised the importance of good nutrition, hydration and protected meal times as an essential part of patient care.
- Patients' nutrition and hydration needs were generally assessed and met. We reviewed five patient records and found that Malnutrition Universal Screening Tool (MUST) risk assessments were completed. We were told that where possible, patients were weighed on admission and then at weekly intervals or if their clinical condition changed. This was in line with national guidance.
- Nutritional assessments were audited monthly for compliance, as part of the nursing quality and performance dashboard. According to the dashboard for December 2016, 12 wards met the trust target for nutritional assessments, with an average of 98% compliance against a trust target of 90%. The wards that did not meet the trust target for compliance were Collingtree (87%), emergency assessment unit (87%) and Holcot (83%). We saw evidence that actions were taken to improve compliance. For example, we observed a safety huddle on Collingtree ward, which included all staff being reminded to weigh all patients that day and complete all MUST risk assessments.
- Staff told us they accessed support from dietetics and the speech and language therapy service (SLT) for those patients who required additional input to maintain their nutritional status. We observed dietitians and speech and language therapists reviewing patients on medical wards during our inspection. Patients identified at risk of malnutrition were prescribed supplementary/high calorie foods and drinks, when needed.
- Dietitians attended some wards routinely, including Allebone, Eleanor and Finedon. For example, dietitians attended the board round on Allebone ward three times a week to discuss and review patient's nutritional requirements.
- We reviewed food replacements and supplements on medical inpatient wards and found all were within expiration dates.
- The patient-led assessment of the care environment (PLACE) audit for 2016 showed the hospital scored in line with the England average for food and hydration.

Patient outcomes

- The service had processes in place to monitor patient outcomes and report findings through national and local audits, and to the trust board. The hospital used this information to benchmark practices against similar organisations.
- The trust took part in the quarterly Sentinel Stroke National Audit Programme (SSNAP) (Royal College of Physicians). This national audit looks at key indicators, grouped into 10 domains covering key aspects of stroke care, such as scanning, implementation of treatments, multidisciplinary working, provision of therapy services and discharge planning. SSNAP rates stroke services overall and against each domain.
- The hospital was rated as band A overall (A being the best and E the worst), in the April to June 2016 audit, which indicates a world-class stroke service. This was an improvement from the previous audit (January to March 2016), when the trust was rated as band B overall. The majority of domain ratings had also improved or remained the same, except for scanning and standards by discharge which decreased from band A (January to March 2016) to band B (April to June 2016). The service scored well for eight domains (band A or B). Two areas where improvements were being made were where the service scored band C for thrombolysis and band D for patients spending at least 90% of their time on the stroke unit. We saw evidence that actions had been taken to improve performance against national recommendations.
- Staff told us that hospital's latest SSNAP results for August to November 2016 showed the trust had improved from a band D to band C for patients spending at least 90% of their time on the stoke unit. The stroke service achieved this improvement despite increased bed pressures trust wide and maintained its band A rating overall.
- The National Heart Failure Audit was established in 2007 to understand practice with the aim of helping clinicians improve the quality of heart failure services and to achieve better outcomes for patients. In the National Heart Failure Audit Report of 2014/15, the trust scored better than the England and Wales average for three of the four standards related to in-hospital care. The scores are reported below as hospital versus the England and Wales average score:
  - Cardiology; 53% versus 49%

- Input from consultant cardiologist; 67% versus 60%
- Input from specialist; 89% versus 78%
- The hospital scored worse than the England and Wales average for the 'received echo' standard; 82% versus 92% respectively.

- In the National Heart Failure Audit Report of 2014/15, the hospital scored better than the England and Wales average for six of the seven standards related to discharge care:
  - Angiotensin-converting-enzyme inhibitor (ACEI) (medicine used for the treatment of high blood pressure and congestive heart failure) on discharge; 97% versus 72%
  - ACEI/Angiotensin receptor blocker (ARB) (medicine used for the treatment of high blood pressure) on discharge: 96% versus 85%
  - Beta blocker on discharge (medicine used to treat conditions such as angina, heart failure and high blood pressure); 96% versus 85%
  - Received discharge planning; 91% versus 86%
  - Referral to heart failure liaison service; 63% versus 59%
  - Referral to heart liaison service for patients with left ventricular systolic dysfunction (LVSD) (failure of the pumping function of the heart) only; 92% versus 69%
  - The hospital scored worse than the England and Wales average for 'referral to cardiology follow-up'; 39% versus 54% respectively.
- The Myocardial Ischemia National Audit Project (MINAP) looks at the management of heart attack and helps clinicians and managers monitor and improve the quality and outcomes of local services. In the most recent MINAP report for April 2013 to March 2014, the hospital scored significantly better than the national average for one of the three indicators, the same as expected for one, and worse in the third:
  - The number of nSTEMI (non-ST-segment-elevation myocardial infarction, which is a common type of heart attack) for patients admitted to a cardiac unit or ward. The trust scored 75% compared with the national average of 56%.
  - The trust was in line with the national average for the number of nSTEMI patients seen by a cardiologist or member of the team.
  - However, the trust scored lower than the national average for the number of nSTEMI patients that were referred for or had angiography (angiography is a type of x-ray used to check the blood vessels). The trust scored 62% compared with the national average of 78%.
- Performance had improved for all three indicators, when compared with the previous year's audit results.
- The hospital took part in the National Diabetes Inpatient Audit (NaDIA). This audit allows hospitals to benchmark diabetes care and to prioritise improvements in service provision that will make a real difference to patients' experiences and outcomes.
- In the 2015 NaDIA, the trust scored better than the England average for three out of 17 applicable indicators, which were; 'able to take control of diabetes care', 'foot risk assessment after 24 hours only' and 'staff knowledge'. However, the trust scored worse than the England average for the remaining 14 domains, which included; 'foot risk assessment during stay', 'insulin errors', 'visit by specialist diabetes team' and 'overall satisfaction'. The largest difference between the trust score and the England average regarded the 'meals choice' indicator. The trust scored 39% versus the England average score of 54%. Overall, the trust saw a decline in performance when compared with the previous year's audit results. The trust performed worse for 10 indicators in 2015 compared with 2014, and better in the remaining seven applicable indicators. Again, the largest difference in the trust score for 2015 compared with 2014 regarded the 'meals choice' indicator. The trust scored 72% in 2014. Actions plans were in place to drive improvements and were monitored by senior staff.
- The hospital took part in the National Lung Cancer Audit 2016 with details of 178 patients from January to December 2015. This audit was set up to monitor the effectiveness of lung cancer services and to drive improvements in care provision and patient outcomes. Performance for the proportion of patients seen by a cancer nurse specialist met the minimum standard of 90%. The trust performed significantly better than the national average for:
  - Proportion of patients with histologically confirmed non-small cell lung cancer (NSCLC) who received surgery
- The trust performed in line with the national average for:
  - Proportion of fit patients with advanced NSCLC receiving chemotherapy

  - Proportion of patients with small cell lung cancer (SCLC) receiving chemotherapy
- Overall, trust performance had improved from the previous year's audit results. The exception was patients seen by a cancer nurse specialist, which had declined from 95% in 2015 to 90% in 2016.
- From March 2015 to February 2016, the risk of readmission for all non-elective (emergency) patients at the trust was higher than the England average for all medical specialities. The risk of readmission for elective (non-emergency) patients at the trust was also higher than the England average with the exception of general medicine (10% better than the England average) and clinical haematology (5% better than the England average). This meant that once discharged, patients were generally more likely to need to come back to the hospital for further treatment.
- The number of patient bed moves out of hours (from 10pm to 7am) was monitored by the hospital. According to the directorate performance scorecards from October to December 2016, there were 49 out of hours' bed moves within inpatient specialities and nine in elderly medicine. We saw evidence that this performance indicator was reviewed and actions were in place to address underperformance, which was predominantly caused by increased bed pressures.
- Endoscopy services were JAG accredited in October 2014. This meant that the service met national standards for clinical quality, training, workforce and quality of the patient experience.

Competent staff

- Staff had the appropriate clinical skills, knowledge and experience for their roles and responsibilities within the clinical area worked. The service had processes in place to identify training needs and compliance, and to address any issues identified.
- All staff underwent a trust induction programme that covered topics such as the trust values, information governance, fire safety and clinical skills, such as basic life support. Role specific training was also provided. Staff we spoke with told us they had received an adequate induction.
- All newly qualified nursing staff employed by the trust were subject to a period of preceptorship and supervision, which varied in length according to the area of work, and subject to competency sign-off.
- New nursing staff worked supernumerary for a short period on commencement of post. We were told that this was for a minimum of two weeks but could be extended according to individual needs.
- Healthcare assistants completed a four-week induction programme on commencement of employment. This was followed by completion of a 'care certificate'.
- Designated supervisors, who were listed on the trust intranet, provided clinical supervision to staff on an ad hoc basis. Clinical supervision could be provided on a one-to-one, group or peer group basis, and staff could discuss issues, problems or challenging situations, they had experienced. The aim of clinical supervision at the trust was to identify solutions, improve practice and increase understanding of professional issues.
- We saw that nursing staff within specialist clinical areas had additional competencies to ensure they were able to manage patients safely and effectively. For example, training was provided and competency was assessed for qualified nursing staff caring for patients requiring respiratory support such as non-invasive ventilation (NIV). NIV was provided on the respiratory (Beckett) ward and emergency assessment units. There was a flowchart to inform staff regarding requirements for NIV training and a database was kept by the matron to monitor compliance. All qualified staff on Beckett Ward were up-to-date with their competencies. On the emergency assessment unit some staff were undergoing completion of the competencies. The matron explained that they had recently reviewed the training and competency process. Staff were now required to also have annual competency checks. Six out of eight senior nursing staff who were usually 'nurse in charge' of the ward were up-to-date and supported the rest of the nursing team, and 11 out of 25 junior nursing staff were up-to-date with the competencies. We saw that dates for updates and training were planned for the staff who required it.
- The service supported in house training and development. For example, one healthcare assistant had recently started a nurse training programme, which would lead to registration as a qualified nurse.
- There were opportunities for staff to undertake additional training courses in order to develop their skills and knowledge. For example, one nurse had

completed a stroke specialist course. Some specialist training was available through the local university and nursing staff confirmed attendance to courses offered, such as mentorship.

- Medical wards had "link nurses" for topics such as diabetes, mental health, safeguarding, learning disability and dementia, infection prevention and control, pain, blood transfusion, pressure prevention, wound care and continence, and falls. Link nurses attended additional training, meetings and/or reviewed new guidance, and shared their learning with the rest of the team. We observed the names of link nurses and their specialist interest displayed on Collingtree and Benham wards.
- The trust supported staff with the revalidation process. Revalidation was introduced by the Nursing and Midwifery Council (NMC) in April 2016 and is the process that all nurses and midwives must follow every three years to maintain their registration.
- The service reported that appraisal compliance for medical staff within medicine directorates was 71%. All but one doctor had completed the revalidation process. Revalidation is the process for doctors to positively affirm they are up-to-date and 'fit to practise' in line with the General Medical Council (GMC).
- Appraisal rates reported in the January 2017 board report showed the medicine directorates did not meet the trust target of 85% compliance across all staff grades. As of December 2016, the compliance rate for staff working in the inpatient specialities directorate and the outpatient and elderly medicine directorate was 73% and 81% respectively. The service had actions in place to address non-compliance. This was an improvement from our previous inspection in September 2014, when we reported that overall compliance for the medical directorate was 69%.

Multidisciplinary working

- All appropriate members of the multidisciplinary team (MDT) were involved with assessing, planning and implementing patient care. Medical records included an admission treatment plan and were updated following MDT review, and according to clinical findings and patient condition.
- MDT working on all wards was effective and involved multiple professionals such as doctors, nurses, therapists, dietitians, pharmacists, discharge co-ordinators, patients and their family members. Medical records recorded MDT involvement with a detailed record of discussions, plans for ongoing care and discharge arrangements.
- We reviewed 12 patient records and found patients were reviewed by the MDT within 24 hours of admission to the service in accordance with trust policy.
- We observed an MDT meeting on the stroke unit, which was well established and well attended. The meeting was led by a consultant, with input from the MDT. The meeting was thorough, efficient and progressive. In attendance at the time of our inspection was one consultant, three therapists, one nurse and a member of the community stroke team. All attendees had a sound understanding of the needs of each patient, care priorities, clinical history and social considerations.
- Stroke services included specialist stroke nurses who were available via a dedicated mobile. Their role included attending the emergency department and assisting with the care and treatment of patients admitted with a suspected stroke. The team followed patients through the service and provided specialist advice and support on the stroke unit.
- There were clear internal referral pathways to therapy and psychiatric services. Staff on Victoria and Holcot wards told us the acute mental health team were easily accessible via a simple on-line referral process. Urgent referrals could be made via telephone/fax and we were told a member of the team would attend within the hour.
- Inpatient medical wards had daily access to therapists. We observed physiotherapists, occupational therapists, speech and language therapists and dietitians on wards during our inspection. Dietitians attended some wards routinely. For example, on Allebone Ward they joined a multidisciplinary board round to discuss patient's progress three times a week.
- In the Dickens therapy Unit (based at one of the three care homes that the hospital had provided beds for those patients assessed as 'fit for discharge'), we saw that the hospital's therapists were on site in the care home on Mondays to Fridays to provide a high level of therapy support for the hospital's patients. Staff at the two care homes we visited reported positive relationships with the hospital's staff to ensure those patients needs were being met.

- Staff on Collingtree ward told us they worked collaboratively with the alcohol liaison team and pharmacy to ensure patients who were detoxifying from alcohol received appropriate treatment and support.
- We spoke with a stroke specialist nurse who reported excellent working relationships with ambulance crews and the emergency department. Paramedics would alert the stroke specialist nurse that they were bringing in a patient with suspected stroke. This meant the stroke specialist nurse could attend the emergency department promptly to review the patient and initiate appropriate treatment and care.
- Discharge coordinators attended the wards daily to assist with tasks to promote discharge. This included arranging transport, and liaison with relatives and ongoing care providers.
- Staff reported good MDT working with specialist services such as tissue viability, infection prevention and control, safeguarding and learning difficulty nurse leads. Nursing staff were able to contact specialists for advice as needed and felt supported by them.
- Nursing staff on all wards reported that working relationships with the speciality consultants was good.
- Key information, such as clinical outcomes, ongoing care needs, tissue viability and medicines, was shared with GPs and members of the community health team on discharge. When patients were discharged from hospital the relevant GP, teams and/or other providers were informed.
- There were specialists within cardiology to support and advise on the effective care and treatment of cardiology patients. Staff told us that they worked closely with the heart failure and acute coronary syndrome specialists.

Seven-day services

- The hospital monitored its current provision of services against NHS Services Seven Days a Week Clinical Standards. 'Seven day services' (7DS) is an NHS England initiative, designed to promote the consistent provision of high quality care in such a way that there is no difference in safety, effectiveness and experience for patients, whether it is a weekday or weekend. The clinical standards were developed to address variations in patient experience and outcomes at the weekend.
- The service was working towards delivering sustainable seven-day services in line with its clinical strategy, with a focus on compliance with the key clinical standards. The hospital provided a copy of a 'scorecard' for their status against these standards for January 2017. Areas of strong performance included patient experience, access to interventions (except for interventional radiology) and access to diagnostics with pathology tests performed and reported within 24 hours. Areas that did not meet standards included consultant review for emergency admissions within 14 hours, emergency patients with management and discharge plan within 24 hours of admission and radiology tests performed and reported within 24 hours.
- A seven-day services project group had been set up and compliance was being monitored through the 'scorecard' for electronic data and case note audits. The project group was concentrating on time to first consultant review within 14 hours (standard 2), access to diagnostics (standard 5) and daily senior review (standard 8).
- Ambulatory care services were available from 8.30am to 9pm, seven days a week. Patients were referred to the ambulatory care unit via their GP and all patients were assessed by a consultant.
- The endoscopy unit was open from 8am to 6pm, Monday to Friday. In addition to this, an on-call team was available 24-hours a day, seven days a week to carry out urgent referrals.
- Hospital inpatients had 24-hour access, seven days a week to consultant directed interventional endoscopy.
- The pharmacy department was 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, for dispense of discharge medicines. There was an out-of-hours emergency medicines cupboard, which was accessible to nursing staff. In addition to this, an on-call pharmacist service was available 24-hours a day, seven days a week.
- Staff on Eleanor, Allebone and Finedon wards told us they had access to therapy services seven days a week. Compton ward, however, did not have access to therapy services at the weekend. Staff felt this could have a detrimental effect on patients' rehabilitation progress.
- The hospital had seven day a week consultant cardiologist cover.

Access to information

- Staff had access to the information they needed to deliver effective care and treatment in a timely manner.

- Clinical staff had access to patient's test results, such as blood tests and diagnostic imaging results, to support them to care for patients safely. These were available via the trust's electronic reporting system.
- Staff told us that discharge-planning considerations commenced on admission with input from the discharge co-ordinators.
- GPs received information on patients care and ongoing treatment in a timely manner. Electronic care summaries were sent to patients GPs on discharge. A copy was also given to the patient.
- Staff identified which community services or ongoing care needs would be required for the patient on discharge. Staff involved the patient, their family and other service providers in discharge planning, as appropriate.
- If GPs had any queries or concerns regarding ongoing patient care needs they could contact the service via telephone or bleep, where they would be able to speak to a relevant member of staff.
- Endoscopy equipment used during clinical procedures was documented in patient's records, along with the individual that had carried out the procedure. This meant that patients could be easily identified, should there be any reason to review patients treated by an individual clinician or with a particular piece of equipment.
- Patients who underwent an endoscopic procedure were given a copy of their results.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The hospital had up-to-date policies regarding consent, the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). Staff could access these via the trust intranet.
- The hospital used nationally recognised consent forms. These included a consent form for patients who were able to consent, and one for patients who were not able to consent to investigations or treatment.
- We observed staff asking patients for their consent prior to care being delivered and procedures carried out.
- Staff we spoke with confirmed they had received MCA and DoLS training. Staff 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. For example, staff on Eleanor ward told us that following a MCA assessment a DoLS referral could be made in relation to specific decisions, such as patients who required a nasogastric tube (a tube passed into the stomach via the nose, which can be used to provide nutritional support) because they were unable to swallow due to their current medical condition.
- Staff referred to the DoLS flowchart, which detailed the steps to follow to progress an application. A doctor and site manager signed DoLS applications.
- Nursing staff were aware of which patients on their ward had a MCA and/or DoLS in place. These were discussed during the staff huddle we observed on Collingtree ward. Ward matrons also had oversight of patients who had a MCA and/or DoLS in place.
- Staff had access to the hospital's specialist nurses who had particular expertise in dealing with vulnerable patients, such as those with learning difficulties and those living with dementia.
- We checked MCA and DoLS documentation during our inspection and found they had generally been completed appropriately. On Becket ward, we found a MCA had been completed appropriately and an urgent authorisation for DoLS had been requested. We could see that an extension to the DoLS for an additional seven days had been requested. We could also see that the trust's safeguarding team were involved in the process. However, the current situation was not clear from the records because the extension to the DoLS authorisation had expired. We discussed this with the nurse in charge of the ward who contacted the safeguarding team for advice and review. We were assured that the safeguarding team had oversight of patients on DoLS. To ensure that care was delivered in the least restrictive manner possible, the safeguarding team reviewed all DoLS applications.

Are medical care services caring?

Good

We rated this service good for caring because:

- During our inspection, we observed care being delivered by nursing, medical, therapy and auxiliary staff, who interacted with patients in a positive caring manner. Staff were focused on ensuring patients received the best possible care.

- Patients were treated with compassion, kindness, dignity and respect during their interactions with staff.
- Staff were observed to interact with patients in a friendly, respectful and considerate manner.
- Patients and relatives were included in decision-making and were assisted to make informed decisions about care, treatments and discharge planning.
- The 2016 patient-led assessment of the care environment (PLACE) results for privacy, dignity and wellbeing were better than the England average.

However:

- Privacy curtains or screens were not always used by the staff in one escalation area to protect patients' dignity and privacy.

Compassionate care

- During our inspection, we observed care being delivered by nursing, medical, therapy and auxiliary staff interacted with patients in a positive caring manner. This included addressing patients by name, introducing themselves by name, actively listening, speaking politely and respectfully, and coming to the patient's level when they were in beds and chairs. We found all patients had nurse call bells within reach and these were answered in a timely manner by staff.
- Staff stressed to us that their primary concern was to ensure all patients received the best possible care. Staff confirmed that when they assessed patients' needs they took into account personal, cultural, social and religious needs. Staff spoke about their patients with empathy, compassion and courtesy. Many referred to discussions they had had with the patient and family members.
- Patients and their relatives were generally positive about the care they had received. One patient on Finedon ward told us they "cannot praise staff enough, the care was exemplary".
- Staff told us and we could see that they received many compliment cards and letters from grateful patients and relatives. Staff were proud of the care they provided. A staff nurse told us that the care given was "what I would like my relatives to receive".
- Patient's privacy and dignity was generally maintained. We saw that staff closed curtains and doors to protect patient's privacy and knocked on doors before they entered. Patient's we spoke with told us they felt their dignity and privacy was maintained. One patient told us they felt staff were "brilliant" at this. However, we were not assured that all patients admitted to escalation areas, as a result of bed pressures, had their privacy and dignity maintained at all times. For example, the day room on Holcot ward was being used as a two-bedded inpatient area and we saw a patient receive treatment on their leg without privacy curtains or screen in place. We informed senior staff at the time, who took actions to address this.
- The patient-led assessment of the care environment audit for 2016 showed the trust scored better than the England average for how the environment supported the delivery of care for privacy, dignity and wellbeing. The trust scored an average of 90%, while the England average was 84%.
- From November 2015 to October 2016, the Friends and Family Test (FFT) response rate for medical care was 26%, which was slightly better than the England average of 25%. The FFT is a feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience. It asks patients if they would recommend the services they have used to their friends and family. We saw FFT results were displayed on medical wards.
- In November 2016, the percentage of patients recommending inpatient medical wards averaged at 91%, which was slightly lower than the England average of 95% for NHS providers. The medical care wards that scored better or in line with the England average were Compton (95%), Dryden (98%), Finedon (100%) and Talbot Butler (98%). The wards that scored worse than the England average were Allebone (88%), Becket (88%), Benham (91%), Brampton (93%), Collingtree (91%), Creaton (85%), Eleanor (88%), emergency assessment unit (85%), Holcot (83%) and Knightley (83%).
- We saw that FFT results were regularly reviewed and shared with staff, and actions were taken to improve performance. The trust reported that the percentage of patients who would recommend inpatient and day-case services had improved month-on-month from April to December 2016.
- The hospital participated in the National Cancer Patient Experience Survey 2015, which was published in July 2016. From April to June 2015, 703 eligible patients from the trust received the survey, and 483 questionnaires were returned completed. This represented a response rate of 69%, which was better than the national response rate of 66%. The hospital scored in line with

the national average for 40 of the 46 indicators relevant to hospital care, treatment and staff. The trust scored better than the national average for two indicators, which were staff assisted patients to get financial help and free prescriptions. However, the trust scored worse than the national average for four indicators, which included patients felt they were always treated with dignity and respect by staff, and were told who to contact if they were worried following discharge. On a scale of zero (very poor) to 10 (very good), patients gave an average satisfaction score of 8.5, which was slightly lower than the national average of 8.7. The service had developed a detailed action plan in response to the results. We saw evidence that the majority of actions had been completed.

Understanding and involvement of patients and those close to

- Staff communicated with patients so that they understood their care, treatment and condition. We observed ward rounds completed that were inclusive of the patient.
- Patient's we spoke with generally felt well informed about their care and treatment. One patient told us they were "kept well informed" and 'staff were available to discuss care when needed'.
- Families, friends and/or carers were involved in patient care and discharge planning. For example, we observed that patients and their significant others were encouraged to record their preferences on Compton, Holcot and Victoria wards. This included the name they liked to be called, routines that were important to them, things that worried or upset them, favourite food and drink, and things that made them laugh or smile.
- Staff assessed patients and used clinical judgment to identify those who might require additional support to understand care and treatment plans.

Emotional support

- Staff acknowledged that admission into hospital could be very distressing for some patients. Staff considered the emotional and social impact this could have on their wellbeing. We observed positive, warm and caring interactions during our inspection.
- Staff supported relatives of distressed or cognitively impaired patients so they were able to attend the wards at any time to assist with the care and support of the patient.
- Therapy staff conducted access visits at home to ensure stroke patients and their families had appropriate support in place to enable them to manage their health, care and wellbeing, and maximise their independence.
- Staff supported patients and their relatives to use the chaplaincy service, which provided spiritual care and religious support for patients, carers and relatives as needed. Multi-faith options were available.

Are medical care services responsive?

Good

We rated responsive as good because:

- In December 2016, the hospital's referral to treatment time (RTT) for admitted pathways for medical services was 97%, which was better than the England average of 90%.
- Due to ongoing bed capacity issues in the hospital, the service had implemented safety driven bed escalation and management process to address patient flow concerns in the hospital. This kept patients safe, even at times of significant pressure on bed capacity.
- Despite high bed occupancy over time and on the days of the inspection, the commitment to the safety and quality of care and treatment for patients was clearly demonstrated by all staff at all levels.
- The hospital had a well-defined process for the management of medically outlying patients.
- The hospital's discharge team supported staff with complex discharge arrangements and senior managers were continually working to improve patient flow out of hospital.
- Staff we spoke with had an effective awareness of patients with complex needs and those patients who required additional support. The adjustments made by staff and facilities provided met patients' needs effectively.
- While some night moves for patients were made due to the bed capacity issues, appropriate risk assessments were carried out.
- Effective systems were in place for responding to complaints.

However:

- Patient's cardiology procedures were cancelled during our inspection, due to being used as an escalation area

for inpatients. There were 207 patients cardiology procedures cancelled on the Heart Centre in the 12 month period ending January 2017. However, the hospital had procedures in place to ensure high priority patients were not cancelled.

Service planning and delivery to meet the needs of local people

- Medical care services were developed in order to provide appropriate care for the local population. Provision included stroke unit, cardiology services, admission units, specialist inpatient wards and a discharge lounge.
- The hospital worked closely with local commissioners to design and implement appropriate services and pathways of care so that the needs of the local community were being met. Senior managers were working closely with other local NHS trust staff to develop cross- county pathways for some specialities.
- Due to ongoing bed capacity issues in the hospital, the service had implemented a safety driven bed escalation process to address patient flow concerns in the hospital. Working with local commissioners, the hospital had purchased 77 beds in three nearby care homes for older people. Medical care and clinical oversight was provided by the hospital and personal and nursing care by the care home staff. All patients transferred to these beds were assessed as being medically 'fit for discharge' and most were awaiting either social care packages of care or a return to their own homes. This arrangement had created extra bed capacity for the hospital and was designed to focus inpatient 'acute' beds on those unwell patients being admitted to the hospital.
- The hospital's senior staff had focused on enhanced working relationships with the local council to improve processes for effective discharge processes that involved social care funding, availability of domiciliary care support for people living in their own homes and housing issues for homeless patients. Multidisciplinary weekly meetings were held focusing on 'stranded patients': those patients who were medically 'fit for discharge' but were unable to return back to the community, in the main due to ongoing social care needs.
- The hospital had taken part in a 12 week trial with the local community NHS trust to assess and discharge patients with cognitive impairments using an evidence-based delirium pathway. Senior managers said this had proven successful in helping facilitate appropriate and safe discharges for some patients with complex needs who had been in hospital for a long time and was being looked at as part of the countywide plans to facilitate discharges.
- The stroke unit had 12 dedicated hyper-acute beds, which were used to treat patients admitted with suspected/confirmed stroke. Patients were admitted to a hyper-acute bed for the initial acute phase of their admission, and could be transferred to a subacute bed for rehabilitation, as their condition became more stable, or discharged home under the ongoing care of the community stroke team, if appropriate.
- Stroke services included specialist stroke nurses who were available via a dedicated mobile phone number. Their role was to assist with the management of patients admitted to the trust with suspected stroke or transient ischaemic attack (TIA) (mini stroke). The team followed patients through the service and provided on ward specialist advice and support.
- The hospital had an ambulatory care unit. This unit had six cubicles and specialised in providing acute care without admission to hospital. There were certain procedures that could be undertaken in the unit including lumbar punctures and administering nebulised medicines.
- The trust had also submitted plans for a new bedded area in July 2016 to increase medical directorates capacity by 60 beds. This would provide a new build Acute Medical Assessment (AMU) unit and release two ward areas (that were being used as the AMU at the time of the inspection).
- We saw that the discharge lounge provided four side rooms for patients who were unable to sit out for transfer and two separate waiting areas. One was for general patients whilst the other provided a quiet area for patients with dementia. The quiet area was manned at all times to ensure patient safety. Patients could be transferred to the department after their morning medication to prepare for discharge. Staff were able to assist with washing and dressing, provided meals and coordinated the discharge. The ward sister had been recently appointed and showed understanding of the role of the department and had identified several areas for improvement, including additional storage area,

relatives room and informed us of additional requirement to improve the service. The discharge lounge was open every day, including weekends, and saw up to 40 patients a day.

Access and flow

- 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. The hospital performance indicator for patients on non-urgent admitted pathways to receive treatment as an inpatient within 18 weeks RTT was 92%, which is in line with national targets.
- Between January 2016 and December 2016, the hospital's referral to treatment time (RTT) for admitted pathways for medical services had been about the same as the England average performance. The latest figures for December 2016 showed 97% of this group of patients were treated within 18 weeks, which was better than the England average of 90%. The hospital's performance had been relatively similar to the England average for the 12 month period, with some months showing performance slightly above and some slightly below the England average.
- Four medical specialities were above the England average for admitted RTT within 18 weeks:
  - Cardiology: 94% trust performance: 84% England average performance
  - Dermatology: 100% trust performance: 87% England average performance
  - Geriatric medicine: 100% trust performance: 99% England average performance
  - Neurology: 100% trust performance: 93% England average performance
- Four medical specialities were below the England average for admitted RTT within 18 weeks:
  - Gastroenterology: 88% trust performance: 95% England average performance
  - General medicine: 93% trust performance: 96% England average performance
  - Rheumatology: 69% trust performance: 95% England average performance
  - Thoracic medicine: 95% trust performance: 95.5% England average performance.
- The medical service risk register included meeting the admitted national performance indicators for RTT.
- From March 2015 to February 2016, patients at the trust had a higher than expected risk of readmission to hospital for non-elective and elective admissions. The elective speciality clinical oncology was notably higher than the expected. Whereas, the elective specialty of general medicine was lower than expected. The hospital explained that they were working to reduce readmissions through a variety of programmes including:
  - Consultant connect, which provides advice and guidance direct line for GP's into four specialities including, respiratory and cardiology. This scheme is planned to roll out to acute medicine during April 2017.
  - Volunteers are working across the assessment units in order to prevent admission of elderly patients who do not need acute inpatient care. The volunteers work four evenings each week and will take patients home, sign post them to appropriate services and call the following day for a welfare check.
  - Pulmonary and cardiac rehabilitation to prevent crisis and re-admission.
  - Early supported discharge for stroke patients.
  - Direct advice and guidance from the ward for oncology and haematology patients.
- In medical care services from November 2015 to October 2016, the average length of stay for elective patients at the trust was 5 days, which was higher than the England average of 4.1 days. For non-elective patients, the average length of stay was 7.1 days, which is higher than the England average of 6.7 days. Elective cardiology reported the lowest average length of stay.
- The hospital held a safety huddle meeting two times a day. A representative from each ward and department attended these meetings. We observed a safety huddle during our inspection. Staff highlighted any staffing issues, capacity issues, potential discharges and patients who were not in the appropriate speciality ward. At these meetings, the commitment to the safety and quality of care and treatment for patients was clearly demonstrated and all staff worked towards this positively.

- Patient flow and bed capacity meetings were held up to five times a day with senior staff focusing on safe and effective patient flow throughout the hospital. There was a clear focus on safe, supported, appropriate discharge and all staff worked positively to improve patient flow. The hospital had a well-defined process for identifying patients for discharge for the next day.
- Bed occupancy was reported to be at 104% on one day of our inspection and frequently over the past year, the hospital had had bed occupancy rates over 95%. There were 105 patients cared for in escalation areas according to the December 2016 medical inpatient specialities' performance scorecard. On the days of the inspection, there were 97 'delayed transfer of care patients': these patients were medically fit for discharge but were not able to return back to the community mainly due to social care needs. This represented an average of 9% of the bed base at the hospital.
- The hospital had a well-defined policy and process for the management of medically outlying patients and senior staff monitored the number of outliers throughout each day to ensure there was appropriate clinical oversight and appropriate nurse staffing levels. Medical patients often were cared for on wards that were not their speciality. These were called medical outlier patients. The risks related to this were documented on the services risk register. These included:
  - Increased risk of harm to patients
  - Increased length of stay
  - Potentially poor patient experience
  - Risk of additional handovers leading to medicine errors

  The existing controls for this risk included completion of risk assessments, having designated medical wards assigned to review outlying medical patients each day and a designated nurse to co-ordinate these medical reviews. The medical services performance dashboard, showed from October to December 2016 there were on average 1,855 bed days of medical patients outlying into other specialities. This was significantly higher than the stated aim of equal to or less than 800 bed days per month and reflective of the increased attendances and number of inpatient admissions to the hospital over the preceding years.
- From September 2015 to August 2016, 64% of patients did not move wards during their admission. However, this meant that 36% of medical patients had moved wards once or more. Some patients were moved between wards overnight. The hospital monitored how often this occurred. The performance scorecards for medicine and urgent care, inpatient and elderly care services, showed that on average 48 patients per month were moved between departments or wards between the hours of 9pm and 8am (October to December 2016). We observed a hospital at night team handover during the inspection and noted that the site supervisor team were aware of the need to avoid and reduce the number of patients that were moved at night. We were told that the site manager would risk assess all patients who were moved out of hours.
- There were patients on the wards who were unable to be discharged due to their ongoing care requirements or social care issues. The hospital's discharge team supported staff with complex discharge arrangements and senior managers were continually working to improve patient flow out of hospital. Senior staff described three pathways for appropriate discharge care;
  - referral for placement (for example in a care home).
  - referral for rehabilitation.
  - referrals for care packages (for a patient in their own home).
- There were rehabilitation and long term decision beds that were used in the three local care homes that the hospital had purchased beds from to support these pathways.
- Delayed discharges were included in the risk register for medical services. Actions to mitigate the risks included:
  - Discharge facilitators and discharge matron in post providing a seven-day service.
  - Robust monitoring of patients with a length of stay greater than 10 days.
  - Nurse led discharge and criteria - training and implementation across all wards.
  - Each day a manager and matron to lead on flow issues for the trust.
  - Daily board rounds on each ward being standardised/audited.
  - Daily ward round with consultants/registrars.
  - Clinical safety huddle meetings twice a day, seven days a week.

- Patients admitted to the emergency assessment unit (EAU) should have been transferred to the appropriate ward within 48 hours. During our inspection, we found that 23 patients out of 32 had been on the EAU for less than 48 hours.
- On Dryden ward we found that a ward round checklist was being used to structure the daily ward round. This included prompts to ensure that patients had an estimated discharge date and that those going home should do so before 10am. These were being used to reduce discharge delays therefore freeing beds for new patient admissions.
- There were areas and departments in the trust that would be used for inpatients when there were significant bed pressures. These were called escalation areas or beds. These were areas that were not usually used for inpatients. The trust had a policy to guide staff regarding this and risk assessments were carried out. There were also clear guidelines regarding the types of patient that would be acceptable for the escalation areas. During our inspection, there were escalation beds open across the trust, including the Heart Centre, Beckett, Holcot, Brampton, Willow and Collingtree wards. There were 105 patients being cared for in areas that were not designed for inpatients, such as the cardiology day case Heart Centre according to the December 2016 medical inpatient specialities' performance scorecard.
- Althorpe ward was usually for elective orthopaedic patients. However, due to winter pressures, the trust had changed the ward to a temporary medical ward. Staff told us that this had been done in a planned manner with a specific date set in advance and training provided to the nursing team in preparation. There was a set criterion for the type of patients that were appropriate to be admitted to Althorpe ward. Staff told us that they were being supported by the discharge team regarding patients with complex discharge arrangements.
- The Heart Centre was being used as an escalation area during the inspection. This meant that inpatients stayed on the unit. The unit was usually a day-care unit and had nine trolley spaces used for patients having cardiology procedures. During the inspection we found that two patients had been moved to chairs waiting discharge and there was a further four inpatients on the unit. This meant that some patient's awaiting day-case cardiology procedures had been cancelled. The unit was unable to accommodate visitors to the unit during the day because of cardiology procedures taking place. This meant that during weekdays vising time was during the evenings. Staff told us that this often caused disappointment for patients and their visitors.
- The Heart Centre was a custom-built area and therefore did not have the facilities for inpatients such as there were no shower amenities. The airflow conditioning designed to reduce infections in the adjacent procedure rooms, meant that the area was cold. We spoke with inpatients on the unit who had to have extra blankets and had fed back to nursing staff about the heating. There were guidelines for staff for when the area was used for example to ensure meals were obtained and extra domestic support. The trust had advised us that they would be undertaking a review of incidents and outcomes from patient feedback mechanisms to ensure there were no safety or patient experience issues that needed further investigation at the Heart Centre.
- There were 207 patients cardiology procedures cancelled on the Heart Centre in the 12 month period ending January 2017. It was clear that there were seasonal variations with no cancellations for the months of June, July and August 2016. However, in the winter months, when the unit would be used as an escalation area due to bed pressures, this rose considerably. For example, the months of January and December 2016 saw 36 patients procedures cancelled and 39 for January 2017. The highest level was for March 2016 when 44 procedures were cancelled. Some patients (23) had cardiology procedures cancelled more than once on the Heart Centre in the 12 month period ending January 2017. The use of escalation areas, including the Heart Centre were entered onto the risk register for medical services. The current risk rating for the Heart Centre was 16 and colour coded red. Existing controls for this risk included ensuring that all high priority heart patients were not cancelled, the consultant was responsible for prioritising patients on clinical need and urgent patients may be transferred to other centres. This information was handed over to the site team and on-call teams on a daily basis. It stated that the area was only to be used as an escalation area when the hospital was under the highest level of bed capacity pressures.
- We visited the discharge lounge as part of the inspection. This was a designated unit where patients that had been discharged could wait for onward transfer. The lounge had two separate areas, with one

designated for patients living with dementia. The discharge lounge was open from 7am to 8pm, Monday to Saturday each week. There were 22 chairs and four side rooms. The unit cared for approximately 20 to 40 patients daily.

Meeting people's individual needs

- Staff we spoke with had an effective awareness of patients with complex needs and those patients who required additional support. Staff told us they had completed dementia training.
- We noted that the hospital were using dementia commissioning for quality and innovation (CQUIN) audit stickers in patients' healthcare records. These were being placed to prompt staff to review the patient's potential diagnosis of dementia prior to discharge and if required, to refer the patient to a memory clinic.
- Staff we spoke with had good awareness of patients with complex needs and those patients who required additional support. Staff told us they had completed dementia and safeguarding training.
- The hospital had a dementia liaison nurse whose role was to provide proactive dementia care provision and specialist support and advice. They explained that dementia steering group meetings were held on a monthly basis that were attended by staff, including members of therapy, facilities, catering, clinical staff, and safeguarding teams.
- Medical wards had dementia, mental health and learning disability link nurses who were available to provide support and guidance to staff. Additional support was also available from specialist nurses.
- The discharge unit had a separate lounge specifically designed for patients living with dementia.
- Wards which cared for patients living with dementia, such as Holcot and Victoria, had 'twiddlemuffs' available for patients. Twiddlemuffs were knitted muffs with interesting bits and bobs attached. Patients with Alzheimer's, arthritis and dementia find them comforting and therapeutic as they help encourage movement and brain stimulation.
- Most of the wards did not have 'dementia friendly' signage. Staff on Holcot ward told us that they had applied for funding for dementia friendly signage and were awaiting confirmation as to whether the application had been approved.
- Staff used a butterfly motif magnet on ward boards to symbolise patients with cognitive impairment, such as living with a dementia. The magnet was also displayed on the wipe-clean boards beside each patient's bed, where appropriate. This enabled all staff to easily identify patients who required additional support.
- Colour-coded bays were evident on wards we visited, such as Brampton, Collingtree and Holcot. This is evident of good practice, as colour-coded bays help patients with cognitive impairment to remember their way back to their bed.
- Colour-coded equipment was in use to alert staff to patients who required assistance with eating and drinking. Nutrition and hydration information was also displayed on wipe-clean boards beside each patient's bed. This ensured all staff knew at a glance if patients had any dietary restrictions, requirements and/or needed assistance, without having to refer to patient records.
- Patients we spoke with were generally positive about the hospital food and told us they were given regular drinks. One patient told us the food was "excellent" and their "vegetarian needs were met".
- Staff knew how to access advice from staff such as the trust's learning disability specialist nurse.
- The patient-led assessment of the care environment audit for 2016 showed the trust scored better than the England average for how the environment supported the delivery of care for patients with dementia and disability. The trust scored an average of 82% for dementia and 89% for disability, while the England average was 75% and 79% respectively.
- Picture books were available to help staff communicate with patients who had cognitive impairment, such as dementia. Patients could use the pictures to tell staff if they were hungry or in pain, for example.
- An interpreting service was available via a dedicated translation service. Face-to-face translation services could be booked through the patient advisory liaison service. Hearing loop was available within the medical service for patients with hearing difficulties. Sign language interpreters could also be provided. Staff gave examples of when interpreters and specialist nurses, such as the learning disability lead nurse and dementia lead nurse, had been used.
- We saw a wide range of information leaflets for patients, carers and relatives on all medical wards. Some leaflets had been produced by the trust and some were from national organisations, such as the British Heart

Foundation and Parkinson's UK. The leaflets we saw were all in English. Staff told us the patient advisory liaison service could provide information leaflets in other languages as needed.

- A patient information leaflet entitled "Coping with your pain whilst you are in hospital" was available. The leaflet was designed to help patients feel more comfortable and reduce pain during their hospital admission, and included guidance on relaxation techniques. The leaflet could be provided in other languages and formats on request, such as Braille and audio.
- Patients had a choice of meals with took account of their individual preferences, respecting cultural and personal choice. Patients had a choice of hot or cold meals. Staff could obtain hot food and snack boxes for patients as needed. This service was available 24 hours a day. A patient on Becket ward told us they had been provided with meals that met their requirements due to religious needs (Halal). Cold snacks and hot meals were available for patients outside of meal times and relatives were able to bring food in for patients.
- Patients had protected mealtimes. This allowed patients to eat their meals without unnecessary interruption, and enabled nursing staff to assist patients who were unable to eat independently. We observed a mealtime on Victoria ward and found staff were attentive to patient's needs. Staff asked patients where they wanted to eat their lunch and assisted them to sit in a chair or repositioned them in bed to ensure they were able to eat and drink comfortably, and without the risk of choking.
- The hospital had introduced finger food boxes, which were available to any patient who had difficulty eating a conventional hot meal, such as patients living with dementia. The benefits of finger foods include helping patients to maintain independence by enabling them to feed themselves, preserving eating skills, renewing interest in food and stimulating appetite, offering more choice, and the freedom to eat when desired.
- We saw that patients had jugs of water on their bedside tables within reach to promote hydration. Hot drinks were served regularly. We saw that oral fluids were readily available on the wards and patients water jugs were refilled at regular intervals throughout the day.
- Hot and cold meals, snacks and regular drinks were available to patients who had been discharged but were waiting for transport or medicines in the discharge lounge.
- Staff told us that they sometimes used passwords for relatives to use when they telephoned the ward, to ensure that individual's needs regarding sharing information was respected.
- Carers of patients living with dementia could access the Carers Assessment and Support Workers, who were based at the hospital. This service provided a listening ear and reassurance to carers of patients with dementia and could signpost them to other services, such as support groups, leisure activities, sitting services and benefits advice.
- All clinical areas were accessible for wheelchair users and disabled toilets were available in wards and public areas. Patients who required assistance with mobility had symbols placed on wipe-clean boards beside the bed to highlight this to ward staff.
- We observed a poster on Eleanor ward which publicised a hairdressing service. Patients could have their hair cut and/or washed on the ward if they wished.
- Patients and those close to them had access to the chaplaincy service and multi-faith room on site.
- Volunteers provided a 'pets as therapy' team, who visited patients with their therapy dogs on seven wards, including Brampton, Creaton and Holcot. The dogs can benefit patients mentally, emotionally and psychologically.

Learning from complaints and concerns

- Effective systems were in place for responding to complaints. Staff told us how they learned from complaints that they received. An example, was given when following a complaint about poor communication, individual staff had one-to-one meetings and training put in place.
- We saw that there were complaints and comments leaflets available for patients and relatives to inform them about the complaints process and how to complain. Some departments also displayed posters with this information.
- In the ambulatory care unit, we saw that there was a six step pathway providing explanation regarding what patients could expect at each stage of their journey, alongside complaints information.
- Staff we spoke with told us they valued patient feedback. For example, Creaton ward had a board where staff were encouraged to write patients comments on. We saw feedback from patients displayed on Collingtree, Dryden, Holcot and Victoria wards. We

also saw evidence that actions were taken in response to patient feedback. For example, new flooring had been laid on Collingtree ward to help reduce the sound of people walking on it at night. Furthermore, feedback from patients on Dryden ward included no clock being visible to patients from one of the bays. We saw that this had been rectified.

Are medical care services well-led?

Good

We rated this service good for well-led because:

- Staff felt that leadership was strong, with visible, supportive and approachable managers.
- The service was focused on providing quality care and had a defined strategy, which was aligned to the trust vision and values, organisational aims and wider healthcare economy goals.
- There was an effective governance and risk management framework in place. Risks identified were reviewed regularly with mitigation and assurances in place.
- The division had a robust audit calendar with processes in place to monitor performance and benchmark against national standards.
- Staff and public engagement was valued. Feedback was encouraged from patients, relatives and staff, and was used to inform service improvements.
- Staff were encouraged to get involved in projects to develop services and improve patient care.
- Staff were proud to work at the hospital and passionate about the care they provided.

Leadership of service

- The medical care service was part of the medicine and urgent care division, and had a clear management structure, defining lines of responsibility and accountability. A divisional director and divisional manager led the division. The medical care service was split into two directorates; inpatient specialities, and outpatients, elderly and stroke services. Both directorates were led by a clinical director and were supported by directorate managers, assistant directorate managers and matrons. The directorates operated a clinically led model of leadership, which aimed to create more local decision-making and ensure greater collaboration between medical, clinical and managerial staff. Clinically led models of leadership have been shown to produce better results and improve the quality and safety of care provision.
- The associate director of nursing, governance leads and business partners from human resources, information technology and finance, further supported the divisional management structure.
- The trust recognised the importance of senior leaders having the right skills, knowledge and experience to carry out their duties. In partnership with experienced healthcare leadership thinkers, the trust had developed a 15-month leadership and management programme for divisional directors and managers, clinical directors, directorate matrons and managers, heads of services, and senior specialists.
- Directorate leads spoke with pride about the work and care their staff delivered on a daily basis despite the pressures faced.
- Ward sisters and junior sisters managed the wards on a day-to-day basis and were supported in their duties by matrons. All ward sisters spoken with told us that clinical leads and matrons were accessible, supportive and visible. We observed matrons attending wards to support staff, discuss activity and share any issues that had arisen.
- The trust ran development programmes for ward sisters, which supported them to develop leadership and management skills. One sister told us they had found this programme very beneficial. Development days were also held, which provided senior staff the opportunity to network with their peers.
- Nurses said that doctors were responsive to their needs and always available to help with patient care. All nursing staff reported excellent local leadership. Similarly, clinical leads and ward sisters told us they were very proud of their teams and recognised that staff worked hard within their roles.
- Staff told us the chief executive and director of nursing, midwifery and patient services were visible on the 'shop floor' and leaders in the medical care service were accessible and had 'open door' policies.
- Staff felt the chief executive communicated well with them, including regular posts via social media platforms.

- A staff nurse told us of the supportive leadership they had received when they joined the team from overseas. They felt that this support had been crucial to the success of their recruitment.
- Staff were aware of the trust's whistleblowing policy and knew how to access the policy on the trust intranet.

Vision and strategy for this service

- The trust had a clear vision and set of values, focused on providing safe, effective and quality care. The vision for the trust was "to provide the best possible care for all our patients". The trust values were 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 division 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.
- The service had clear aims and objectives to ensure continued development. We reviewed the integrated business plan 2016/17, which included short-, medium and long-term plans for the service. Priorities included:
  - Increasing bed capacity with a planned 60-bedded emergency assessment unit
  - Developing collaborative country wide services for dermatology, rheumatology and cardiology
  - Implementing seven day services within endoscopy
  - Developing strong links with primary care services to support the patient at home
  - Developing the virtual community ward model for elderly patients
- Staff we spoke with were aware of the vision and strategy and told us they had been involved in its development.

Governance, risk management and quality measurement

- The service had a robust governance structure and risk management framework to support the delivery of good quality care.
- Monthly directorate governance meetings were held, which fed into monthly divisional governance meetings, who in turn reported to the trust governance group. We reviewed three sets of directorate and divisional governance minutes, which showed incidents, risks, audits, safety and quality improvements, clinical effectiveness, and patient experience were discussed.
- Any potential serious incidents within the service were escalated to the governance team and reviewed at the weekly harm group meeting. If an incident was declared as a serious incident an appropriate senior member of staff would be appointed to lead the investigation and conduct a root cause analysis.
- We reviewed the root cause analyses of two serious incident investigations. We saw detailed root cause analyses had been completed, which included recognition of care management and service delivery problems, contributory factors, lessons learned and actions to be completed to reduce the risk of further incidents. We also saw evidence that patients were informed and the duty of candour was followed. Staff were able to give examples of lessons that had been learnt from incidents during our inspection.
- The division had a risk register, which identified each risk in detail alongside a description of the mitigation and assurances in place. There were 40 risks listed for the medical directorates. These included areas such as discharge delays, creating extra bed capacity, escalation areas, and staffing levels. Staff we spoke with were aware of risks within their clinical areas. We saw that risk registers were reviewed regularly at directorate and divisional governance meetings.
- There was internal clinical audit activity and monitoring of performance and quality within the service.
- The service had a robust audit programme in place to ensure they were continuously improving their 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.
- Each medical 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 board and any red and amber areas were discussed and reviewed by the senior nursing team. The matrons were required to take action against any performance measurements that fell below the expected standard. The matrons and

ward sister/charge nurse had two months in which to action the required improvements and assure the nursing and midwifery board that these actions were sustainable. According to the dashboard for December 2016, the majority of quality care indicators were green rated, which meant the expected standards had been met. The results of the dashboard were discussed monthly at the trust board meeting. We reviewed the board papers for January 2017 and saw evidence that actions had been taken to address areas of non-compliance and improve outcomes.

- We raised the use of the Heart Centre for inpatients and the impact on patients having cardiology procedures cancelled with the directorate manager. They explained that the unit was only used as an escalation area when the hospital was under extreme pressure and this was guided by policy. To reduce the risks regarding cancelling patients' procedures, cardiology consultants were involved in decisions and advised on priority of patients based on clinical needs. However, there were some patients that had their procedures cancelled more than once. Issues related to patient safety and cancellations were documented on the divisional risk register.
- Staff told us that they received feedback in various ways, such as the daily team safety huddles, ward meetings, email, newsletters, and communication folders. Performance issues would be taken up with the individual staff member and managed in line with trust policies.
- In medicine, the service worked with the trust Improving Quality and Efficiency (IQE) team on a number of projects project relating to patient safety. Examples included reducing the number of cannulas used and inappropriate cannulations, streamlining the discharge process for patients, usage of intravenous fluids, improving weekend handovers for medical staff and care for patients with learning disabilities. These projects were some examples of the joint working between the IQE, trust Quality Improvement team and medical care team to further support the safety improvements made by the service.

Culture within the service

- All staff we met were welcoming, friendly and helpful. It was evident that staff cared about the services they provided and were proud to work at the trust.
- All staff we spoke with were committed to providing the best possible care for patients.
- Staff felt there was a positive working culture and all wards reported good team working.
- Nursing staff told us they felt respected and valued and reported very positive relationships with consultants.
- Staff agreed there was a culture of openness and honesty throughout the service. Multidisciplinary teams worked collaboratively and were focused on improving patient care and service provision. During our inspection we attended one multidisciplinary team meeting and observed positive and respectful interactions, which were focused on patient needs, care and treatment. Directorate leads also told us how the service had worked collaboratively with other divisions, such as surgery, to manage increased bed pressures.
- Staff we spoke with understood their roles and responsibilities with regards to the Duty of Candour. Staff knew how to raise concerns and there was a policy for 'whistle-blowing'.
- There was a clinical lead for sepsis at the trust and we saw evidence that the trust actively promoted sepsis awareness. For example, staff on Victoria ward told us all staff had been invited to attend screenings of a film, which told the true story of a man who had lost all four limbs due to sepsis. We were told that 60 per cent of staff had signed up to attend. We also saw a two-page spread entitled "spotting the signs of sepsis", written by the sepsis lead, featured in the winter 2016/17 edition of the trust magazine.

Public engagement

- One of the divisional 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 medical 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.
- Wards displayed 'infograms', which contained information on how each ward was performing in relation to FFT results. The infograms were produced monthly and included the FFT response rate, the percentage of patients who would and would not recommend the service, patient comments, and learning from feedback received. For example, 92% of patients recommended Dryden ward for December

2016. Patient comments included, "The staff on Dryden ward manage to combine a friendly outlook along with a very professional approach. Although extremely busy, nothing is too much trouble. As well as providing outstanding care, the team is able to maintain a high level of cleanliness throughout the ward".

- The trust had developed 'real-time' and 'right-time' surveys, based on questions used in the National Inpatient Survey and areas that matter most to patients when they are in hospital. Four inpatient wards piloted the real-time survey from August 2016 and a further three wards from October 2016. The survey report was made available to ward managers on the same day the results were collected, which would enable staff to make immediate changes for the benefit of patients. The 'right-time' survey was introduced in October 2016. Questionnaires were sent to 600 adults who had attended as an inpatient around one to two weeks following their discharge. We saw evidence that the results of the survey would be discussed at the patient and carer experience and engagement group (PCEEG) in February 2017.
- We saw evidence in ward meeting and safety huddle minutes that patient feedback was shared with all members of the team. For example, we saw that a complaint received on Collingtree ward was shared with staff at the safety huddle. We also found details of the complaint in the communication folder and staff had signed to confirm they had read it.
- The community stroke team captured patient feedback via a patient survey. The majority of comments received were positive, with 108 positive, 11 neutral and 18 negative comments received. We saw evidence that areas for improvement were identified, such as improving the information given to patients on discharge.
- Wards displayed information for patients and their families about ways in which they could comment on their experiences in a confidential setting, such as through accessing the patient advice and liaison service.
- The service had established good links with numerous volunteer organisations, charities, and national support groups, such as Macmillan, Age UK, Northamptonshire Cancer Partnership, and Pets as Therapy team.

Staff engagement

- Staff told us they felt actively engaged and involved in the planning and delivering services. The directorate leads gave us examples of where staff had worked collaboratively to improve the service. For example, more day case procedures were carried out over the winter period, when bed pressures were increased, to reduce the number of admissions to the wards. Further examples included the 'infograms', which were created by staff on the band six development programme.
- Staff told us of innovative ways that the trust were using to facilitate staff raising ideas and solutions. Protected time was given to the project called 'pathway to excellence'.
- The trust had taken action to improve staff morale via the 'compliments collation'. Positive feedback was collated on a monthly basis and shared within the divisions. In December 2016, the medicine division received over 1,400 positive comments from FFT, online reviews, thank you cards and formal letters. This initiative had been shortlisted for a Patient Experience National Award (PENNA) due to the effect it had on staff morale. The awards were to be announced in March 2017.
- Staff described monthly ward meetings taking place. Minutes were available to staff who were unable to attend. Staff also received daily updates regarding on any issues affecting the ward and/or trust at safety huddle meetings.
- Leaders of ward areas described ways in which they ensured that they were responsive to issues and concerns raised by staff. For example, they arranged regular one-to-one meetings to support staff.
- Staff on Eleanor ward told us they felt empowered by consultants to make decisions and improvements to care provision.
- We saw effective team working across all clinical areas.
- Staff stated that they felt confident to raise concerns with their line managers and knew of the trust's whistleblowing policy.

Innovation, improvement and sustainability

- Staff were focused on continually improving the quality of care and the patient experience. For example, we saw evidence that the service was committed to improving the care of elderly patients, such as those living with dementia. Colour-coded bays were evident on some of the wards we visited and finger food boxes had been introduced, which made it easier for patients to eat when they wanted and helped them to maintain

independence. Directorate leads told us of plans that were being developed in collaboration with primary care and community services to support the care of elderly patients at home.

- The trust was also actively fundraising in order to transform a room in the elderly medicine centre into a therapy suite. This suite would include pop-up reminiscence rooms that can turn any care space into a therapeutic and calming environment.
- The trust was one of five shortlisted in 2016 for a CHKS award for patient safety. CHKS is a leading provider of healthcare intelligence and quality improvement services. In order to be shortlisted, the trust had to demonstrate outstanding performance in providing a safe hospital environment for patients, based on a range of indicators, including rates of hospital-acquired infections and mortality.
- Improvements to quality and innovation were recognised and rewarded through the annual staff 'best possible care' awards. Within the awards scheme there were categories for patient experience, patient safety, clinical team of the year and innovation in practice. Dryden ward had been nominated for the 2016 patient safety award and the innovation in practice award.
- One patient, who had been regularly attending the trust for many years, told us they had seen real improvements made to the service since the chief executive had been in post.
- Relatives and friends could keep in touch with patients via a mobile telephone application, which was linked to the patient's bedside television and telephone account.
- Staff had access to 'sleep well packs' to help patients rest and sleep during their admission. The packs included ear plugs, eye mask and information leaflet, which contained tips to aid relaxation.

Surgery

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

Information about the service

Northampton General Hospital NHS Trust (NGH) provides a range of surgical services to the population of Northamptonshire, including trauma, orthopaedic, ophthalmic, urology, and general surgery. The emergency theatre provided a 24-hour service.

There are 161 surgical beds across eight surgical wards; Abington ward, Althorp ward, Cedar ward, Rowan ward, Spencer ward, Willow ward, Singlehurst ward, and Hawthorn ward, which also has a surgical admissions unit (SAU). The Manfield day case unit was being used to care for 12 inpatients during the inspection. There are 17 operating theatres in five separate locations, including a day surgery unit with two theatres. There is one theatre at Danetre Hospital, which was not inspected as part of this inspection.

The trust had 27,373 surgical admissions from April 2015 to March 2016. There were 8,688 (32%) emergency admissions, 14,641 (54%) day case admissions, and 4,044 (15%) elective (pre-planned) surgical admissions.

All patients are admitted under the direct care of a consultant and a senior house officer, who support surgical care 24 hour a day, seven days a week. Patients are cared for and supported by registered nurses, care assistants and allied health professionals, such as physiotherapists, employed by the hospital.

As part of the inspection, we visited the operating theatres, the theatre recovery areas, the surgical wards, the SAU, Manfield day case unit, and the pre-assessment clinics. We spoke with 57 staff, including staff on the wards and in theatres, nurses, healthcare assistants, doctors, consultants, therapists, and ward managers. We spoke with 13 patients, observed care and treatment and reviewed 21 patient records, including medical and nursing notes. We received comments from people who contacted us to tell us about their experiences, and reviewed performance information about the hospital.

Surgery

Summary of findings

We rated surgical services as good for safe, effective, caring, responsive and well-led. Overall, we rated the service as good because:

- There was a culture of incident reporting and staff said they received feedback and learning from serious incidents. Staff were able to speak openly about issues and serious incidents. All staff were aware of the recent never event and actions taken.
- The environment was visibly clean and staff followed the trust policy on infection control.
- Medical and nurse staffing was appropriate and there were adequate emergency cover arrangements.
- Treatment and care were provided in accordance with evidence-based national guidelines. There was positive practice, for example; assessments of patients' needs, monitoring of nutrition and falls risk assessments. Multidisciplinary working was effective.
- There were processes and procedures in place for staff to manage patients' pain and ensure that patients' nutrition and hydration needs were met.
- In the 2016 Patient Reporting Outcomes Measures (PROMS), the hospital generally performed better than the England average apart from some mixed outcomes for hip and knee replacements.
- The hospital performed better than the England average in the 2015 Bowel Cancer Audit. The hospital performed in line with the England average in the National Emergency Laparotomy Audit 2016 and the 2015 National Vascular Registry.
- Staff had an awareness of the Mental Capacity Act (MCA), Deprivation of Liberty Safeguards (DoLS) and safeguarding procedures to keep people safe.
- The consent process commenced in outpatients and consent was reconfirmed at the time of admission.
- Patients told us that staff treated them in a caring way, and they were kept informed and involved in the treatment they received. We saw patients being treated with dignity and respect.
- The average length of stay was similar to the England average.
- Between January 2016 and December 2016, the hospital's referral to treatment time (RTT) for admitted pathways for surgical services was about the same as the England overall performance.
- From October 2015 to September 2016, the number of patients whose operation was cancelled on the day of surgery was 4%, below the England average of 8%.
- The service had an effective complaints system in place and learning was evident.
- There was support for people living with a dementia or learning disability and reasonable adjustments were made to the service.
- Surgical services were well-led. Senior staff were visible on the wards and theatre areas and staff appreciated this support. There was generally a strong awareness amongst staff of the trust's values.

However:

- There were 300 patients in trauma and orthopaedics and 180 patients in ophthalmology who waited over 18 weeks for surgery. Some patients waited over 35 weeks for surgery. These patients had been risk assessed to check if their condition had deteriorated whilst waiting.
- The 24 hour reviews of venous thromboembolism (VTE) assessments were not always recorded. The hospital was taking urgent actions to address this.
- Patients' medical records were not always stored securely. We raised this on inspection and the trust responded by purchasing locked notes trolleys for all wards.
- The medicines refrigerator on Willow ward had recorded a temperature of 26° C, which was above the recommended range, on 15 separate occasions. The hospital took action once we raised it as a concern.
- The trust had a higher than expected risk of readmission for elective and non-elective admissions.
- Not all staff were aware of patients' outcomes relating to national audits or performance measures, such as the national hip fracture audit.

Surgery

Are surgery services safe?

Good

We rated safe as good because:

- Staff were confident in reporting incidents and were aware of the importance of the Duty of Candour.
- There was access to appropriate equipment to provide safe care and treatment.
- Medicines were appropriately managed and stored safely within the service.
- We observed the World Health Organisation's 'Five Steps to Safer Surgery' checklists being completed and audits showed 95% compliance from January 2016 to December 2016.
- The service had procedures for the reporting of all new pressure ulcers, slips, trips and falls. Actions were being taken to ensure harm free care.
- There was strong knowledge of signs of the deteriorating patient and we saw that patients were appropriately escalated if their condition deteriorated.
- Staff were aware of safeguarding procedures to keep patients safe. Staff had completed the trust's mandatory training.
- Medical and nurse staffing was appropriate and there was adequate emergency cover. Patients' needs were being met despite there being a number of vacancies for nursing staff in surgery. Safe staffing levels were being achieved by the use of bank and agency staff.
- Nursing and medical handovers were well structured within the surgical wards visited.
- The environment was visibly clean and staff followed the trust policy on infection control.

However:

- There were 300 patients in trauma and orthopaedics and 180 patients in ophthalmology waiting over 18 weeks for surgery. Some patients were waiting over 35 weeks for surgery. These patients had been risk assessed to check if their condition had deteriorated whilst waiting for surgery.
- The 24 hour reviews of venous thromboembolism (VTE) assessments were not always recorded due to the hospital's transition from paper to an electronic recording system in December 2016. The hospital was taking urgent actions to address this.
- Patients' medical records were not always stored securely. We raised this on inspection and the trust responded promptly by purchasing locked notes trolleys for all wards.
- The medicines refrigerator on Willow ward had recorded a temperature of 26 degrees Celsius, which was above the recommended range on 15 separate occasions, with no evidence of any action having been taken. The hospital took action once we raised it as a concern.

Incidents

- Staff understood their responsibilities to raise concerns, to record safety incidents and near misses, and to report them internally and externally.
- A system and process for reporting incidents was in place. Staff understood the mechanism of reporting incidents. This was confirmed verbally, both at junior and senior level. The incident reporting form was accessible via an electronic online system.
- In accordance with the serious incident framework 2015, the trust reported six serious incidents (SIs) in surgery which met the reporting criteria set by NHS England between December 2015 and November 2016. Of these, the most common type of incident reported was surgical/invasive procedure incident meeting SI criteria (five). Two incidents related to complications identified during surgery and one was a patient fall. A full investigation took place. All lessons learnt were cascaded to the team during ward and theatre handovers, daily huddles and staff meetings. Staff confirmed this during our inspection.
- There was one never event for the surgical division at Northampton General Hospital from December 2015 to November 2016. 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 reported never event related to an incorrect lens insertion during cataract surgery, (a condition that affects the lens of the eye). This was identified during the surgery and a replacement lens was inserted at this time. We saw a full investigation took place and lessons learnt included that the consultant would select the lens required, verbally confirm the size with the operating staff and the lens size would be documented on the white board in theatre for all staff to view.

- 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.
- Staff understood their responsibilities with regard to the duty of candour legislation. Nursing and medical staff were fully aware of the duty of candour and described a working environment in which any mistakes in a patient's care or treatment would be investigated and discussed with the patient and their representatives. An apology was given, whether there was any harm or not. We saw evidence that the duty of candour had been applied following the never event in accordance with trust policy.
- 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.
- We saw each surgical speciality held regular mortality and morbidity meetings and individual cases were discussed and lessons learnt included improving communication between staff and teams, ensuring adequate resuscitation documentation in place and ensuring VTE assessments were completed.

Safety thermometer

- The NHS safety thermometer is an improvement tool for measuring, monitoring and analysing patient harms and 'harm free care'. Information was displayed in the ward corridors for patients, relatives, and staff. This included information about patients' falls, pressure ulcers, and infections. Staff we spoke with were aware of the data and used this as a safety indicator of the care they provided and where risks had been minimised.
- Data from the NHS Safety Thermometer for surgery reported 37 pressure ulcers, three falls with harm and three catheter urinary tract infections (CUTIs) between January 2016 and January 2017. The prevalence rate for pressure ulcers had dropped since January 2016 and the prevalence rate for falls and CUTIs fluctuated throughout the 13 month period.
- Action plans were in place to reduce incidents such as one to one nursing for patient at risk of falls and using specialist mattresses to prevent pressure ulcers.

Cleanliness, infection control and hygiene

- At the time of our inspection, the environment and equipment in the wards and theatres were visibly clean and tidy.
- Staff had received training about infection prevention and control during their initial induction and during annual mandatory training. We saw that 83% of nursing staff had completed their training in infection prevention and control, which was slightly under the hospital's target of 85%. Further training dates had been arranged.
- There was a specific cleaning schedule in place for all wards and theatres. Cleaning staff told us that the standard of cleanliness and compliance with the schedule were checked by their supervisor and we saw evidence that monthly checks had been completed.
- We observed that staff followed the trust's policy regarding infection prevention and control. This included being 'arms bare below the elbow'.
- Hand hygiene gels were available throughout the wards and theatres. We observed all staff using alcohol hand gel when entering and exiting the wards, theatres, and day case unit.
- Personal protective equipment, such as gloves and aprons, were available in sufficient quantities and used appropriately. On Hawthorn ward there were different coloured aprons for each different coloured bay, for example blue bay had blue aprons. Staff told us this helped to remind them not to go into another coloured bay wearing a specific coloured apron, and prompted them to remove the apron when they left the coloured bay.
- The hospital carried out monthly hand hygiene audits and all surgical wards and clinical areas showed 100% compliance in December 2016.
- Waste management was handled appropriately with separate colour coded arrangements for general waste, clinical waste, and sharps bins. The bins were not overfilled.
- There were six reported surgical site infections at the hospital for hip and knee surgery from April 2016 to December 2016. Data showed that just fewer than 2% of patients developed a surgical site infection following knee surgery, which was above the England average of

0.5%. We saw an action plan in place. This included the use of topical washes for elective orthopaedic patients, discussing and sharing learning from all patients who developed a surgical site infection at consultants' meetings and to produce a leaflet for patients on preventing surgical wound infections.
- From August 2016 to January 2017, there had been onereported case of Clostridium Difficile and no MRSA cases on the surgical wards.

Environment and equipment

- The ward and theatres were spacious and well lit. Corridors were free from obstruction to allow prompt access.
- Resuscitation equipment, for use in an emergency, was checked daily and documented as complete and ready for use.
- There was a difficult airway trolley in all theatres visited. This equipment was checked daily. This meant staff could effectively respond in an emergency.
- Anaesthetic equipment was checked daily prior to use as per guidelines.
- There was sufficient equipment to maintain safe and effective care, such as anaesthetic equipment, theatre instruments, blood pressure, and temperature monitors, commodes and bedpans. Regular checks were carried out on theatre ventilation systems to ensure they were effective.
- There was a medical equipment library within the hospital and staff could request additional equipment such as a specialist mattress, which portering staff would deliver to the ward in a timely manner.
- Electrical appliances and equipment we checked during the inspection had been electrically safety tested to ensure they were safe to use and each had a sticker with appropriate dates to show this had taken place.
- We saw that hoists and firefighting equipment had been regularly checked and serviced.

Medicines

- The handing and storage of medicines was appropriate and in line with the hospital's policy.
- The pharmacy department was open between Monday to Friday between 8.45am and 5.30pm and between 8.45 and 1 pm at the weekends. There was an out of hour's on-call pharmacist service.
- The pharmacy team visited all wards each weekday. A clinical pharmacist monitored the prescribing of medicines, visited the wards daily, and was readily available for advice about medicines. We saw evidence of reconciliation and that allergies were recorded on drug charts.
- There was a dedicated pharmacist within the pre-operative assessment clinic, to provide information to patients about their medication pre and post-surgery.
- All medicines were stored safely and only accessible to appropriate staff.
- There was a medicines management policy, which included information on safe administration of controlled drugs and administration of medicines, which staff could access via the hospital intranet.
- Medicines were stored in a secure temperature controlled room that had suitable storage and preparation facilities for all types of medicines, such as controlled drugs and antibiotics. We saw records of the daily checks of ambient temperatures in the medicines storage room had been routinely completed. However, the medicines refrigerator on Willow ward had recorded a temperature of 26 degrees celsius, which was above the recommended range of between 2-8° degrees celsius, on 15 separate occasions with no evidence of any action being taken. This was raised with the ward manager during our inspection who took action to address the concern.
- The temperatures of the treatment room were being recorded on all wards. On Willow ward, there were numerous readings of temperatures exceeding the recommended 25 degrees celsius and during warmer months, the temperature readings had reached almost 33 degress celsius. These temperatures can affect the shelf life of medicines and we were subsequently told that the pharmacy department were removing stock early from this ward to ensure it remained suitable for use.
- During the inspection, the lock on the drug fridge on Hawthorn ward was broken, the fridge was in a locked cupboard, and only authorised staff had access. This had been reported to the maintenance team and an incident form had been completed. The ward manager was aware and reviewing this daily.
- Drug cupboards were left unlocked in the anaesthetic rooms, whilst theatres were in use, to allow easy access. A risk assessment was in progress. The controlled drug cupboards were locked at all times.
- Controlled drugs were stored in a locked unit and the keys held separately from the main drug keys. We

reviewed two controlled drug book on two separate wards and found entries and expiry dates, were all completed in line with guidance. The cupboards did not hold any other equipment or medicines.

- Entries in the controlled drug register were made regarding the administration to the patient and were signed appropriately. New stocks were checked and signed for, and any destruction of medicines was recorded.
- Nursing staff wore a red apron to indicate they were administering medicines, to alert staff not to disturb them, to prevent drug errors. We saw all drug trolleys were locked when not in use and either stored securely in the main wards or in locked cupboards. However, the trolleys storing medicines on Willow ward had access codes, which had not been changed since they were implemented over a year ago. This was raised with the ward manager during our inspection, who was implementing a process to change the access codes on a regular basis. All other wards had key access to medication trolleys.
- Discharge letters containing details about medicines were validated by a pharmacist to ensure accuracy.
- All intravenous fluids were stored safely behind locked doors and only accessible to appropriate staff.

Records

- Records were legible, accurate, and up to date. We reviewed 21 sets of nursing and medical records and found they were in order and information was easy to access.
- Records included details of the patient's admission, risk assessments, pre-assessments forms, treatment plans, and records of therapies provided.
- The records we reviewed showed that the World Health Organisation (WHO) 'Five Steps to Safer Surgery' checklist, designed to prevent avoidable harm, was completed for all patients.
- The nursing and medical notes were not always stored away from public view. On the Manfield day case unit and Singlehurst ward, we saw patient notes were left unattended and accessible to patients or visitors. Notes trolleys were generally behind the nurses' station, but these were not lockable. Therefore, we were not always assured of the security of medical records at all times, as the nurses' station was not always guaranteed to be manned. This was raised with senior managers at the time of the inspection and the trust informed us they would purchase keypad lockable notes trollies for all areas holding notes.
- White boards displaying patients' names, some treatment and care, such as investigations required, physiotherapy input and social care needs, were behind the nurses' station, but visible to all other patients and visitors. Therefore we were not reassured that this respected patients' confidentiality. This was raised with senior managers during our inspection. The trust removed the patients' full names and replaced this with initials and surname. They also ensured they had patients' permission to display this information.
- The hospital had recently implemented electronic systems to record routine observations and staff had access to electronic devices to record these. Some information was stored on the electronic device and some were documented on paper records, such as fluid balance records, which were stored at the patient bedside. We looked at samples of paper and electronic records, which were complete, legible and with entries timed, dated, and signed.
- Many professionals used stamps in the healthcare records, which included name and professional body registered number. This helped to identify who had made entries.

Safeguarding

- The hospital had safeguarding policies and procedures available to staff on the intranet, including out of hours contact details for hospital staff.
- Staff received training and had a thorough understanding of their responsibilities in relation to the safeguarding of vulnerable adults and children.
- Nursing and medical staff were able to explain safeguarding arrangements and when they were required to report issues, to protect the safety of vulnerable patients.
- Staff had access to the trust's safeguarding team and they told us they were helpful and responsive.
- The trust reported in January 2017, that 90% of nursing staff and 84% of medical staff had up to date training in both adult safeguarding and children safeguarding levels one and two. This was in line with the trust's target of 85%.

Mandatory training

- Mandatory training was provided for staff and included infection control, fire, moving and handling and health and safety. Some training was delivered via face-to-face sessions and others were available electronically.
- There was an induction programme for all new staff and staff that had attended felt that the programme met their needs.
- The trust's training record for January 2017 showed that for the surgical division, 86% of nursing and medical staff had completed their mandatory training in line with the trust target of 85%. Further training dates had been arranged.

Assessing and responding to patient risk

- Risks to patients who were undergoing surgical procedures had been assessed and their safety monitored and maintained. For example, all elective patients attended a preoperative assessment clinic and the trust used the WHO 'Five Steps to Safer Surgery' checklist, in line with national guidelines.
- Risk assessments were undertaken in areas such as falls, malnutrition, and pressure ulcers. These were documented in the patient's records and included actions to mitigate any identified risks.
- There were 300 patients in trauma and orthopaedics and 180 patients in ophthalmology who waited over 18 weeks for surgery. Some patients waited over 35 weeks for surgery, the longest wait was at 42 weeks, and no patients had waited over 52 weeks for surgery. These patients had been risk assessed to check if their condition had deteriorated whilst waiting for surgery. Senior staff told us the hospital had a defined process for carrying out assessments and harm reviews and that all patients that waited over 18 weeks would be reviewed by the relevant consultant. Staff completed an electronic incident record if there was any concern that the waiting time may have had a negative impact for those patients. No incidents had been reported where harm may have been experienced, in the past year.
- The initial venous thromboembolism (VTE) (blood clot that can form in the veins of the leg or the lungs) assessments were recorded, which was compliant with guidance from the National Institute of Health and Care Excellence (NICE 2010) for reducing the risk of venous thromboembolism in adults. VTE assessments and the 24 hour reviews had traditionally been recorded manually by medical staff in the patient's medical records. In December 2016, the hospital had introduced an electronic system to record VTE reviews and these were not always being completed. We reviewed 21 sets of medical and electronic records and found 17 had incomplete reviews of VTE assessments carried out. Nursing staff had raised this with the medical staff and it was found that some medical staff did not have passwords to access the electronic systems. This was raised with the senior management team during our inspection.
- Of the 21 records we looked at, 17 patients had not had their VTE assessment reviewed 24 hours after admission. The most outstanding assessment we saw was 31 days overdue. We raised the issue with ward staff and senior staff during the inspection. Audits of VTE assessments showed compliance decreased from 85% in November 2016 to 22% in December 2016. This coincided with the introduction of an electronic system for recording VTE assessments, rather than the original paper based assessment. There was also an issue as not all medical staff could access the electronic system. The trust were aware of the issues and had communicated the importance of reviewing VTE assessments to surgical staff. We also observed nurses reminding medical staff to complete VTE assessments on the new electronic system, but compliance had not improved. The trust responded to our concerns in a timely way by accelerating their progress with implementing the new electronic system, reviewing policies and protocols and having senior medical staff conduct spot audits.
- The national early warning score (NEWS) was used to identify deteriorating patients, in accordance with NICE clinical guidance Acutely ill adults in hospital: recognising and responding to deterioration, CG50, 2007. Staff used the NEWS to record routine physiological observations, such as blood pressure, temperature, heart rate and the monitoring of a patient's clinical condition. There were clear directions for actions to take when patients' scores increased, indicating a deterioration and members of staff were aware of these. We reviewed patients' notes and found NEWS charts were being used to record patients vital signs.
- The trust had an outreach team and a hospital at night team, who provided clinical support with deteriorating patients.

- There was 24-hour access to emergency surgery teams, including theatres and doctors. During the night, there was a senior house officer who covered the surgical wards, who was supported by a registrar and the on-call consultant for surgery.
- The trust had four different versions of the WHO 'Five Steps to Safer Surgery' checklist; these were speciality specific. We were concerned that there may be confusion on which form to use, therefore, we asked the trust for reassurance. The trust responded that this had been discussed at the joint anaesthetic and surgical governance meeting, with plans to review and update the documentation in line with national guidance. In addition, to avoid potential confusion, a colour coding mechanism to distinguish local and general anaesthetic checklists had been introduced.
- We saw audits of the WHO 'Five Steps to Safer Surgery' showed 95% compliance from January 2016 to December 2016. Observational audits were carried out and theatre managers audited each other's departments. Action plans included entering the patient's full name, date of operation and allergies on the white board for all staff to view.
- Patients for elective surgery attended a preoperative assessment clinic. Most patients were seen on the same day as their outpatient appointment, to prevent another visit. A full medical assessment and required tests were undertaken, for example, MRSA screening and any blood tests. If required, patients were reviewed by an anaesthetist and had a dedicated appointment.

Nursing staffing

- Nursing staff numbers, skill mix review and workforce indicators such as sickness and staff turnover, were assessed using an electronic rostering tool. The planned and actual staffing numbers were displayed on the wards visited. Staffing levels were appropriate to meet patients' needs during our inspection. Actual staffing levels met planned staffing levels in the areas we visited.
- The trust performed biannual staffing reviews for all wards, including the surgical wards, which included an acuity tool and professional judgement to identify the appropriate workforce to allocate nursing numbers.
- Vacancies rates for December 2016 were 7% in the surgical division. The trust reported that from February 2016 to January 2017, bank and agency usage was 10% within the surgical division. Turnover in the same period was 6% and staff sickness was 4%.
- Staff worked extra shifts and bank and agency staff were being used to cover nursing vacancies. Some agency staff were booked for blocks of shifts in advance. This assisted with safe staffing levels and continuity of care. We saw evidence that all new agency staff had an induction checklist completed, to ensure that they become familiar with the ward and theatre layout and processes.
- We observed two nursing handovers that were well structured, and used electronic information and paper records. The information discussed included patients going to theatre, appointments for investigations, patients being discharged, pain management, medication and Mental Capacity Act (MCA) assessments. The handovers occurred outside the bays, which ensured that patient privacy, dignity, and confidentiality were maintained.

Surgical staffing

- The trust reported 16% vacancy rates for medical staff within the surgical division. Locum staff had been used to cover shifts and these had been mainly block booked.
- We spoke with one locum middle grade doctor who had worked in the trust for six months. They told us they had a full induction, access to training and support from consultants when required.
- From March 2015 to March 2016, there were 6% of locum surgical doctors within trauma and orthopaedic. Between January 2016 and December 2016, the trust reported a sickness rate of 0.9% in surgical care and a staff turnover rate of 3%.
- In August 2016, the proportion of consultant staff and junior medical staff reported to be working at the trust was similar to the England average.
- Surgical consultants worked weekends and carried out ward rounds to ensure that there was provision of consultant led care and decision-making. There was consultant cover for emergencies 24 hours a day.
- There was a trauma and orthopaedic consultant on call seven days a week, to be available for any emergencies. There was a dedicated orthogeriatrician to support patients with a fractured neck of femur. Orthogeriatricians aimed to visit patients on the ward on the day of admission to assist with care planning.
- We observed the medical handover, which was well attended, consultant led and appropriate information was shared. For example, new admissions overnight,

patients waiting to be seen in the emergency department and patients of concern on the wards were discussed. The consultant discussed the workload and allocated actions.
- Medical handover ward rounds occurred daily on each ward. There was positive interaction between doctors and nursing staff.

Major incident awareness and training

- Staff were aware of the trust's major incident policy in place, relating to all departments within the trust, including surgical services. There were clear instructions for staff to follow in the event of a fire or other major incident. Arrangements were in place for loss of power.
- Some staff told us there had been fire evacuation exercises and were able to explain the actions to be taken in the event of a fire.

Are surgery services effective?

Good

We rated effective as good because:

- Patients generally received care according to NICE and Royal College of Surgeons' guidelines.
- Policies were relevant and provided evidence-based guidance, based on national standards, best practice, and legislation.
- In the 2016 Patient Reporting Outcomes Measures (PROMS), the hospital generally performed better than the England average apart from some mixed outcomes for hip and knee replacements.
- The hospital performed better than the England average in the 2015 Bowel Cancer Audit. The hospital performed in line with the England average in the National Emergency Laparotomy Audit 2016 and the 2015 National Vascular Registry.
- There were processes and procedures in place for staff to manage patients' pain and ensure that patients' nutrition and hydration needs were met.
- We saw effective multidisciplinary team working that delivered coordinated care to patients.
- Staff had the skills, knowledge, and experience to deliver effective care and treatment to patients.
- Staff had access to patient related information, when required.
- Consent was obtained in line with legislation and staff were clear about their roles and responsibilities around the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

However:

- The National Hip Fracture Database audit showed the risk-adjusted 30-day mortality rate fell within the expected range nationally, but the audit's other outcomes were worse than the national average.
- The trust had a higher than expected risk of readmission for elective and non-elective admissions.

Evidence-based care and treatment

- Policies were up to date and based on guidance from the National Institute for Health and Care Excellence (NICE) and other professional associations, such as the Association for Perioperative Practice (AfPP). For example, the hospital had systems in place to provide care in line with NICE clinical guideline (CG50) 'Acutely ill adults in hospital: recognising and responding to deterioration'. Local policies, such as infection control policies, were written in line with national guidelines. Staff we spoke with were aware of these policies and knew how to access them on the trust's intranet.
- The service had a robust clinical audit plan that included monitoring practice against guidelines to ensure compliance. Audits included surgical site infection, chronic wound care and environmental cleanliness.
- Assessments for patients were comprehensive, covering all health and social care needs (clinical needs, mental health, physical health, and nutrition and hydration needs). Patients' care and treatment was planned and delivered in line with evidence-based guidelines, for example, nutritional and hydration needs, falls assessments and consent.
- Venous thromboembolism (VTE) initial assessments were completed in line with NICE clinical guidelines (NICE CG92 Venous thromboembolism: reducing the risk for patients in hospital) but had not all been reviewed within 24 hours due to the transition problems from a paper based system to an electronic system in December 2016.
- Care bundles were used to improve the quality of care. A care bundle is a set of interventions that, when used together, significantly improve patient outcomes. They involve multidisciplinary teams working to deliver care

supported by evidence-based research and practices, with the ultimate outcome of improving patient care. For example, the service used the peripheral intravenous cannula care bundle and urinary catheter care bundle. Compliance with the care bundles was audited to monitor best practice. From November 2016 to January 2017, surgical wards achieved an average of 97% compliance with all elements in the cannula and catheter care bundles.

- Care pathways were used, which included risk assessments, such as risk of falls and mobility. Care pathways help patients to recover post-operatively; they are evidence based and focus on holistic patient assessments, pain relief, and the management of fluids and diet. For example, the enhanced recovery pathway was used on Rowan ward and the hip fracture pathway was used on Abington ward.
- The pre-operative assessment clinics assessed patients in accordance with NICE clinical guidance for someone due to have a planned (elective) surgical operation (NICE Preoperative tests for elective surgery, CG3,2003). For example, MRSA screening and blood tests were included.
- Emergency surgery was managed in accordance with National Confidential Enquiry into Patient Outcome and Death (NCEPOD) recommendations and national guidelines, including Royal College of Surgeons (RCS) standards for emergency surgery.
- Medical device implants were recorded on the National Joint Register to ensure outcomes for patients undergoing joint replacement surgery were monitored.
- Orthopaedic patients aged 65 or over were seen by consultant geriatricians, in line with guidance.

Pain relief

- Our observation of practice, review of records and discussions with patients confirmed that pain was assessed and managed appropriately.
- We observed staff asking patients if they were in pain and saw that pain relief was provided in a timely manner. All patients we spoke with felt their pain was managed effectively.
- Patient records showed that pain had been risk assessed using the National Early Warning Score (NEWS) and analgesia medication was given as prescribed. Pain management for individual patients was discussed at handovers as required.
- Pain relief was discussed at pre-assessment appointments and included reviews by anaesthetists where required. Patients booked for day case surgery were encouraged to bring their own analgesia, such as paracetamol, where appropriate. Staff could access pain relief for patients who had not brought their own.
- There was a dedicated pain team to support patients with epidurals who were being cared for on surgical wards. Staff could refer patients and contact the team for advice from 8am to 6pm, Monday to Friday. There was an on-call anaesthetist available if staff had any concerns at weekends or out of hours. The acute pain service was consultant-led, with the support from specialist pain nurses and healthcare assistants.
- Patient-controlled analgesia equipment was used where appropriate, so that patients were empowered to manage their own pain. Anaesthetists and specialist pain nurses conducted daily reviews of patients using the equipment to ensure their pain was being managed appropriately.
- The service monitored pain management on surgical wards as part of their nursing performance dashboard. From October to December 2016, they achieved over 98% compliance with meeting pain management standards.

Nutrition and hydration

- The hospital used the Malnutrition Universal Screening Tool (MUST) as a way of screening patients for risk of malnutrition. We looked at 21 patients' records and found that MUST assessments had been completed appropriately. Patients who had bowel surgery or those who were found to be at risk of malnutrition were referred to dietitians.
- Where applicable, patients' nutrition and hydration intake had been recorded. Staff used fluid balance charts and food diaries to monitor patients' intake. We saw that patients had jugs of water on their bedside tables within reach, to promote hydration. Care support staff checked that regular drinks were available where required. The care support staff assisted patients with menu choices and ensured dietary needs were met.
- Staff assessed patients who were complaining of nausea or vomiting and staff prescribed treatment as required. This was discussed at handover.
- Pre-operative fasting guidelines used for adults were aligned with the recommendations of the Royal College of Anaesthetists (RCOA), which states that patients can

have an intake of water up to two hours before induction of anaesthesia and a minimum pre-operative fasting time of six hours for food solids, milk, and milk-containing drinks. Staff advised us they would seek advice from the anaesthetist if patients had been fasting for long periods, depending on where they were on the theatre lists. These patients were offered fluid and light diet, if appropriate.

Patient outcomes

- The hospital participated in national audits to monitor patients' outcomes, such as the Hip Fracture Audit and the elective surgery Patient Reported Outcome Measures (PROMS) programme. Patient outcomes were variable.
- In the 2016 Hip Fracture Audit outcomes were:
  - The risk-adjusted 30-day mortality rate was 5.5% which fell within the expected range. The trust 2015 figure was 6.7%.
  - The proportion of patients having surgery on the day of or day after admission was 70.2%, which did not meet the national standard of 85%. The trust 2015 figure was 69.3%.
  - The perioperative medical assessment rate was 90.1%, which did not meet the national standard of 100%. The trust 2015 figure was 93.7%.
  - The proportion of patients not developing pressure ulcers was 89.4%, which falls in the worst 25% of trusts. The trust 2015 figure was 92%.
  - The length of stay was 24.8 days, which falls in the worst 25% of trusts. The trust 2015 figure was 21.4 days.
- The trust were reviewing the issues raised in the Hip Fracture Audit and had actions in place to improve. For example, they recognised that length of stay was affected when medically fit patients were waiting for rehabilitation or community beds. They were looking at improving processes for the discharge and transfer of these patients with the aim of reducing length of stay.
- From Hospital Episode Statistics data provided by the trust from March 2015 to February 2016, patients at the trust had a higher than expected risk of readmission for elective and non-elective admissions. General surgery had the highest relative risk of readmission.
- Patient Reported Outcome Measures (PROMs)assess the quality of care delivered to NHS patients from the patient perspective. Currently covering four clinical procedures, PROMs calculate the health gains after surgical treatment using pre- and post-operative surveys. The four procedures were:

- hip replacements
- knee replacements
- groin hernia
- varicose veins

- The PROMs from April 2015 to March 2016, showed:
  - Groin herniaindex, hip replacement index, hip replacement oxford hip score, Knee replacement oxford knee score, varicose vein –Aberdeen varicose vein questionnaire, varicose vein index indicators showed more patients' health improving and fewer patients' health worsening than the England averages. These were calculated using the standardised measurement tool for health status, EuroQol dimensions questionnaires (EQ VAS, EQ 5D).
  - Hip replacement EQ VAS and Knee replacement EQ VAS indicators showed fewer patients' health improving and more patients' health worsening than the England averages.
  - Knee replacement EQ – 5D index, knee replacement – oxford knee score and hip replacement oxford hip score were in line with the England averages.
- In the 2015 Bowel Cancer Audit, 70% of patients undergoing a major resection had a post-operative length of stay greater than five days. This was better than the England aggregate. The service performed within the expected range for:
  - The risk-adjusted 90-day post-operative mortality rate was 2.7% which was within the expected range. The 2014 figure was 4.6%.
  - The risk-adjusted 2-year post-operative mortality rate was 17.5% which falls within the expected range. The 2014 figure was 33.5%.
  - The risk-adjusted 90-day unplanned readmission rate was 18.2% which falls within the expected range. The 2014 figure was 21.3%.
  - The risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major resection was 57% which falls within the expected range. The 2014 figure was 58%.
- In the 2015 National Vascular Registry (NVR) audit, the hospital achieved within the expected range for post-operative mortality rate of abdominal aortic aneurysms and 30-day mortality and stroke rate. An

abdominal aortic aneurysm is a swelling of the main blood vessel that leads away from the heart to the rest of the body. The median time from symptom to carotid endarterectomy surgery was 14 days, which was equal to the England national standard. A carotid endarterectomy is a surgical procedure to unblock a carotid artery, which is a blood vessel that supplies the head and neck.

- In the 2016 Oesophago-Gastric Cancer National Audit (OGCNCA), the hospital performed better than the England national average for the proportion of patients diagnosed after emergency admission and patients treated with curative intent. Curative intent refers to health care practices that treat patients with the intent of curing them, for example, by chemotherapy. The age and sex adjusted proportion of patients diagnosed after an emergency admission was 19%. This placed the trust within the highest 25% of all trusts for this measure. The 90-day post-operative mortality rate for these treatments was not available at this trust, as the trust did not report this data.
- The 2016 National Emergency Laparotomy Audit (NELA) results were red, amber and green (RAG) rated. Red was below 85%, amber between 85-94% and green between 95-100%.
  - The hospital achieved a green rating for pre-operative documentation of risk of death. This was based on 199 cases.
  - The hospital achieved a green rating for access to theatres within clinically appropriate periods. This was based on 136 cases.
  - The hospital achieved a green rating for high-risk cases with a consultant surgeon and anaesthetist present in the theatre. This was based on 113 cases.
  - The hospital achieved a green rating for highest-risk cases admitted to critical care post-operatively. This was based on 76 cases.
  - The risk-adjusted 30-day mortality rate for the hospital was within expectations, based on 199 cases.
- The surgical service used a nursing performance dashboard that included clinical quality indicators such as compliance with falls assessments, documentation audits, complaints, and patient experience scores. Results were reported by ward so that performance could be monitored and reviewed at a local level. Areas of variable or poor performance were discussed at trust board and divisional meetings and actions were taken to improve.
- The trust reported consultant-specific data as part of the 'Everyone Counts' NHS England programme that is aimed at enabling members of the public to access information about outcomes after surgery. There were seven specialties that were included in the programme, such as vascular, colorectal, and urological surgery. The consultant outcomes reported were all within the expected range.

Competent staff

- Staff had the skills, knowledge, and experience to deliver effective care and treatment to patients.
- There was an induction programme for all staff that included orientation to the wards and training such as fire safety, infection control, and manual handling. There was also a surgical induction programme for all staff, which involved study sessions on preparing patients for theatre and preventing surgical site infections.
- Newly qualified nursing staff were supported through a preceptorship programme, which offered role specific training and support, including ward-based competencies.
- Nursing staff (both agency and permanent) felt adequately trained within their departments. Agency nurses on Abington ward had undergone training in administering intravenous drugs, to ensure they were competent to do so. There were monthly and quarterly clinical supervision programmes and nurses we spoke with felt supported through revalidation.
- All registered nurses and professional staff that worked in the wards and theatres had valid registrations. This confirmed that nurses, doctors and other practitioners, such as physiotherapists, were trained and eligible to practise within the UK. The electronic rostering system prompted managers when staff members' revalidation was required. There was a process in place to check registrations were renewed. If staff had not completed their revalidation in time, they would not be able to work as a registered practitioner and their pay would reflect this. There were workshops available to support nursing staff with their revalidation.
- Surgical nurses were given the opportunity to develop. For example, nurses were offered the opportunity to

become link nurses for particular specialties. This involved developing their expertise in a topic such as safeguarding, falls, blood transfusion, stoma care, and nutrition. Link nurses were responsible for communicating information and sharing best practice in their specialty to surgical staff.

- Practice development nurses had set up sessions for surgical nurses to gain competencies in caring for medical patients. This was to enable them to provide higher quality care to medical outliers on surgical wards and included acute illness management. A medical outlier is a patient who requires medical care but is being cared for on another specialty ward, for example surgery, due to lack of medical beds.
- Junior doctors within surgery each had an appointed clinical supervisor and specific personal development plans that they felt enhanced their training opportunities. They told us they felt supported and the consultants were accessible, approachable, and available when required.
- Role specific training for the surgical division was 80% in December 2016. This was below the trust target of 85%. This had improved by the time of their inspection and they were meeting the trust target.
- Staff received annual appraisals to identify any training needs. In February 2017, 82% of all staff in the surgical department had received an annual appraisal.
- Surgeons' appraisal rate at the time of inspection was 75%, in line with the hospital's trajectory plan for the year.
- All staff we spoke with had received their appraisal or had it scheduled for the current year.
- Surgical wards were part of the 'PL@N: Practice Learning @ Northampton General Hospital' scheme for student nurses, which had run since May 2016. In addition to a qualified mentor, student nurses were allocated a registered nurse who acted as a coach to help them develop their practice. Students were coached as they delivered care and had education sessions away from the ward. Students we spoke with were extremely positive about the scheme and felt their skills had greatly improved as a result.

Multidisciplinary working

- Our observation of practice, review of records and discussion with staff confirmed effective multidisciplinary team working to deliver coordinated patient care.
- All relevant staff, teams and services were involved in assessing, planning and delivering care and treatment. Staff worked collaboratively to understand and meet the range and complexity of peoples' needs. For example, multidisciplinary meetings included physiotherapists and occupational therapists.
- Patient care on surgical wards was supported by teams from a variety of disciplines, including physiotherapists, dietitians, a pain team, and pharmacists. There were ward-based physiotherapy staff on wards such as Althorp, Abington, and Rowan. We observed a positive working relationship between ward staff, doctors, and therapists.
- Staff described the multidisciplinary team as being supportive of each other. Therapists told us they felt supported and that their contribution to overall patient care was valued.
- There was daily communication between discharge co-ordinators, nurses and therapists, so that discharges were planned and delivered effectively.
- Staff could access the learning disability lead, critical care outreach team, pain management team, social workers, and safeguarding teams for advice and support.
- Staff worked with the critical care outreach team and hospital at night team to provide clinical support for deteriorating patients. There was an escalation policy for patients who required immediate review, for example, those with sepsis.
- Staff communicated with community health teams where necessary, for example, when discharging older patients with complex needs. Discharge letters were sent that included information from risk assessments, such as skin pressure damage.
- Pre-assessment staff communicated with ward staff and therapists to pass on information from pre-assessment appointments, for example discharge planning. Patient records showed that discharge planning commenced at pre-assessment and included questions on any walking or mobility aids used, the patient's living arrangements and any care they received. This meant staff were informed as to what arrangements would need to be in place for discharge.
- Nurses could contact medical staff to provide support and assess surgical patients' needs where necessary. All staff we spoke with said that medical staff were accessible and attended to calls promptly.

Surgery

Seven-day services

- Consultants conducted daily ward rounds seven days a week. On weekdays, this included physiotherapists and occupational therapists where appropriate. At weekends, on-call consultants saw all new patients and were available to provide advice and information out of hours.
- The service did not provide full seven-day services for dietetics or speech and language therapy. Access to physiotherapy and occupational therapy at weekends and out of hours was available for high-risk patients and those who had already been referred.
- The surgical division had identified that they were not meeting standards for providing seven-day services in 2016: for example, they had not met the standard for 90% of inpatients being seen within 14 hours of arrival at hospital. We saw an action plan to improve this, which included recruiting consultants within surgery and radiology.
- Pharmacy support was available seven days a week; their hours were 10am to 4pm on Saturdays and 1pm to 4pm on Sundays. Staff could access medications out of hours by contacting an on-call senior nurse.
- Theatres, anaesthetics, and recovery had staff on duty out of hours and at weekends to cover emergencies. There was emergency access to 24-hour interventional radiology.
- There was emergency access to all key diagnostic services 24 hours a day, seven days a week to support clinical decision-making.

Access to information

- There were computers throughout the individual ward areas for staff to access patient information including test results, diagnostics, and records systems. Staff were able to demonstrate how they accessed information on the trust's electronic system.
- There were arrangements to ensure staff had all the necessary information to deliver effective care. For example, risk assessments, physiotherapy notes, and dietetics referrals were included in patient notes. This meant staff, including agency and locum staff, had access to patient-related information and records when required.
- Staff used standardised documents for handover between shifts to ensure all relevant information was passed on to the clinicians who were taking over. The document included reason for admission, any allergies, nutritional scores, falls risks, and anything that had been escalated during the previous shift. Handover also included patients' care needs after discharge and their home life situation, to ensure discharges could be planned appropriately.
- Summary letters were sent to patients' GPs at the time of discharge via an electronic system that GPs could access. Discharge letters included details of the treatment provided, follow up arrangements and all medicines provided on the day of discharge. Pharmacists also sent details of any medication changes to local chemists.
- Patients were given a copy of the discharge letter that was sent to the GP and relevant information leaflets, such as post-operative care.
- The service used a combination of paper-based and electronic systems for recording patient information. For example, blood pressure, temperature, and nutrition scores were recorded on the electronic system. All nurses had secure log in details and could access the electronic system. Some medical staff told us that they did not have log in details for the system; the trust had recognised that this was an issue in relation to recording VTE assessments and were working towards all medical staff having access to the system.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff understood the guidance and legislation relevant to consent and informed decision-making. Patients were supported to make decisions as required by legislation and guidance, including the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS).
- The trust's consent policy outlined staff responsibilities when obtaining consent. Staff showed us how they access the policy on the trust's electronic system. The policy was in date and reflected legislation and guidance.
- In Feb 2017, 87% of staff in the surgical division had received training in MCA 2005 and DoLS. This was above the trust target of 85%.
- The hospital used four nationally recognised consent forms. For example, there was a consent form for consenting adult patients, another for patients who were not able to give consent for their operation or

procedure, one for children and another for procedures under a local anaesthetic. Staff we spoke with were aware of the consent forms and knew when each should be used.

- We reviewed 21 sets of notes. All consent forms we saw were completed appropriately; they contained details of the operation or procedure and any associated risks. Patients were able to have a copy if they wished.
- There were no consent forms available in other languages; however, interpreter services were available over the phone or in person. Staff we spoke with described examples of when they had used an interpreter to ensure patients whose first language was not English fully understood what they were consenting to.
- The consent process commenced in outpatient appointments. Consent was discussed again once patients were admitted for surgery.
- Where a formal mental capacity assessment was required, nurses sought advice from senior nurses or medical staff, to ensure the assessments were carried out in line with legislation.
- We reviewed seven sets of notes for patients who were being cared for under MCA and DoLS. All decisions were recorded and assessments were in date and completed appropriately.
- One patient had an Independent Mental Capacity Advocacy (IMCA). This provided independent safeguards for people who lack capacity to make certain decisions and have nobody, such as friends and family, with who it is appropriate to consult regarding those decisions. We saw documentation that the IMCA had been consulted and involved in making decisions about the patients care, in line with the Mental Capacity Act 2005.
- The trust conducted audits of consent to monitor compliance with legislation and guidance. Results were presented at clinical governance meetings and there were action plans to improve. For example, an audit of consent obtained for patients having peripherally inserted central catheter (PICC) lines showed that 88% of patient notes contained evidence of appropriate consent. The consent process for a PICC line insertion should involve the doctor who advises the insertion and the clinician who inserts the line, as well as the patients themselves. PICC lines allow intravenous medicines to be given and can remain in place over the course of an inpatient's treatment. Following the audit, results and the importance of gaining appropriate consent were communicated to surgical teams.

Are surgery services caring?

Good

We rated caring as good because:

- Staff treated patients with compassion, kindness, dignity, and respect.
- Feedback from patients and their families was positive about the way staff treated them.
- Care and treatment was explained in ways patients and relatives could understand and patients were encouraged to make their own decisions.
- Staff were aware of the need for emotional support for patients and we observed caring interactions throughout the department.
- Patients were encouraged to be as independent and mobile as possible following their surgery.
- The surgical department were in line with the England average in the NHS Friends and Family Test from October 2016 to December 2016. Response rates were above the England average.

Compassionate care

- Throughout our inspection, we saw patients were treated with compassion, kindness, dignity, and respect. Staff respected patients' social, cultural, and religious needs.
- We observed positive interactions between staff, patients, and relatives. Staff introduced themselves and took time to interact in a considerate and sensitive manner.
- Staff respected patients' privacy and dignity. For example, they drew curtains around patients when delivering personal care.
- We spoke with 13 patients in the surgical department. They spoke positively about the way staff treated them. Examples of their comments included, 'staff are caring and understanding' and 'my modesty and dignity is protected'.

- We observed nurses, healthcare assistants and physiotherapists assisting patients to mobilise with walking aids after their operations. The interactions were respectful and compassionate.
- Staff we spoke with said they tried to make patients feel as normal as possible after surgery. For example, on Abington ward, staff followed a hip fracture care pathway that included encouraging patients to eat and drink orally and sit out of bed for meals. This promoted a normal routine for post-operative patients.
- We observed call bells being answered promptly on wards and patients told us staff responded to them in a timely way.
- The surgical division scored in line with the England average in the NHS Friends and Family Test from October 2016 to December 2016. The NHS Friends and Family Test asked people if they would recommend hospital services. Positive recommendation results were at 95% in December 2016. Response rates were also above the England average; 35% of eligible patients responded in December 2016, compared to the England average of 23%.
- The service also gathered feedback through a local patient experience survey. We saw actions to improve areas that received low scores. For example, patient experience results were poor for the level of noise at night on Willow Ward in October 2016. As a result, staff were encouraged to give patients sleep kits that included an eye mask and ear plugs. This was shared between wards and discussed at staff huddle meetings. During our inspection, one patient mentioned to a nurse that they had not slept well due to noises on the ward. The nurse promptly brought the patient a sleep kit for the following night.
- Wards we visited had thank you cards from patients. Comments included that staff were 'kind and caring', gave 'amazing care' and 'took time to explain all that was going on'.

Understanding and involvement of patients and those close to them

- Staff communicated with patients and families in ways they could understand and patients felt they had been encouraged to make their own decisions. We observed nurses and medical staff answering patients and relatives' questions about their care.
- Staff recognised when patients may need additional support to understand and be involved in their care, for example those requiring an interpreter or a mental capacity advocate. Staff could give examples of when they had used face-to-face and telephone interpreters to ensure patients fully understood their treatment.
- We observed a nurse making a telephone call to a patient's relative in the morning to update them on how their relative had been over night. The conversation was respectful and compassionate.
- For patients with complex needs, staff contacted relatives to let them know what time the patient would be ready for discharge. Relatives of patients on the Manfield day surgery unit were offered a direct telephone line to the department so that they could call with any questions.

Emotional support

- Staff throughout the service understood the need for emotional support. We spoke with patients and relatives who all felt that their emotional wellbeing was cared for. We observed staff reassuring a patient who was anxious about their treatment.
- Staff showed an awareness of patients' mental health needs and referred patients for specialist support if required.
- Clinical nurse specialists, such as stoma care nurses, provided emotional support and advice to patients and those close to them. Patients received specialist support when coming to terms with adaptions in their everyday lives and were encouraged to manage their own health.
- Staff had access to an on call chaplain and other spiritual advisors could be arranged to meet patients' needs.

Are surgery services responsive?

Good

We rated responsive as good because:

- Service planning met the needs of the local people and the community.
- Between January 2016 and December 2016, the hospital's referral to treatment time (RTT) for admitted pathways for surgical services was about the same as the England overall performance.
- From October 2015 to September 2016, the number of patients whose operation was cancelled on the day of surgery was 4%, below the England average of 8%.

- The average length of stay was similar to the England average.
- The complaints system was effective.
- Access and discharge arrangements were effective and timely.
- There was support for people with a learning disability, and reasonable adjustments were made to the service provided. Arrangements were in place to support patients living with a dementia. An interpreting service was available and used.

However:

- Not all staff were aware how to access information leaflets or consent forms available in languages other than English.

Service planning and delivery to meet the needs of local people

- The service understood the different needs of the people it served and acted on these to plan, design and deliver services.
- The service planned and delivered services in a way that ensured there was a range of appropriate provision to meet needs. This included supporting people to access and receive care as close to their home as possible and wherever possible provided accommodation that was gender specific. They also ensured the environment and facilities were appropriate and required levels of equipment were available promptly.
- The needs of the local population had been identified and taken into account when planning services.
- The ophthalmology department was working on integrating their services with community providers, to improve care for patients on their elective pathways.
- Drop in pre-operative assessment appointments were available to enable patients to be seen on the same day and prevent another visit to the hospital.

Access and flow

- Between January 2016 and December 2016, the hospital's referral to treatment time (RTT) for admitted pathways for surgical services was about the same as the England overall performance.
- Between January 2016 and December 2016, the trust's referral to treatment time (RTT) for admitted pathways for surgical services had been about the same as the England overall performance. The trust performed just below the England average in the period from March 2016 to October 2016, after which it had improved to just above the national average. The latest figures for December 2016 showed 74.3% of this group of patients were treated within 18 weeks which was slightly better than the England average of 73.4%.
- General surgery, plastic surgery, oral surgery, urology and ear nose and throat surgery were all similar or better than the England average.
- Ophthalmology RTT performance was 73.4%, which was below the England average of 77.8%. Trauma and orthopaedics surgery RTT performance was 46.4%, below the England average of 65.9%.
- There were 300 patients in trauma and orthopaedics waiting over 18 weeks and 180 patients in ophthalmology waiting over 18 weeks for surgery. There were no patients waiting over 52 weeks. The trust had a contract with a local independent hospital to carry out some surgical procedures to reduce the waiting times.
- From April 2015 to March 2016, the average length of stay for surgical elective patients was 2.7 days, compared to 3.3 days for the England average. For surgical non-elective patients, the average length of stay was 5.5 days, compared to 5.1 for the England average.
- A last-minute cancellation is a cancellation for non-clinical reasons on the day the patient was due to arrive, after they have arrived in hospital or on the day of their operation. If a patient has not been treated within 28 days of a last-minute cancellation then this is recorded as a breach of the standard and the patient should be offered treatment at the time and hospital of their choice. For the period January 2014 to September 2016, the hospital cancelled 1,625 operations. Of the 1,625 cancellations, 3.1% weren't treated within 28 days with a marked rise in January to March 2016 to 7.7%, although this mirrored the England average and the junior doctor strikes were likely a contributing factor during this period.
- The hospital's proportion of cancelled operations as a percentage of elective admissions for the period January 2014 to September 2016 was greater than the England average, with a trend of worsening performance. In the quarter October to December 2016, the hospital reported just over 2% of cancelled operations as a percentage of elective admissions, worse than the England average of around 1%.

Surgery

- From October 2015 to September 2016, the number of patients whose operation was cancelled on the day of surgery, mainly due to lack of beds, was 863 and 34 were not rebooked to be treated within 28 days. This represents 4% of cancelled operations not being treated within 28 days, which was lower than the England average for the same period at 8%.
- From July 2016 to December 2016, nine patients were nursed in recovery overnight. This was mainly due to bed pressures. Root cause analysis and incidents forms were completed for all cases.
- An on call theatre team facilitated emergency surgery. Consultants in each speciality were on call at night and weekends and therefore, could facilitate emergency procedures if necessary.
- Theatre utilisation was monitored and reviewed at monthly performance meetings. The average theatre utilisation at the time of inspection was 76%. Improving the theatre utilisation was part of the surgical business plan for 2016/17.
- During our inspection, 12 additional beds were opened on the Mansfield day surgery unit for inpatients due to bed pressures. We found the ward was adequately staffed with the day case staff. The ward was fully functioning with medication, catering facilities and support services.
- In the Manfield day surgery unit, part of the recovery area was being used to admit and prepare patients for surgery, as the day case unit was being used for inpatient beds. The consultant and anaesthetist saw patients prior to their operation. Patients had staggered admissions to prevent long waits and to assist with the flow through the department. Patients were kept up to date on waiting times and patients waiting for long periods were offered water if appropriate.
- Some patients were discharged directly from recovery and we saw staff discussing discharge arrangements with patients.
- The hospital had a nurse led pre-operative assessment clinic. All patients had a pre-operative assessment, which included for example, testing for MRSA.

Meeting people's individual needs

- Surgical services were planned to take into account the individual needs of patients.
- Patients who attended the pre-operative assessment clinic were given information leaflets regarding anaesthetic, preventing thrombosis, wound care, pain management and fasting instructions. However, these information leaflets were not available in other languages.
- Patients were also offered advice on smoking cessation, alcohol intake and dietary advice, if required during the preoperative assessment.
- Staff told us they had access to translation services in person or via the telephone system.
- Theatre staff arranged for carers to accompany the patient to theatre where they had specific needs, such as a learning or sensory disability. Staff told us of one occasion were a patient with a learning disability required more than one procedure by different consultants and these were both done at the same time, to prevent the patient returning to the hospital.
- The trust had a named dementia lead and learning disability lead. Staff confirmed they were able to readily access these staff to discuss any concerns and to receive advice.
- The 'butterfly' scheme was used to discreetly identify patients living with dementia. The use of the symbol enabled staff to identify patients who had a dementia diagnosis and ensure additional care and support were available.
- The surgical department took part in 'John's Campaign' for patients living with dementia. John's Campaign promotes hospitals to allow carers of patients living with dementia to stay with them in hospital, particularly during meal times as eating and drinking can be difficult for some of these patients when in hospital. Staff provided carers with food so that they could eat with their relative and felt that it had a positive effect on the patients' wellbeing.
- The service was in the process of implementing a new 'What is my plan?' document for patients to complete. The document included the name of the patient's consultant, nurse and ward manager. It prompted patients to ask questions on what was going to happen to them, including any multidisciplinary input, and when they could expect to go home. Staff we spoke with were positive about this new document and felt it would improve patient experience as they had a complaint theme around communication at discharge.
- Staff and patients reported they did not have mixed gender bays on surgical wards. We did not observe any mixed gender bays during our inspection.

- We observed a breakfast and lunchtime on Rowan ward; staff ensured patients were comfortable and could reach their meal trays. There was a breakfast room on Abington Ward to promote a normal routine for patients and encourage them to get out of bed for meals.
- There were processes in place to identify and support patients that needed assistance with eating and drinking. For example, wards used the red tray system where food was served on red trays for patients who may require assistance with their meals. Finger foods and snack boxes were available for patients living with dementia. This was to enable independent eating and maintain dignity, as using cutlery can be difficult for people living with dementia.
- Patients were given choices of meals, which included gluten-free and halal options. If patients were hungry outside of protected meal times, there was an out of hours catering service for light meals and snacks.
- Staff were available to help serve food and assist those patients who needed help. We observed positive interaction between staff and patients to encourage patients to eat their meals.
- There was a prayer room for use by patients and their families.

Learning from complaints and concerns

- Reported complaints were handled in line with the trust's policy. Staff directed patients and relatives to the Patient Advice and Liaison Service (PALS) if they were unable to deal with their concerns directly.
- Information was available in the main hospital areas on how patients could make a complaint. The PALS provided support to patients and relatives who wished to make a complaint.
- The ward sisters received all the complaints relevant to their service and gave feedback to staff at ward team meetings regarding complaints in which they were involved.
- Staff we spoke with managed verbal complaints and were aware of the need to escalate complaints that they were not able to resolve. Staff told us these complaints were dealt with as soon as they occurred, by either the ward sister or matron.
- Written complaints were managed by the matron and at directorate level. A full investigation was carried out and a written response provided to patients. Some staff told us that outcomes, lessons learnt and actions were not always fully cascaded to the staff within the wards or theatres.
- Notice boards on the wards included 'You said' 'We did', in response to patient comments. For example on some wards, such as Willow and Hawthorn wards, patients had complained about the noise level at night. As a result, a sleep well pack was given to patients who had difficulty sleeping at night, which included earplugs and an eye mask.
- In the past year prior to the inspection, there had been 141 complaints; complaints were discussed at the surgical quality governance meetings. The main themes were delays, care and treatment and cancellations. Seventy percent had been investigated within 25 days in accordance with the hospital's policy. Actions taken included discussion of themes at staff huddle ward meetings, and weekly audits of notes.

Are surgery services well-led?

Good

We rated well-led as good because:

- The senior surgical management team had a clear vision in place to deliver good quality services and care to patients. The surgical directorate and division had a strategy in place with clear objectives.
- The service had regular divisional board meetings with representation from all areas of surgery including consultants, matrons, and theatre managers. Matrons and ward sisters also had meetings to discuss quality indicators, such as staffing levels, patients' safety concerns and bed occupancy.
- We saw strong leadership, commitment and support from the senior team within the surgical division.
- There were comprehensive risk registers for all surgical areas, which included all known areas of risk identified in surgical services.
- The culture of learning from incidents was promoted amongst staff, and they told us they were encouraged to report incidents.
- A number of staff we spoke with had been working at the trust for over 10 years and said it was a good place to work.

However:

- Most staff we spoke with were unaware of the national audits, such as PROMs and hip fractures database undertaken by the trust and information on outcomes was not shared with all staff groups.

Leadership of service

- There was a divisional director, divisional manager and an associate director of nursing who lead the surgical services division. We met the management team; they were dedicated to their roles and responsibilities.
- Each ward and theatre had a manager who provided day to day leadership to staff members. There were matrons for the different surgical specialities who staff found to be responsive and supportive. Matrons kept staff informed of trust wide developments through ward manager meetings and provided guidance where required.
- We saw strong leadership, commitment and support from the ward managers and theatre managers. The local management teams were responsive, accessible and available to support staff.
- Junior surgical doctors reported consultant surgeons to be supportive. Junior doctors told us they felt well supervised by consultants.
- The nursing team, diagnostic team, physiotherapy team and administration team communicated well together and supported each other.
- Staff were aware of the chief executive officer (CEO) and the director of nursing, midwifery and patient services and told us they were very approachable. Staff reported the director of nursing, midwifery and patient services would often visit the wards at the weekend when she was on call.

Vision and strategy for this service

- The trust's vision was to provide the best possible care for all their patients; most staff were familiar with this. Staff had an understanding of the trust's vision and were able to briefly discuss what this meant.
- We saw a trust operational plan for 2016/17, which had identified areas within the surgical division as priorities. This included delivering excellence in the care of the elective patient, focusing on dedicated orthopaedic and ophthalmology services to increase quality, reduce clinical variation and provide centres of excellence in the county.
- We saw a surgical division annual plan for 2016/17, which included strategic priorities such as availability of beds and recruitment. Action plans included redesigning job plans to maximise use of theatres, improving theatre utilisation and improving communication, morale and training of staff. Senior staff were aware of these action plans.

Governance, risk management and quality measurement

- The trust had a clear surgical services divisional framework for governance arrangements. Ward managers attended divisional meetings, which enabled the sharing of information across specialities.
- Surgical services had regular surgical divisional quality governance meetings with management representation from surgical areas including consultants, matrons, and directorate managers. We saw minutes of meetings where quality issues such as complaints, incidents and audits were discussed.
- Each specialty within surgery held its own clinical governance meetings. We reviewed minutes of these which included incidents, complaints, audits, policy updates and training. These meetings that were well attended by members of the multidisciplinary team and minutes were available for those that could not attend.
- The department managers held team meetings within specific wards and theatres to cascade information. Most departments had daily staff huddles at handover to share information such as recent incidents, complaints, new policies and any relevant updates.
- The trust had completed local and national audits. For example, environmental audits were conducted and compliance with the World Health Organisation 'Five Steps to Safer Surgery' checklist was monitored in line with the trust's policy and national standards. However most staff we spoke with were unaware of the national audits, such as Patient Reporting Outcomes Measures (PROMs) and hip fractures database, undertaken by the trust and information on outcomes was not shared with all staff groups.
- The trust had systems in place to identify risks. The surgical division held its own risk register and clinical leads we spoke with were able to identify the top risks. Each risk has an assigned owner and a review date. Risks included inability to achieve 18 week RTT due to

Manfield day surgery unit being used as an escalation area and surgical beds being used for medical patients: control measures included daily monitoring, and outsourcing surgical patients to another provider.
- Delayed discharges control measures included daily ward rounds to include multi-agency staff and a review by the discharge team. Staff training control measures included training cluster days, sharing of information at team meetings and governance meetings.
- In surgery, the service worked with the trust Improving Quality and Efficiency (IQE) team on a number of projects project relating to patient safety. Examples included projects to reduce pre-operative waiting times, Who checklist safer surgery project, optimising patients' fitness for surgery, nurse led oral hygiene clinics, improving surgical staff handovers, and to improve elective theatre use efficiency. These projects were some examples of the joint working between the IQE, trust Quality Improvement team and surgical care team to further support the safety improvements made by the service'

Culture within the service

- Staff were enthusiastic about working for the trust and how they were treated by them as a whole. They also felt respected and valued.
- We spoke with a number of staff who had worked for the trust for over 10 years and all said they felt part of the team and enjoyed working at the hospital. Staff were proud to work for the trust.
- Across all wards and theatres, staff consistently told us of their commitment to provide safe and caring services, and spoke positively about the care they delivered. There were high numbers of medical patients on the surgical wards; staff were positive about caring for these patients and had attended specific training to gain skills to care for medical patients.
- Most staff felt listened to and involved in changes within the trust; many staff spoke of involvement in staff meetings.
- Senior managers said they were well supported and there was effective communication with the executive team. There was a culture of openness and transparency.

Public engagement

- The trust and staff recognised the importance of the views of patients and the public. They used surveys and questionnaires to gather information to enable service improvement.
- Information on patient experience was reported alongside other performance data. This information was used to make informed decisions about the service. Examples included implementing individual bedside televisions and radios on the wards for inpatients.

Staff engagement

- Staff were encouraged to share their views at their team meetings.
- All staff we spoke with were focused on and committed to providing a high standard of safe care and were proud of the services that they provided.
- Staff in all surgical areas focussed on improving the quality of care for patients by ensuring they had all the information available to provide safe care.
- Staff felt that their efforts to improve the quality of care for patients were recognised by both the patient and the trust team, who acknowledged the positive practice the team had contributed regarding the quality of care to patients.
- There was general agreement from management and staff in the wards and theatres that recruitment and retention of nursing staff was seen as a priority by the trust.
- Senior managers we spoke with said they felt well supported and there was effective communication with other managers and the executive team.

Innovation, improvement and sustainability

- The team safety "huddle' meeting, had been introduced within the hospital to improve communication across departments. This appeared to have been positively received by staff from different departments and disciplines.
- The surgical division had a strategy to improve theatre utilisation and ensure surgical beds were used for surgical patients.
- Some wards and teams at the hospital had been nominated and awarded local and national awards. The preoperative assessment team had been awarded a service improvement award in 2016 for improving patient flow and reducing waiting times.

Surgery

- Rowan ward was shortlisted for a Nursing Times award for outstanding student placement and some band 7 nurses had been shortlisted for the East Midlands leadership awards.

End of life care

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

Information about the service

Northampton General Hospital NHS Trust (NGH) is an 800-bedded acute trust. The trust has 619 beds on the main site.

An end of life care register was developed by the hospital following the CQC inspection in 2014. The aim of the register is to identify patients, who are thought to be imminently dying, ensuring they are screened by the specialist palliative care team and an appropriate plan is put in place to support wards in the delivery of high quality patient centred care.

The hospital reported 1,310 in-hospital deaths from 1 October 2015 to 30 September 2016. The trust has a palliative care-coding rate for 2016/17 of 3.50%, which now approximates closely to the national rate of 3.51%.

The specialist palliative care team (SPCT) received 638 referrals for the year April 2015 to March 2016. In line with national trends, there was an increase in non-cancer referrals, which made up approximately 34%.

The SPCT supports patients, giving advice on symptoms such as pain control, sickness, and poor appetite. The team also offers emotional and psychological support, and helps families and carers in all settings. There is one lead end of life care lead and 4.6 whole time equivalent (WTE) clinical nurse specialists (CNS) in palliative care, based at NGH. The service has one consultant who provides one WTE. The SPCT nursing team provide a Monday to Sunday, 9am to 5pm, face–to-face palliative care service at NGH. There is a CNS on duty at NGH on a Saturday and two CNSs are on duty every Sunday to see inpatients with complex needs and any urgent new referrals.

The trust employs two WTE chaplains who provide chaplaincy support to the trust. The chaplains provide an on-call service, which can be accessed 24 hours a day seven days a week. The chaplains have the support of approximately twelve volunteers who cover all denominations. The hospital has a chapel, which can be used by members of other faiths. The chaplaincy team has access to contacts in the community for support for other religions. In addition to the chaplaincy team, the bereavement office provides support to relatives after a loved one's death.

There are three full-time mortuary staff, one mortuary manager, and two anatomical pathology technologists (ATP). The mortuary is staffed by the APTs from 8.30am to 4.30pm, Monday to Friday, and Saturdays between 8am and 12 noon. Out of these hours, the mortuary is accessed by the senior operational team. The viewing area and access for relatives is open seven days a week.

We carried out an announced focused inspection on 7, 8 and 9 February 2017. We visited all areas where inpatient end of life care was provided, including the wards, the mortuary, and viewing room, the bereavement office and the chapel.

During our inspection, we spoke with two patients and two relatives. We also spoke with 39 members of staff, including the palliative care team, mortuary staff, chaplaincy, nursing staff, medical staff, a resuscitation officer, a porter, an

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operations manager and patient affairs staff. We observed care and treatment, and looked at 33 care records and 'do not attempt cardio-pulmonary resuscitation' (DNACPR) forms. We received comments from patients and we reviewed the trust's performance data.

Summary of findings

We rated the service as good for safety, caring, responsive and well-led. We rated effectiveness as requires improvement. We found that:

- The service had appropriate systems in place to recognise and minimise patient risk. Learning from incidents had been shared and implemented within the service.
- Appropriate equipment was available to meet patient needs, such as syringe drivers and pressure relieving equipment.
- There were appropriate arrangements in place to safeguard adults and children from abuse and to recognise and manage patients whose condition was deteriorating.
- Arrangements for handling medicines were appropriate. Patients' individual care records were accurate, complete, legible and up to date.
- Nurse staffing levels met patients' needs at the time of the inspection. There was sufficient consultant provision in palliative care at the hospital at the time of the inspection.
- A care planning tool to replace the Liverpool Care Pathway had been implemented and was embedded across all wards in the hospital
- Patient outcomes were mixed and the service had produced a detailed action plan to address the shortfalls and issues raised by the national care of the dying audit of hospitals (NCDAH) 2014 to 2015. Local audits were in place to measure the effectiveness and outcomes of the service.
- Staff were competent in their roles and supported by effective processes for ongoing professional development.
- Appropriate systems were in place to assess and manage patients' pain relief needs and patients' dietary and hydration needs were being met
- Multidisciplinary working was effective. The service was provided seven days a week.
- Patients were supported and treated with dignity and respect. Patients and those close to them were very happy with the care that had been provided to them.
- Patients had timely access to initial assessment, with 97% of patients referred to the palliative care team

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seen within 24 hours, between February 2016 and January 2017. The service was able to meet the needs of patients with vulnerabilities and from different cultures and backgrounds.

- The hospital did not have a commissioned formal 24 hour 'rapid discharge' service. However, the SPCT worked with a local end of life care discharge service, the Macmillan Social Care Co-coordinator, primary care teams, local hospices as well as a local Community Hospital (Daventry) to meet patient preferences regarding place of care and place of death where possible. This supported patients to be discharged at an appropriate time and when all necessary care arrangements were in place.
- Leadership of the SPCT was well defined and leaders were knowledgeable about quality issues and priorities. They understood what the challenges were and took action to address them.
- There was an effective governance framework to support the delivery of the strategy and quality care. Learning from audits and performance outcomes was used to drive improvements in the service. The risk register was generally reflective of risks.

However:

- The service did not have a system in place to de-nature liquid controlled medications (CD). The service immediately rectified this during the inspection.
- Not all patients' records were stored appropriately but the trust took immediate action to address this concern.
- There was not always a clear record of discussions about do not attempt cardiopulmonary resuscitation (DNACPR) with patients who had capacity. Mental capacity assessments were not always clearly recorded to underpin decisions about 'do not attempt cardio-pulmonary resuscitation' (DNACPR).
- Whilst the hospital did collect information on the numbers of patients who were rapidly discharged (from regional data), however, it was not systematically used within the whole SPCT to drive improvements.

Are end of life care services safe?

Good

We rated the service as good for safe because:

- The staff within the end of life care service understood their responsibilities for ensuring patients were protected from the risk of harm. The service had appropriate systems in place to recognise and minimise patient risk.
- Learning from incidents had been shared and implemented within the service.
- Appropriate equipment was available to meet patient needs, such as syringe drivers and pressure relieving equipment.
- Arrangements for handling medicines were appropriate.
- Patients' individual care records were accurate, complete, legible and up to date
- There were appropriate arrangements in place to safeguard adults and children from abuse.
- Appropriate systems were in place to recognise and manage patients whose condition was deteriorating.
- Nurse staffing levels met patients' needs at the time of the inspection. Actual staffing levels met planned staffing levels. Most wards also had a palliative care link nurse who acted as the connection to the Specialist palliative care team (SPCT).
- There was sufficient consultant provision in palliative care at the hospital at the time of the inspection.

However:

- The service did not have a system in place to de-nature liquid controlled medications . The service immediately rectified this during the inspection.
- Not all patients' records were stored appropriately but the trust took immediate action to address this concern.

Incidents

- The trust used an electronic incident reporting tool to report incidents. Staff we spoke with understood their responsibilities to raise and record safety incidents, concerns and near misses.
- There have been no never events relating to end of life care from December 2015 to November 2016. 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. Never events include incidents such as wrong site surgery, retained instrument post-operation or wrong route of administration of chemotherapy.

- The service had reported no serious incidents (SIs) in end of life care that met the reporting criteria set by NHS England from December 2015 to November 2016.
- We saw three incidents had been recorded that had affected patients who were receiving end of life care. There was evidence of learning from incidents across teams at team meetings, at weekly multi-disciplinary meetings, the operational group and at the strategy group. We saw evidence of these discussions and learning points in meeting minutes. This had improved since the last inspection. At the last inspection, we found staff had mixed views about the effectiveness of the trust's system of feedback so staff could learn from incidents and concerns.
- 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.
- While the specialist palliative care team (SPCT), chaplaincy team and mortuary team had not recorded any serious incidents, staff we spoke with were aware of their responsibilities and principles with regard to duty of candour regulation, including the thresholds for application of the duty of candour. They were aware they would be required to inform the patient or their relatives of the incident, make an apology and explained how the trust should respond to any incidents.
- The SPCT did not have a quality and safety dashboard specific to their service, however they did have access to the dashboards for each ward and specialty. The SPCT team attended divisional share and learn meetings that reported on incidents alongside other safety information. Share and learn meetings are designed to support teams to improve culture around raising concerns or incidents, update on national and local developments

Cleanliness, infection control and hygiene

- Standards of cleanliness and hygiene were maintained in the mortuary chapel and viewing areas. These areas were visibly clean and well ventilated. In the mortuary, a designated member of staff cleaned all clinical areas. Cleaning schedules for each area were seen. This showed that cleaning had been completed routinely and in a timely manner, which provided assurance that the areas were cleaned regularly and within a specified time scale.
- There were sufficient facilities for hand washing, bins for general and clinical waste, and appropriate signage in the mortuary.
- SPCT and mortuary staff wore clean uniforms. We saw staff complied with the trust's infection prevention and control policies. This included being 'arms bare below the elbow', hand washing before and after every episode of direct contact or care, and correct use of protective personal equipment (PPE) such as disposable gloves and aprons.
- The service ensured that after death, the health and safety of everyone that came into contact with the deceased person's body was protected. The trust had safety precautions and systems in place to prevent and protect patients and staff from a healthcare-associated infection.
- Trust infection control guidelines were up to date, reflected national guidance and were available in the mortuary and on the intranet. There was a standard of practice document for the receipt of bodies (suspected infection) on the intranet and in the mortuary. Staff were able to direct us to policies necessary for their practice. Mortuary staff and porters told us about the procedures they followed and equipment they used, which assured us they were able recognise, assess and manage risks.
- Ward staff we spoke with were aware of the procedures to be taken when performing 'last offices' in order to minimise infection risks. The term last offices relates to the care given to a body after death. It is a process that demonstrates respect for the deceased and is focused on respecting their religious and cultural beliefs, as well as health and safety and legal requirements.

- Porters we spoke with said that they were aware of the PPE protocol for the mortuary and said they were able to access the necessary equipment. However, on the day of inspection, there were no aprons available in the cupboard accessible for the porters to use while in the mortuary. This was raised with the mortuary manager who ensured sufficient supplies of aprons were replaced immediately.

Environment and equipment

- There was not a designated ward for patients receiving end of life care. Staff told us they tried to allocate side rooms to patients who were receiving end of life care, in order to offer quiet and private surroundings for the patient and their families. They also said that often patients at the end of life had to be cared for on open wards, as the use of single rooms were prioritised for patients who required isolation.
- Appropriate equipment was available to meet patient needs, such as syringe drivers and pressure relieving equipment. Staff told us and we saw syringe pumps, used to give a continuous dose of painkiller and other medicines, were available to help with symptom control in a timely manner. Syringe pumps were maintained and used in accordance with professional recommendations.
- Staff and the relatives we spoke with told us patients had access to appropriate equipment, such as syringe drivers, pressure-relieving equipment, such as mattresses, and hoists to keep them safe and comfortable.
- Equipment being used was checked and maintained in line with trust policy.
- The facilities provided met the needs of patients. The service provided cold safe storage for adults, children and babies who had died at the hospital and had the facility for the family and next of kin to view their deceased relative.
- The mortuary was equipped to store 136 deceased patients, 115 in permanent body storage units (fridges) and five in long-term storage. There were also 16 temporary storage units, which could be set up within half a day, to cope with fluctuations in demand. There were five spaces suitable for bariatric patients and a further eight spaces for semi-bariatric patients. There were specific storage trolleys and larger fridges to accommodate these patients. The service also had a cold store room, which allowed for storage of a super obese deceased person without the need for moving the patient from their bed.
- Staff told us these facilities were sufficient to meet the needs of the hospital and local population. We checked the thermometers that monitored the temperature of the storage units, and found that they were within range. Records of these checks had been maintained. Appropriate alarm systems were in place to alert staff if temperatures went above the manufacturer's recommended settings.
- There had been a recurrent problem with a door seal into one of the storage units. While the problem had not resulted in any incidents, for example, prolonged increase in temperature, staff had been called in twice via the alarm system, in the past year during out of hours, to check the unit. Staff told us the servicing company had visited to look at the unit but were unable to provide a solution to ensure long-term repair. Staff were monitoring the temperature and were ensuring the door was shut properly as part of their routine check. At the time of inspection, there were no plans to replace the door.
- The mortuary viewing area was well-maintained and was suitably decorated with comfortable chairs and appropriate non-denominational furnishings.
- Equipment in the mortuary was well-maintained. We saw test stickers on equipment, which assured us that the equipment maintenance was timely and equipment was fit for purpose.
- The service had appropriate concealment trolleys for transferred deceased patients when required. The service did have a bariatric concealment trolley, however we were told the trolley was not fit for purpose. Due to the size of the bays on the wards, there was not room for the trolley to be used effectively. The route from some wards required the trolley to manoeuvre around tight turns in the corridors or to enable door access. This made the trolley difficult to use. Staff told us of one historic occasion when a deceased bariatric patient had been transferred to the mortuary on a hospital bed and felt this was not dignified practice. Issues using the bariatric trolley were not on the service's risk register at the time of inspection. We raised this with the trust management team at the time of inspection. Senior managers were aware of the bariatric trolley issue and that it had been discussed at the end of

life strategy group on several occasions with updates from portering staff. A bariatric trolley or substitute was only required approximately every six months. An alternative system involving a modified large x-ray trolley with the sides up and a shaped cover over the top was available, which provided a dignified transfer to the mortuary. The service was investigating a new solution for this issue, which was a purpose made cover for an ordinary bed, specifically designed for bariatric patients. The issue was on the agenda for discussion at the next end of life strategy group. A case for the newly identified equipment was being prepared by the staff. No incidents had been reported in relation to inappropriate use of bariatric trolleys and the service had not received any complaints.

Medicines

- Systems, processes and practices that were essential to keep patients safe from avoidable harm were put in place and communicated to staff. There was guidance for prescribing palliative medication and guidance for use of anticipatory medication at the end of life. These were reviewed, up to date and met national guidance such as Palliative Adult Network Guidelines (PANG) (2011) and the Palliative Care Formulary (2011) and were approved by the Medicines Optimisation Committee. We saw that anticipatory end of life care medication was appropriately prescribed. Medical staff we spoke with said they felt confident in this practice.
- The specialist palliative care nurses worked closely with ward based medical and nursing staff and pharmacy staff to support the prescription of anticipatory medicines. Anticipatory medicines, or 'just in case' medication is a way of prescribing to enable prompt symptom relief at whatever time the patient develops distressing symptoms, and is based on the premise that although each patient is an individual with individual needs, many acute events during the palliative period can be predicted and management measures put in place in advance.
- Arrangements for handling medicines were appropriate. We saw there were systems in place for the training, prescribing, recording, handling, storage and security, dispensing and safe administration of medication.
- Medicines were readily available to patients requiring treatment for palliative care. These were stored securely and according to their recommended storage temperature of below 25°C.
- The storage of and recording the use of controlled drugs was appropriate. The service did not have a system in place to de-nature liquid controlled medications (CD). Some prescription medicines are controlled under the Misuse of Drugs legislation (and subsequent amendments). These medicines are called controlled medicines or controlled drugs. Examples include morphine and pethidine. Denaturing of controlled drugs typically involves physically mixing the medicines with a binding matrix to make the material physically irretrievable in the waste chain. The resultant material is classified, described, and disposed of as a waste medicine. We saw the staff were squeezing the residue of unused medication following removal from the syringe drivers into a sharps bin. This was not in line with Home Office advice and the Safer Management of Controlled Drugs: a guide to good practice in secondary care 2007 Department of Health (DoH) or Healthcare Waste Regulations (DoH). The Environmental Permitting (England and Wales) Regulations 2010 provided an exemption (T28) for the denaturing of controlled drugs at the premises of production. However, no exemption is provided for the denaturing of controlled drugs at a place other than a place of production. This meant that there was no exemption for the denaturing of waste CDs returned by patients or healthcare workers or for drugs brought together at a collection point or denaturing sessions. This issue was raised at the time of the inspection and denaturing kits were provided immediately to address this issue.

Records

- Patients' individual care records were written in a way that kept people 'safe from avoidable harm. At the last inspection, we found inconsistencies in the standard of record keeping, with gaps in some patients' records relating to the daily nursing care that they had received. We found no concerns about the standard of record keeping on the current inspection in the 33 records we looked at. We saw patients' individual care records were accurate, complete, legible and up to date.
- Records were not always stored securely. On all wards we visited, the records were potentially accessible to anyone accessing the wards. Some records were stored on trolleys that were not lockable or where trolleys were lockable, they were left unlocked. Some records trolleys were kept out on the ward meaning that patients and

visitors could potentially access confidential patient records. Senior managers took immediate actions to rectify this concern by purchasing lockable note trolleys for all ward areas.

- Generally, patients' 'do not attempt cardio-pulmonary resuscitation' (DNACPR) records were completed in accordance with trust policy. We reviewed 33 DNACPR across all ward areas and the corresponding medical notes. The DNACPR forms were stored in paper form in the front of the patients' notes. The forms had a red edging so they were easily identifiable. All the forms we reviewed were signed and dated. We saw all forms (100%) were countersigned by a consultant within 24 hours as per trust protocol. However, three forms did not include a summary of why cardio pulmonary resuscitation was not in the patients' best interests despite guidance in the trust's policy.
- At the last inspection, we also had concerns about the level of compliance in completing DNACPR forms. The trust had taken immediate action and had implemented a revised form and had provided appropriate training for staff on the new system.
- We saw that where doctors were able to complete certificates with a cause of death (other than those referred for post-mortem), 88% of GPs were informed of the cause of death using the electronic death notifications system. Twelve percent of GPs who did not have access to the electronic system were informed of the cause of death via letter.

Safeguarding

- There had been no reported safeguarding concerns relating to patients receiving end of life care from December 2015 to November 2016.
- There were appropriate arrangements in place to safeguard adults and children from abuse. Staff we spoke with told us they understood their responsibilities and adhered to safeguarding policies and procedures. The trust's policies for safeguarding adults and children reflected local and national guidance. Staff were able to tell the inspection team what signs of abuse were, and how to use the trust policy. In addition, staff were able to identify their responsibilities with regard to reporting safeguarding concerns. Support was also available from the trust's safeguarding leads when required. The safeguarding team aligned the level of training to positions following the Intercollegiate Document. This means that the chaplains, porters, bereavements officers and the mortuary team were only required to complete safeguarding adults level one and safeguarding children level one. The SPCT were required to complete safeguarding children level one and two and safeguarding adults level one and two training.
- Most of the specialist palliative care team (SPCT) staff were compliant with safeguarding training. The service did meet the trust target of 85% overall for all safeguarding training.
- We found all of the SPCT team, were compliant with their safeguarding children levels one and two. However, 86% of the SPCT team had attended safeguarding adults level one and 71% had attended level two safeguarding adults training. This did not meet the trust target of 85%. We saw plans were in place to provide further training dates.
- All of the mortuary staff were up to date with their safeguarding adult level one and safeguarding children level one training.
- We found all of the chaplaincy staff were up to date with their safeguarding adult level one and safeguarding children level one training.
- Porters' compliance for safeguarding children level one training was at 70% and their safeguarding adult level one compliance was at 77%.

Mandatory training

- We saw 100% of the mortuary team were compliant with their mandatory training.
- Evidence showed 89% of the SPCT, bereavement team and chaplaincy team were up to date with their mandatory training, which was above the trust target of 85%. However, 72% of the porters were up to date with their mandatory training which was below the trust target. Mandatory training included equality and diversity, health and safety, fire safety, moving and handling.
- The SPCT provided an awareness training session on end of life care for all staff as part of their induction training. The National Care of the Dying Audit of Hospitals (NCDAH) 2014- 2015 confirmed that the trust provided formal in-house training for nursing staff. This included communication skills training for care in the last hours or days of life. However, they were not able to demonstrate they provided similar training for medical

staff or allied health professionals. However, since the audit the trust had started to provide education for all staff on the care of dying patients as part of mandatory training.

Assessing and responding to patient risk

- Appropriate systems were in place to recognise and manage patients whose condition was deteriorating. The service carried out comprehensive risk assessments for patients and these were reviewed frequently by the SPCT.
- There was a triage system for all SPCT referrals. The SPCT clinical nurse specialists held daily review meetings to discuss and allocate new referrals, review their workload, and discuss patients seen. Staff identified and responded appropriately to the changing risks to patients, including deteriorating health and wellbeing, medical emergencies or behaviours that challenged.
- In addition to the daily review, the team held weekly multidisciplinary meetings where caseloads would be reviewed and allocated appropriately between clinical nurse specialists. During the meeting, the team discussed diagnostic challenges, management options and any other pertinent issues relating to their current patients.
- At the time of inspection, there was no county wide electronic palliative care co-ordination system (EPaCCS) to identify EOLC patients on admission to the hospital. However the strategy for end of life care across Northamptonshire 2014 to 2019 had identified a need to deliver EPaCCS for the county but at the time of inspection, this had not been achieved and there was no date provided for completion of this task. EPaCCS provides an electronic version of care plan and advance care plan. This system enables the recording and sharing of people's care preferences and key details about their care at the end of life. GP referrals did sometimes reflect this information, but the emphasis for identifying patients was with the admitting clinicians who then referred the patient to the SPCT or EOLC team.
- The service used the dying person's care plan (DPCP) to guide treatment. The care plan guided staff to identify patients' increased needs such as the need for mouth care, or a need for change to medication, for example, to provide pain relief or the need to set up a syringe driver.
- There was a system in place to monitor patients' risk of clinically deteriorating, including those patients receiving end of life care. The service used the National Early Warning Score (NEWS) assessment tool for ensuring that deteriorating patients were identified and treated appropriately. The assessment tool scored each patient according to their blood pressure, pulse, respirations, and conscious status. It prompted staff to follow clear procedures, should a patient's vital signs fall out of expected parameters. We checked five NEWS chart documents and found them to have been recorded correctly
- We saw that risk assessments, for example, risk of falls, tissue viability and moving and handling were effectively completed in patients' notes. We saw actions occurred where risks were identified. For example, we saw a referral to dietitians and speech and language therapist for a patient experiencing dietary issues, a referral to the tissue viability nurse for concerns about pressure areas and a referral to the occupational therapist and physiotherapist for a patient identified as being at risk of falling had all been made when required.
- Intentional rounding was in place on the wards to monitor people's needs. Intentional rounding is a structured approach whereby nurses conduct checks on patients at set times to assess and manage their fundamental care needs. Care needs such as changes required to medication or the need to commence mouth care was monitored by staff during these checks. We saw that for patients on the DPCP, the timing for checks were adjusted appropriately for the need of the patients, for example, the times between each check could be reduced if interventions were required more often.

Nursing staffing

- Nurse staffing levels met patients' needs at the time of the inspection. Actual staffing levels met planned staffing levels. We saw evidence of this on inspection.
- There were sufficient SPCT clinical nurse specialists (CNS) at the hospital. There was one lead end of life care lead and just over four and a half whole time equivalent (WTE) CNS in palliative care. The staffing levels were above National Institute of Health and Care Excellence (NICE) guidelines, 'Commissioning guidance for palliative care', published collaboratively with the Association for Palliative Medicine of Great Britain and Ireland, Consultant Nurse in Palliative Care Reference

Group, Marie Curie Cancer Care, National Council for Palliative Care, and Palliative Care Section of the Royal Society of Medicine, London, UK. December 2012. The guidance recommends 1.0 WTE hospital specialist palliative care nurse per 250 hospital beds. The hospital had 800 beds, which would require a just over three specialist palliative care nurses, therefore, the service exceeded this requirement.

- The SPCT nursing team provided a Monday to Sunday, 9am to 5pm, face-to-face palliative care service. One CNS was on duty on Saturdays and two CNSs were on duty on Sundays to see inpatients with complex needs and any urgent new referrals. This met the recommendation from the NICE guidelines for 'End of life care for adults', Quality standard [QS13] Published date: November 2011 Last updated: October 2013 which states 'palliative care services should ensure provision to: visit and assess people approaching the end of life face-to-face in any setting from 9am to 5pm, seven days a week'.
- Nursing handovers we observed were well structured and informative. The handover included a review of all current palliative and end of life care patients. Care and treatment were assessed and planned and workloads were allocated.
- There were nominated champions for end of life care on most wards across the trust.
- At the time of inspection the SPCT were not using locum or bank staff however we saw the team did have an induction process for temporary staff should the need arise.

Medical staffing

- There was sufficient consultant provision in palliative care at the hospital at the time of the inspection.
- Medical staffing had been of concern at the last inspection as there had been no dedicated consultant in palliative medicine for the hospital. Support had been provided by the local hospice on an ad-hoc basis.
- Since the last inspection, the trust had employed one palliative care consultant who had been in post since January 2017. The service was supported by a visiting consultant from the local hospice, who provided four half-day sessions of clinical support per week. The staffing levels met the National Institute of Health and Care Excellence (NICE) guidelines, commissioning guidance for palliative care, published collaboratively with the association for palliative medicine of Great Britain and Ireland, Consultant Nurse in Palliative Care Reference Group, Marie Curie Cancer Care, National Council for Palliative Care, and Palliative Care Section of the Royal Society of Medicine, London, UK. December 2012
- We did not see any evidence of use of locum staff in the palliative care team in the inspection period. Cover for annual leave and sickness cover was provided by the visiting consultant from the local hospice.

Other staffing

- The trust employed a resuscitation team that comprised three whole time equivalent (WTE) senior resuscitation officers and one part time resuscitation officer. At the time of inspection, the team had a vacancy for one WTE resuscitation officer; the post was being advertised. The team also had a full time administrator. The team provided basic life support and immediate life support training onsite. They attended emergency calls within the hospital where resuscitation was likely to be required.
- There were three full-time mortuary staff; one also fulfilled the role of mortuary manager. All staff were trained anatomical pathology technologists (ATP). All staff had completed necessary training and could work and be left unsupervised. The mortuary was staffed from 8.30am to 4.30pm, Monday to Friday and Saturdays between 8am and 12noon. At the time of inspection, the team had a vacancy for a pathologist. The post was being advertised. Post-mortems were being carried out at the service by an external provider, two mornings per week. Porters transported the deceased from the hospital wards to the mortuary and provided out of hours access to the mortuary.
- The trust employed two WTE chaplains who provided chaplaincy support to the trust. The chaplains provided an on call service, which could be accessed 24 hours a day seven days a week. One of the chaplains planned to retire in March 2017. Plans were in place to replace this post. The chaplains were in the process of reviewing the hospital's current chaplaincy needs.

Major incident awareness and training

- The trust had a major incident plan in place. There were clear instructions for staff to follow in the event of a fire or other major incident. SPCT and mortuary staff we spoke with were aware of this plan.

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- The mortuary had storage contingency plans. The mortuary had additional storage capacity for an additional 16 deceased patients and foldable racking systems were available on site that could be used to increase storage facilities. The manager told us that while there were no formal arrangements in place, the mortuary had a good working relationship with two local hospital mortuaries, which could support the service, in the case of a major incident, if more capacity was required. External additional storage had not been required since 2010.
- Mortuary staff told us that there were alarm systems in place to alert staff in the event of mechanical failure of the fridges. These alarms were routed to main reception who would alert the mortuary manager. On the occasion of an out of hours' fridge failure, the on-call mortuary staff would be contacted via the main reception to enable them to contact on-call repair service.

Are end of life care services effective?

Requires improvement

We rated this service as requires improvement for effective because:

- There was not always a clear record of discussions about 'do not attempt cardio-pulmonary resuscitation' (DNACPR) with patients who had capacity. Mental capacity assessments were not always clearly recorded to underpin decisions about 'do not attempt cardio-pulmonary resuscitation' (DNACPR). We looked at 33 DNACPR forms across all ward areas and the emergency department. Out of these, 18 forms stated that the doctor had not informed the patient directly where a clinical decision for a DNACPR had been made. In these cases, there was no formal mental capacity assessment of the patients' ability to understand this decision. The trust took urgent actions to address this once we had raised it as a concern.

However:

- Patients had their needs assessed and their care planned and delivered in line with evidence-based, guidance, standards and best practice.
- A care planning tool to replace the Liverpool Care Pathway had been implemented and was embedded across all wards in the hospital
- Patient outcomes were mixed and the service had produced a detailed action plan to address the shortfalls and issues raised by the national care of the dying audit of hospitals (NCDAH) 2014 to 2015.
- Local audits were in place to measure the effectiveness and outcomes of the service.
- Staff were competent in their roles and supported by effective processes for ongoing professional development.
- Appropriate systems were in place to assess and manage patients' pain relief needs
- Patients' dietary and hydration needs were being met
- Multidisciplinary working was effective.
- Information needed to deliver effective care and treatment was available to relevant staff in a timely and accessible way.
- The service was provided seven days a week.
- While the trust did not collect information on the number of patients who were discharged to their preferred place within 24 hours. However, they did have access to this information via a local external source.

Evidence-based care and treatment

- Patients had their needs assessed and their care planned and delivered in line with evidence-based, guidance, standards and best practice.
- Information, policies and procedures needed to deliver effective care and treatment were available to relevant staff in a timely and accessible way. Trust policies, procedures and guidelines were available to nurses, doctors and support staff on the intranet. They were able to access them when necessary.
- Following the removal of the "Liverpool Care Pathway" (LCP) nationally, the trust had developed a replacement called the dying person's care plan (DPCP). The DPCP was embedded on all wards across the trust. The DPCP was in line with the recommendations published in June 2014 by the Leadership Alliance for the Care of Dying People (LACDP 2014), National Institute for Health and Care Excellence (NICE) guidance quality standard (QS13) 'End of Life Care for Adults' and NICE clinical guidance (CG140) 'Opioids in Palliative Care'. It provided individual care plans for patients believed to be dying and provided staff with guidance for individuals' care

and treatment. This had been implemented and embedded across the hospital. The service was in the process of reviewing and updating the dying person's care plan and planned to roll out a new revised document following the review.

- All staff had access to multidisciplinary care records, which provided a care plan, which specified the patients' wishes. Dying person's care plans (DPCP) were in place for patients where it had been identified that they were in their last days or hours of life. The DPCP specified patients' wishes regarding end of life care. Records we saw on the wards indicated the patients' preferred place of care and place of death. Staff had documented the wishes and preferences of patients and their families. In October 2016, an audit showed that 63% of patients who were imminently dying had a care plan in place.
- The amber care bundle had been successfully implemented on ten wards within the trust. The trust planned to implement the care bundle on the remaining wards in the coming year. The amber care bundle is a simple approach used in hospitals when clinicians are uncertain whether a patient may recover and are concerned that they may only have a few months left to live. It encourages staff, patients and families to continue with treatment in the hope of a recovery; while talking openly about people's wishes and putting plans in place should the worst happen. It consists of four elements
  - Talking to the person and their family to let them know that the healthcare team has concerns about their condition, and to establish their preferences and wishes.
  - Deciding together how the person will be cared for should their condition get worse.
  - Documenting a medical plan.
  - Agreeing these plans with all of the clinical team looking after the person. The person's condition is then monitored closely and followed up on daily basis to record any changes and address any concerns that they or their family may have.
- We saw clinicians were discussing patients who were likely to be in the last 12 months of life. The service was using the amber care bundle for patients who were facing an uncertain recovery.
- The SPCT had carried out an audit between February 2016 and January 2017 on whether a patient's preferred place of death was recorded. Care records of patients known to the SPCT, who had died at the hospital were reviewed. The service used the audit to evaluate the quality of the information collated in the care plan and to identify training needs. We saw the service had an ongoing action plan to work on the themes identified.
- The service had carried out an internal review of end of life care to benchmark the service against national recommendations and CQC's five key questions. This had been undertaken by the associate director of nursing, the head of governance, and the end of life project lead in June 2016. The aim was to assess the provision of end of life care across the trust, to ascertain the quality of care and its compliance with regulatory frameworks, national policy and recognised quality indicators. The review looked at the key questions:
  - Was end of life care safe? They had identified areas of achievement and good practice as having a high standard of safe care, including, patient safety huddles and a safe and effective mortuary service. Safety huddles, sometimes known as safety briefings, are team meeting, led by a senior staff member; they involve all levels of staff and provide an opportunity for a discussion about patient safety issues. They had identified areas for improvement, for example, documentation and record keeping, review, and assessment of dying patients, weekend medical review, and attendance at end of life training and communication with mortuary staff.
  - Was end of life care effective? They had identified areas of achievement and good practice as staff were responsive to the needs of dying patients, provision of specialist care for people in their own home following hospital, and there was a Macmillan social care co-ordinator. They had identified areas for improvement, including the implementation of amber care bundles on all wards.
  - Was end of life caring? They had identified areas of achievement and good practice, for example, the emergency department, who provided compassionate and sensitive care. They had identified areas for improvement, for example, inadequate environments for relatives and carers.
  - Was end of life care responsive? They had identified areas of achievement and of good practice, for example, prompt reviews by SPCT and the end of life team, seven day a week SPCT cover, the end of life

register, and they do not attempt cardio-pulmonary resuscitation' (DNACPR) documentation. They had identified areas for improvement, for example, out of hours' responsive care.
    - Was end of life care well led? They had identified areas of achievement, for example, an improved governance structure, including an end of life care lead nurse who had been appointed. They had identified areas for improvement as the appointment of a consultant in palliative medicine.
- The DPCP prompted staff to involve the patient and those close to them in sensitive communication and decisions about treatment and care to the extent that the dying person wanted.
- We saw the forms staff used to monitor the use of syringe drivers were completed appropriately, and in accordance with the recommended national guidelines. Safer ambulatory syringe drivers 16 December 2011 and local guidance.
- The service met NICE QS3 Statement 5: 'Patients assessed to be at risk of VTE are offered VTE prophylaxis in accordance with NICE guidance' by having appropriate systems in place to deliver this.
- The end of life team had developed "Recognising Dying" cards to support the clinical team in the recognition of patients thought to be in the last days or hours of their life. On the reverse side of the card was an aid to prompt the implementation of the amber care bundle.
- The mortuary had been licenced by the Human Tissue Authority (HTA) to allow post-mortem examinations and storage of bodies. The trust informed us that the HTA renewed the licence annually, following a self-assessment audit.
- The mortuary policies were up to date, evidence based and relevant for the service they provided. Ward staff, mortuary staff, and porters were aware of these policies and told us about the procedures they followed and equipment they used. Standards of practice for the mortuary were based on national guidelines. We saw and staff told us there was an evidenced based standard operating procedure (SOP) for performing 'last offices', in order to minimise infection risks. The term last offices relates to the care given to a body after death. The SOP provided staff with necessary guidance. Staff we spoke with were confident in this practice.

Pain relief

- Appropriate systems were in place to assess and manage patients' pain relief needs. There was trust guidance for prescribing palliative medication and guidance for the use of anticipatory medication at end of life, which provided guidance for providing pain relief. The guidance was in line with NICE clinical guidance (CG140) 'Opioids in Palliative Care' and the Core Standards for Pain Management Services in the UK (Faculty of Pain Medicine, 2015).
- There were clear guidelines for medical staff to follow when writing up anticipatory medicines for patients. We saw that anticipatory end of life care medication was appropriately prescribed. Anticipatory medications refer to medication prescribed in anticipation of managing symptoms, such as pain and nausea, which are common near the end of a patient's life. These are prepared in anticipation so that these medicines can be given, if required, without unnecessary delay.
- The service used comprehensive prescription and medication administration record charts for patients. These charts facilitated the safe administration of medicines including pain reliving medications. Specialised prescription charts supported prescribers to follow the agreed protocols for patients who had medicines administered via syringe pumps. We saw medicines delivered via syringe pumps were prescribed appropriately.
- Pain control of patients was reviewed regularly, prompted by the dying person's care plan. For example, the document prompted staff to assess regularly and observe for verbal and non-verbal signs of pain, anticipate when pain might occur (such as, on movement), record pain, intervention and outcomes. This ensured that as required medication was prescribed to manage any breakthrough pain. As required pain relief was given in between regular, scheduled pain relief. Breakthrough pain is a sudden flare of pain that "breaks through" the long-acting medication prescribed to treat moderate to severe persistent pain.
- Patients said their pain was well managed by staff.

Nutrition and hydration

- Patients' dietary and hydration needs were being met.
- Staff had access to and made referrals to a dietitian employed by the trust. We saw in patient records that

the dietitian visited patients on the ward and advised on what patients could eat and drink. Staff supported the patients to make suitable menu choices based on the dietitian's recommendations.

- The dying person's care plan provided prompts for staff specifically about nutrition and hydration for dying patients. It prompted the staff to assess every four hours that the patient had received food and fluids to support their individual needs. It stated that patients were to be supported to take food and thickened fluids, for as long as they were able. The care plan prompted staff to explain the plan of care with the patient and relatives.
- Nutritional assessments were completed in the notes we reviewed. Nutrition and fluid charts were thorough and summarised accurately.
- The Malnutrition Universal Screening Tool (MUST) was used to identify patients at risk of malnutrition and they were generally completed well. It included management guidelines to be used to develop a care plan. The tool was used in line with recommendations from the British Dietetic Association (BDA) and Royal College of Nursing (RCN).

Patient outcomes

- The service had processes in place to monitor patient outcomes and report findings through national and local audits to the trust board. The trust used this information to benchmark practices against similar organisations.
- The trust took part in the National Care of the Dying Audit of Hospitals (NCDAH) 2014 to 2015. The results were published in March 2016. The trust achieved four of the eight organisational key performance indicators (KPIs). They were able to demonstrate they:
  - Had a lay member on the trust board with a responsibility for end of life care, from 1 April 2014 to 31 March 2015.
  - Provided formal in-house training, which included communication skills training for care in the last hours or days of life for both registered and non-registered nursing staff.
  - Had one or more end of life care facilitators as of 1 May 2015.
- They were not able to demonstrate they:
  - Sought bereaved relatives or friends' views during the last two financial years from 1 April 2013 to 31 March 2015.
  - Provided formal in-house training, which included communication skills training for care in the last hours or days of life for medical staff or allied health professionals.
  - Provided access to specialist palliative care for at least 9am -5pm, Monday to Sunday.
- The trust performed worse than the England average for four of the five clinical indicators from (NCDAH) 2014 to 2015. The trust could not demonstrate that:
  - There was documented evidence, within the last episode of care that it was recognised the patient would probably die in the coming hours or days.
  - There was documented evidence within the last episode of care, there was a health professional recognition the patient would probably die in the coming hours or days, and imminent death had been discussed, with a nominated person important to the patient.
  - The needs of the person important to the patient were asked about.
  - A holistic assessment of the patient's needs regarding an individual plan of care had been carried out in the last 24 hours of life.
- The trust performed the same as the England average on the clinical indicator:
  - The patient was given an opportunity to have concerns listened to.
- The service had produced an action plan to address the shortfalls and issues raised by the NCDAH (2014 to 2015). The SPCT monitored and reviewed the action plan on a monthly basis at the team meeting and reported quarterly to the trust's board.
- We saw action had been taken to address the shortfalls identified. The service had carried out an internal and external review of end of life care in June 2016. The service had highlight areas of good practice and provided guidance on how services could be improved. An example was the introduction of a seven-day-a-week service in February 2016. A clinical nurse specialist (CNS) was rostered to cover Saturdays and two CNSs were rostered to cover Sunday visits across the hospital. A process had also been established to obtain carer feedback. The trust worked with the patient advice and liaison team to develop a process for capturing the experience of families when they collected the death certificate. It was called the "real time right time" survey. This was launched in autumn 2016 following a positive pilot in the summer 2016.

End of life care

- The service carried out an audit of the usage of the DPCP in October 2016. Over half (63%) of patients who were imminently dying had a care plan in place. The audit demonstrated evidence of senior medical review and discussion with patients and/or family. However, there was a lack of evidence related to the patients' priorities or preferences of care and 'last offices'. We saw 52% of the total number of deaths had been identified on the end of life care register. The service had an action plan in place to try to address this issue. The service were monitoring and training was being provided in these areas.
- There were plans are in place to roll out the amber care bundle to four additional wards. There had been positive evaluation from the end of life companion volunteer pilot.
- The service took part in the local commissioning for quality and innovation (CQUIN) related to patients' preferred place of death between April 2016 and December 2016. The goal was to ensure people were asked where their preferred place of death was and that those preferences were met. The CQUIN data also identified a number of themes for improvement. For example, the service had identified reasons for why the information had not been collected in all cases. The service was monitoring this through its operational group.
- The trust reported some negative themes to the Clinical Commissioning Group (CCG) had identified regarding patient outcomes from the CQUIN data, which were being addressed and monitored by an action plan. These included:
  - Some delayed referrals to the specialist palliative care team: this was an ongoing theme from quarter one and quarter two, with an ongoing action plan to raise awareness of the referral criteria.
  - A lack of advanced care planning in some cases, as a number of patients with respiratory disease had been discharged from the hospital, with an exacerbation of their illness, within a few months or weeks of their final admission. There was no evidence of any advanced care planning or discussion about preferred place of death prior to their final admission. This was an ongoing theme from quarter one and quarter two with an ongoing action plan. This was monitored through the end of life care operational group and strategy group.
  - Rapid deterioration of some patients, as a number of patients who experienced delayed referral to the SPCT were then too ill for discharge planning to be successful. This was an ongoing theme from quarter one and quarter two with an ongoing action plan. This was monitored through the operational group and strategy group.
  - Unable to discharge patients home, their preferred place of death, if they required high flow oxygen this type of therapy was not available in the community setting.
- The trust was not part of the Gold Standards Framework accreditation scheme at the time of inspection.

Competent staff

- Staff had the right qualifications, skills, knowledge and experience to do their job and were supported by effective supervision and appraisal systems.
- Staff told us that appraisals took place and they were up to date. At the time of inspection, all of the SPCT had up to date appraisals. We saw all of the mortuary team were up to date with their appraisals and the chaplaincy team were compliant with appraisals. The trust target for appraisal compliance was 85%, which was in line with CCG expectations.
- The SPCT had attended relevant study days and training courses to maintain their competence, for example, palliative care modules at degree and masters level.
- The service was using a nationally recognised education programme regarding quality end of life care for all patients. Quality End of Life Care for All (QELCA): the aim was to address the staff's ability to manage the end of life care needs of patients in their care. The trust recognised the need to promote a compassionate and palliative care minded approach to end of life care on the wards. Participants completed a pre and post questionnaire: an evaluation of each learning session and placement. Results suggested an increase in confidence and competence in the participants' end of life care skills. As the course developed, an evaluation of the impact of the program indicated benefits to patients and carers at the end of life including:
  - Reorganisation of a ward's layout to incorporate a visitor's room.
  - Commitment to ensure one member of staff trained in end of life care was on duty each day.
  - Ward audit of 'Dying Persons Care Plan', to evaluate completion of documentation.

  - Ward led teaching sessions related to end of life care.
  - New signage to enhance privacy and dignity at end of life.
  - Effective communication was a key component of the course and the majority of participants had since attended the 'Sage and Thyme' communication workshop. The SAGE & THYME ® model was developed by clinical staff at the University Hospital of South Manchester NHS Foundation Trust (UHSM) and a patient in 2006. It was designed to train all grades of staff how to listen and respond to patients/ clients or carers who are distressed or concerned. It places published research evidence about effective communication skills within a memorable structure for clinical practice.
- Since the last inspection, a whole time equivalent palliative care consultant had been employed and provided education and training to teams caring for palliative patients.
- Most wards had a palliative care link nurse who acted as the link with the SPCT. The palliative care link nurses attended training sessions approximately five times per year. These sessions assisted in maintaining competency for their palliative care link nurse role. We saw an agenda for these training days, which included symptom control and management training such as skin care and bowel care. The palliative care link nurse shared relevant knowledge, processes and skills to their ward teams during team meetings and shared documents through the ward newsletter.
- Doctors working in the palliative care services maintained their revalidation working in conjunction with the local hospice.
- The SPCT were responsible for providing end of life care training and embedding the care of the dying person care plan. The team provided assistance when required to other disciplines and organised standalone courses and study days. We saw that SPCT provided training on the trust induction, training for overseas nurses and on the clinical support worker training.
- The service provided an education programme for nursing staff on the use of the syringe pump. All new nursing staff received training on this equipment as part of their induction. On-going training was available to maintain competence and confidence in using the equipment. Nurses who used the equipment regularly told us they felt confident and competent in using this equipment. Nursing staff, who did not routinely use this equipment, knew where to gain advice and support to enable them to use the equipment confidently.
- The mortuary staff were aware of recent developments in anatomical pathology technology. They maintained their awareness of recent developments, accessing information through the Association of Anatomical Pathology Technology and the Human Tissue Authority newsletters and website.
- The mortuary team did not have regular formal supervision. The mortuary manager addressed performance issues, concerns, and complaints informally.
- The resuscitation team provided the basic life support and immediate life support training on site. The team were responsible for the trust's resuscitation policy.
- The bereavement team had received support and training in having difficult conversations, and recognising distress.

Multidisciplinary working

- Multidisciplinary working was effective. All required staff, including those in different teams and services, were involved in assessing, planning and delivering people's care and treatment. Referrals to the SPCT came from a wide source of wards across the hospital. The SPCT told us they had a good working relationship with all ward teams. They told us staff on all wards had been supportive of end of life care.
- Care was delivered in a co-ordinated way when different teams or services were involved. The SPCT team had established close links with other providers in the local area of end of life care, including the local hospice, primary care providers and community nurses. The aim of this was to improve patients' experiences as they moved between care settings. We saw documented evidence of a multidisciplinary approach to care.
- There was effective communication between the SPCT and other services within the hospital. Medical staff told us they sought guidance and acted upon advice from the specialist palliative care team.
- The SPCT held a weekly palliative care multidisciplinary (MDT) meetings. The SPCT also regularly attended the specialist teams' MDT meetings to provide support and guidance.

End of life care

- The SPCT and ward staff worked together to assess and plan ongoing care and treatment in a timely way when people were due to move between teams or services, including referral, discharge and transition.
- At the time of inspection, there was not yet a county wide electronic palliative care co-ordination system (EPaCCS) to identify end of life care patients on admission. On occasion, GP referrals did identify patients with the admitting clinicians, who then referred the patient to the SPCT or end of life care team. The strategy for end of life care across Northamptonshire 2014 to 20119 had identified an area that aimed to deliver EPaCCS for Northamptonshire: this had not yet been achieved and there was no date provided for completion of this task.
- Patients were discharged from the service at an appropriate time of day. Any out of hours' discharges resulted in an incident being raised via the electronic incident recording system. We did not see any incidents regarding inappropriate time of discharge between December 2015 and November 2016.
- We saw joint working with tumour site-specific nurses, for example, lung, prostate, gynaecological and head and neck cancers. These specialists offered support and information following diagnosis, during and after treatment. They liaised with colleagues to arrange care, equipment and financial advice.
- We saw joint working with other Macmillan professionals, such as speech and language therapists, occupational therapists, physiotherapists, social care coordinators, clinical psychologists and the welfare rights service.
- There was a clear pathway for transfer of care from hospital to community services, including care plans and medication. The local Clinical Commissioning Group had commissioned a local independent healthcare provider to work closely with the service to facilitate safe discharge for patients who had been identified as being in the last eight weeks of life and wished to be cared for at the end of life in their own home, nursing home or residential home.
- There was close joint working between the SPCT and the tissue visibility team (TVT). The TVT had met with the lead nurse for specialist palliative care and end of life care to address any issues around repositioning of patients, who were at the end of their life. These were then raised at the share and learn meetings.
- The trust employed tumour site-specific clinical nurse specialists (CNS) who supported patients with most of the common cancers such as lung, prostate, gynaecological and head and neck. These specialists offered support and information following diagnosis, during and after treatment. They liaised with colleagues to arrange care, equipment and financial advice.

Seven-day services

- The SPCT provided seven-day, face-to-face access to specialist palliative care. The team was available from 9am to 5pm, Monday to Sunday. Outside these hours, specialist palliative care advice was available via a 24-hour advice line, which was manged by the local hospice. The staff in the hospital accessed the on-call doctors if a patient required a review on an evening or weekend, when members of the palliative care team were not available.
- The mortuary was staffed between 8.30am and 4.30pm, Monday to Friday, and 8.30am and 12noon on Saturdays. Outside of these hours, the mortuary could be accessed via the senior operational team. The viewing area and access for relatives was open seven days a week.
- The bereavement office was open from 9am until 5pm on Mondays to Fridays, staff told us in exceptional circumstances; arrangements would be made to issue death certificates out of hours on the grounds of religious or cultural needs. The hospital's senior operational team coordinated this.
- The chaplaincy team provided cover 24 hours a day, seven days a week. They were able to provide an on-call service outside their normal working hours.

Access to information

- Information needed to deliver effective care and treatment was available to relevant staff in a timely and accessible way.
- The DNACPR forms were at the front of the patients' notes. The forms had red edging, which made them easily identifiable and allowed easy access in an emergency. These forms stayed with the patients, going with them into the community and then when going back into hospital.
- There was no countywide end of life register or information technology system between the trust, mental health services, GPs and primary care teams. There was a risk some information would not be shared

effectively. However, there was a hospital wide end of life register in the trust. This enabled the hospital to have an up to date register of all patients currently receiving end of life care within the trust. The risk had been mitigated by SPCT staff maintaining phone contact with the patients' GPs, ensuring appropriate referrals were made and use of the care plan for the dying person between services. This meant information such as discharge summaries, reasons for admission, changes to medication and DNACPR status was shared.

- The end of life nurse had worked with the information technology (IT) department to add an amber care bundle question on the electronic discharge summary. This informed the patient's GP that the patient had an uncertain recovery during the last hospital admission and highlighted the importance of further conversations regarding individual preferences and priorities of care. The team had also developed information about the amber care bundle for patients and carers. This was available on all wards that used the amber care bundle.
- When older people with complex needs were being discharged, we saw that the staff involved those close to the patient so that correct clothing or equipment could be brought into hospital.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- There was not always a clear record of discussions about DNACPR with patients who had capacity. Mental capacity assessments were not always clearly recorded to underpin decisions about DNACPR.
- We did not see robust evidence of mental capacity assessments being recorded. Following the case of Tracey v Addenbrooks, it was clarified that whilst the decision for resuscitation is to be based on clinical judgement, the information must be given to the patient and/or family where relevant. (The case was a landmark judgment handed down in relation to Janet Tracey in 2014, which found that an NHS trust had a legal duty to tell a patient, with mental capacity, that a do not attempt cardiac pulmonary resuscitation (DNACPR) order had been placed on her medical records.)
- We reviewed 33 DNACPR forms and patient medical records across all ward areas and the emergency department.
- On 15 DNACPR forms (45% of those we reviewed), the doctor completing the form had identified that the patient did not have capacity. However, in 14 of these cases, no formal record of the mental capacity assessment recorded of the patient's ability to understand this decision and to participate in any discussions. This meant that there was no documented evidence that staff had acted in accordance with the requirements of the Mental Capacity Act 2005 (MCA) and associated code of practice.
- We saw in the notes of one patient that the doctor carrying out the decision used the 'two- stage test' to assess whether the patient did or did not have capacity. The two-stage test is where the clinician identifies whether there is an impairment of or disturbance in the functioning of the person's mind or brain. If an impairment or disturbance of the mind or brain is identified, then staff move onto the second stage of the test. The second stage of the test tests whether that the person is able to make a decision if they can understand the information about the decision to be made, retain that information in their mind, use or weigh-up the information as part of the decision process and communicate their decision. If a person is unable to meet these four criteria, they are assessed to lack mental capacity (Mental Capacity Act 2005: Code of Practice).
- We saw two DNACPR forms where the doctor completing the form had not informed the patient directly and had not recorded that the patient did not have capacity. We could not identify a reason for not informing the patient of the DNACPR decision.
- On one form, the doctor had identified the patient had capacity but had not discussed the DNACPR with them at the request of the family to avoid unnecessary distress. This was against the patient's legal rights and in breach of the mental capacity act. We raised this with the nurse in charge at the time of inspection, who discussed this with the relevant medical staff to address the situation.
- 32 DNACPR forms stated that the decision about DNACPR had been communicated with a relative if the patient lacked mental capacity and was unable to participate in discussions. We saw in 26 cases (79%), the patients' medical records or treatment escalation plans included a summary of communication about DNACPR with either the patient or their relatives.
- Seven sets of medical notes or treatment escalation plans (21%) did not evidence that the decision about DNACPR had been communicated with the patient, a relative or next of kin or why this had not been done.

End of life care

Clinicians may be asked to justify their decisions about DNACPR. Without a summary of the discussion, there was a risk that staff completing the document would not have evidence of the discussion they had.

- Nursing staff we spoke with demonstrated a good understanding of their responsibilities regarding the MCA and knew what to do when patients were unable to give informed consent. We saw mental capacity assessments for decisions around provision of treatment and consent for intervention.
- DNACPR was discussed at the safety huddles and monitored through the DNACPR audit undertaken by the resuscitation team.
- We saw the trust carried out routine DNACPR audits. The trust provided us with the data from a DNACPR audit carried out between April 2016 and January 2017. The audit showed that all forms audited had been signed by the correct grade of doctor: 84% of the forms had been signed by nurse in charge and 81% of the forms showed DNACPR had been discussed with the patient, and/or the family.
- We raised this as a concern during the inspection, and the trust took urgent actions to clarify with all staff the procedure for recording patient's capacity status as well as carrying out further audits to ensure this was being complied with.
- The resuscitation team had developed an action plan from the most recent documentation audit results. The action plan identified commonly missed information and the specialty with most missed information. The resuscitation team fed back the audit information to each specialty and carried out targeted training sessions when necessary.
- Staff we spoke to, understood the deprivation of liberty safeguards and explained the process they would follow if they felt a patient was at risk of harm to themselves or others.

Are end of life care services caring?

Good

We rated the service to be good for caring because:

- Patients were supported and treated with dignity and respect.
- Patients and those close to them were very happy with the care that had been provided to them.
- We saw staff carry out care to patients in a respectful and careful manner.
- Records showed patients were involved in making decision about their care.
- We saw evidence that the staff had spent time talking with patients and their relatives.
- Patients and those close to them were communicated with and received necessary information in a way that they could understand.

Compassionate care

- We saw staff carrying out care for patients with a kind, caring, compassionate attitude. Staff spoke with patients politely and respected their privacy and dignity by asking for consent to proceed with tasks.
- We observed staff had positive relationships with patients and those close to them. Staff spent time talking with patients and those close to them.
- Staff showed an encouraging, sensitive and supportive attitude to patients and those close to them. We observed ward staff and specialist palliative care team (SPCT) clinical nurse specialists (CNS) had positive relationships with patients and those close to them.
- Relatives told us staff made sure that people's privacy and dignity was always respected when they provided care, particularly during physical or intimate care. Staff asked patients how best they could assist them and informed them of the steps they would be taking. We saw staff ensured patients were not left uncovered unnecessarily.
- Staff understood and respected patients' personal, cultural, social and religious needs.
- We saw and relatives told us staff provided care in line with patient wishes.
- We saw from the National Care of the Dying Audit 2016 that the trust performed the same as the England average on the clinical indicator that patients were given an opportunity to have concerns listened to.
- Staff responded in a compassionate, timely and appropriate way when people experienced physical pain, discomfort or emotional distress.
- The SPCT staff we observed were respectful and maintained patients' dignity. There was a person-centred culture and we saw staff responding to patients' wishes promptly.

End of life care

- Staff respected confidentiality and conversations about patients' needs were discussed away from open, shared areas. Conversations were observed to be taking place in offices and not in the middle of the wards or corridors where they could not be over heard.
- Mortuary staff were observed to handle bodies in a professional and respectful way. There were processes in place for the mortuary staff to provide feedback to ward staff and porters, should there be any concerns.
- The hospital had processes in place to honouring people's wishes for organ and tissue donation.

Understanding and involvement of patients and those close to them

- Staff communicated with patients in a way that they understood their care, treatment and condition.
- Patients we spoke with told us that staff communicated with them so that they understood their care, treatment and condition. We reviewed 10 sets of notes: each demonstrated people and their relatives were being kept actively involved in their care.
- Patients we spoke with stated that the care they received was very good and they felt involved in their care.
- We saw staff had recognised when patients and those close to them needed additional support to help them understand and be involved in their care and treatment and enabled them to access this. We saw staff had accessed advocates appropriately.
- We saw staff assisting patients to eat and drink at lunchtime. Staff sat down with patients to do this. We observed them speaking appropriately, making the mealtime relaxed.
- We were provided with feedback about the service from July to September 2016. We saw there had been 337 adult deaths at the hospital. Of these, 299 had been managed by bereavement service. We saw the majority of families were satisfied with the level of care their loved ones had received. There were two negative concerns in relation to issues that had occurred on the wards. Both of these were concerns about communication. We saw action had been taken to prevent similar occurrences in the future; an electronic incident report was created, apologies were made and information was given to the families about making formal complaints. We saw a summary of the positive feedback, which referred to both the ward staff and the SPCT. Positive feedback included that the patient felt the hospital ward was made to feel home from home, staff genuinely cared for the patient and staff were informative, helpful, lovely and friendly. Information from the bereavement survey was fed back to the end of life strategy group, the clinical quality effectiveness group and to the executive board.
- Staff made sure that patients and those close to them were able to find further information or ask questions about their care and treatment.

Emotional support

- Staff understood the impact that a patient's care, treatment or condition would have on the wellbeing of the patients and those close to them.
- Staff in the bereavement team told us their role was to signpost people to further services such as the local hospice or bereavement support charities.
- Staff in the chaplaincy team were available to offer spiritual support to patients 24 hours a day, seven days a week when required.
- Staff in the chaplaincy team worked closely with the bereavement midwife based in the hospital maternity department. They arranged and delivered a regular remembrance service for those whose babies and children had miscarried or died. This was provided approximately every two months, and was supported by a national stillbirth and neonatal death charity. We saw a wide range of people attended this.
- The team also provided an annual remembrance service at a local church, for families and friends of adults who had died in the hospital.

Are end of life care services responsive?

Good

We rated responsiveness as good because:

- The service collected information about the needs of the local population, and used this to inform how services were planned and delivered.
- Patients had timely access to initial assessment, with 97% of patients referred to the palliative care team seen within 24 hours, between February 2016 and January 2017.
- The service collected information on the percentage of patients who died in their preferred location through a local commissioning for quality and innovation (CQUIN)

for end of life care for 2016 to 2017. Learning from this CQUIN programme was being used to drive improvements in the service and service leads were monitoring the effectiveness of the action plan in place.
- The service was able to meet the needs of patients with vulnerabilities and from different cultures and backgrounds.
- The trust did not have a commissioned formal 24 hour 'rapid discharge' service. However, the Specialist Palliative Care team (SPCT) worked with a local end of life care discharge service, the Macmillan Social Care Co-coordinator, primary care teams, local hospices as well as a local Community Hospital (Daventry) to meet patient preferences regarding place of care and place of death where possible. This supported patients to be discharged at an appropriate time and when all necessary care arrangements were in place.
- While there were no designated overnight accommodation facilities on site, wards provided recliner chairs or made their day room available for relatives for those who wished to remain at their relative's bedside.
- Appropriate support and advice was available for relatives.
- There had been no complaints about end of life care from December 2015 to November 2016.

However:

- Whilst the hospital did collect information on the numbers of patients who were rapidly discharged (from regional data), however, it was not systematically used within the whole SPCT to drive improvements.
- There was a Christian chapel on site. It was a quiet space where people of all faiths and none could pray or reflect. However, there was little attempt to make the area inclusive to those of other faiths.

Service planning and delivery to meet the needs of local people

- The service collected information about the needs of the local population, and used this to inform how services were planned and delivered.
- The SPCT team had established close links with other providers in the local area, including the local hospice, primary care providers and community nurses. The aim of this was to improve patients' experiences as they moved between care settings. We saw documented evidence of a multidisciplinary approach to care.
- The service collected information about the percentage of patients who were imminently dying and who had a care plan in place. The service used this information to monitor the use of the care plan across the trust.
- The service collected information on the total number of deaths that had been identified on the hospital's end of life care register. In October 2016, 52% of total number of deaths had been identified on the end of life care register. The service used this information to monitor the timeliness of identification of imminent death to see if this was being done effectively.
- The specialist palliative care team (SPCT) received 638 referrals for the year April 2015 to March 2016, which was a 22% increase in caseload from the previous 12 months. The service stated this increase was due to the screening assessments of all patients identified as being in the last few days of life. In line with national trends, there was an increase in non-cancer referrals, which made up approximately 34% of the workload.
- The service took part in the local commissioning for quality and innovation (CQUIN) for end of life care for 2016 to 2017, which related to whether patients' wishes regarding their preferred places of death were met. The CQUINs payments' framework encourages care providers to share and continually improve how care is delivered and to achieve transparency and overall improvement in healthcare. This was a collaborative CQUIN for NGH, and two other health trusts in Northamptonshire, to help deliver person-centred end of life care through improved integration within and between providers of healthcare along the pathway.
- There was not a designated ward for patients receiving end of life care. Staff told us they tried to allocate side rooms to patients who were receiving end of life care, in order to offer quiet and private surroundings for the patient and their families. They also said that often patients at the end of life had to be cared for on open wards, as the use of single rooms were prioritised for patients who required isolation.
- The hospital did not have designated overnight accommodation facilities on site: however wards provided recliner chairs for those who wished to remain at their relative's bedside. Some wards made their day room available for relatives to use on such occasions.
- Reduced parking fees for relatives of patients receiving end of life care could be arranged by staff, to enable relatives to spend the maximum amount of time with their relative.

End of life care

- The service provided support to honour the spiritual and cultural wishes of the deceased person and their family and carers, whilst making sure legal obligations were met. Staff had information about the differing requirements of different religious groups. The trust did not have facilities in the mortuary for family and carers to prepare the body for transfer however, this could be arranged at the funeral directors premises.
- The service had a designated bereavement service, which was based within its own unit called the Evelyn centre. The bereavement service was open Monday to Friday, from 8.30am to 4.30pm. There was an answerphone service for out of hours' phone messages. The bereavement service provided sympathetic information, advice and support to bereaved relatives and carers by helping them through the practical arrangements that follow a death, such as registering the death and making contact with a funeral director and the Coroner and Coroner's Office, if required. They ensured they returned the deceased person's possessions to the relatives in a sensitive caring manner.
- We saw the service would provide information about local counselling services. The trust had a Macmillan information centre in the oncology department at the hospital. The information centre offered a team of experts and trained volunteers to answer questions and information regarding local support groups and help for the financial problems cancer may create. Patients and those close to them were able to access booklets, leaflets and other sources of information, free of charge.
- The service worked closely with the two local hospices. The service had a visiting consultant from the local hospice, who provided four half-day sessions of clinical support per week. This assisted the close liaison with the hospice regarding shared patients. The leads for education in the trust and the hospice regularly collaborated. For example, they had recently worked together on some work around preferred place of death.
- SPCT information for patients and relatives were available on the intranet. All staff had access to this information 24 hours a day, seven days a week. Staff we spoke with on the wards were able to direct us to this information and stated that they used it to support their practice.

Meeting people's individual needs

- Services were generally planned and delivered in a way that took account of the needs of different people on the grounds of age, disability, gender, race, religion or belief and sexual orientation.
- The service was also able to meet the needs of patients living with a dementia or with a learning disability. We saw information and pain relief tools that were adapted specifically for people living with dementia and with learning disabilities. Pain control of patients was reviewed regularly, prompted by the dying person's care plan. For example, the document prompted staff to assess regularly and observe for verbal and non-verbal signs of pain, anticipate when pain might occur (such as, on movement), record pain, intervention and outcomes. It prompted staff to use a pain assessment tool specifically designed for people living with dementia, a learning disability or a cognitive impairment.
- The Emergency department (ED) had developed an end of life care room that was situated adjacent to the resuscitation area. The room had been decorated with pastel colours and was close to a kitchenette and separate family quiet room. There was signage outside of the room to indicate when it was occupied to minimise the risk of patients and their loved ones being disturbed. Staff had received specific training in communicating with patients and their loved ones in these situations and had access to useful support and information via their dedicated intranet page. There was a specific pathway and guidance for managing these situations when the patient was a child or young person. The ED had developed a specific continuation of care record for patients who were in the end of life care room; this included ensuring that they had received consultation and timely review for symptom control.
- The maternity department had two bereavement midwives who provided support to women and those close to them. We saw there was a specialist room called the snowdrop nursery that had been refurbished by a bereavement charity. The snowdrop nursery had a courtyard for women to use and was sensitively designed, with a dedicated entrance and exit for families. Staff supported women to collect mementos such as photographs, footprints and handprints and provided information about making a memory box for parents.
- Staff told us that if a patient died when the family were not present, they ensured that they offered the family the opportunity to come to the ward before the

deceased person was moved to the mortuary. The mortuary's viewing area provided a suitable environment for relatives to be able to view their close one.

- The hospital had a Macmillan cancer support information centre to ensure that people affected by cancer had access to comprehensive and appropriate information and support. The centre was open from 9am to 5pm, Monday to Friday. The service offered a drop-in service for information and support, as well as health, financial and life management advice. The team at the centre could refer to other healthcare professionals, provided details of local and national support services and organisations, details about complementary therapies and outreach sessions in the community.
- The information centre offered a team of experts and trained volunteers to answer questions, provide information regarding local support groups and help with the financial problems cancer can create. Patients and those close to them were able to access booklets, leaflets and other sources of information, free of charge.
- The hospital had leaflets available for relatives, for example, leaflets explaining procedures to be undertaken after the death of a patient. Leaflets for carers about end of life care at the hospital and information about decisions about cardiopulmonary resuscitation were also available. We did not see any leaflets in any languages other than English. Staff told us leaflets could be provided in other languages, large print, braille and in an audio format on request. Staff also told us they had access to translator services. The patient advice and liaison service (PALS) could book professional interpreters for patients.
- The chaplains attended to anyone asking for support. Support from a specific faith was provided through local religious leaders who could be called. The team had a group of voluntary visitors, from across the community, who visited patients to offer spiritual support. For patients who wished to take communion, the chaplain or an authorised member of the team brought communion to their bedside.
- There was a Christian chapel on site. The chapel was open 24 hours a day, seven days a week and was used by patients, relatives, carers and staff. The chaplaincy team provided Christian spiritual and pastoral care and religious support for patients, relatives and staff across the trust. Staff alerted the chaplaincy team if a patient asked to see them or patients could refer themselves. For patients who wished to take communion, but could not attend the chapel, the chaplain or an authorised member of the team brought communion to their bedside. There was a book for people to write their prayer requests in.
- Staff told us while this was a Christian chapel, it was a quiet space where people of all faiths and none could pray or reflect. However, there was little attempt to make the area inclusive to those of other faiths. For example, there was nothing with which to easily cover crosses or store bibles. Some attempts had been made, for example, an A4 size computer generated sign had been placed to identify the direction of Mecca, however, the sign had been altered by hand, and someone had crossed out the word Mecca and replaced it with the word Qibla. In Islam, the word Qibla is used by Muslims to indicate the direction to face to perform ritual prayers and points towards the city of Mecca. There were religious books for the use of those of other faiths such as Guru Granth Sahib and the Koran however: these had been left on a windowsill and were not stored respectfully.
- There was room in the chapel area that could be used for a wudu (an Islamic washing ritual). However, at the time of the inspection, the room was being used as a kitchen, washing up had been left on the sink area and there was a mop and mop bucket present. We raised the issue about the washroom being used as a kitchen during the inspection and the area was tidied.
- The bereavement office staff were available from Monday to Friday, 9am to 5pm, with a telephone message service outside of these hours. The bereavement officers' main role was to liaise with bereaved families and co-ordinate the issue of the medical certificate so that the death could be registered and the funeral arranged. They arranged visits to the chapel of rest, liaised with relatives about death certificates and provided relatives with information such as how to register a death, cremation papers and the coroner's office. They also returned property to family and carers.
- There was an open visiting policy for patients receiving end of life care. There were no visiting time restrictions for family and friends visiting a patient in the last days or hours of life.

- The service had piloted, evaluated and fully implemented an end of life companion volunteer scheme for dying patients who may not have any visitors. The service had support from the local community in caring for patients at the end of their life

Access and flow

- Patients had timely access to initial assessment, diagnosis or urgent treatment with 94% of patients referred to the palliative care team seen within 24 hours, in December 2016.
- Patients were referred directly to SPCT following the daily safety huddle, on the SPCT ward visits or via a telephone referral. Ward staff told us the SPCT were responsive, with 94% of patients referred to the palliative care team seen within 24 hours in December 2016. The service audited the referral/response times for the service to measure against the agreed operational standards in order to provide a full year of data.
- Between 1 February 2016 and 31 January 2017, 1,183 referrals were recorded. 62 patients died before seen. (Of these people, 57 died on the day of referral. five other patients died on the day after referral). This left 1,121 accepted referrals and 97% were seen within 24 hours of referral (same day or next day), 86% were seen on the same day as referred. One percent were non-urgent referrals received on Friday and seen on the Monday (as per the agreed operational policy). For three patients, assessment was deferred for four days for clinical reasons (e.g. non-urgent referral and joint visit arranged with site-specific clinical nurse specialist). All patients referred were seen within four days.
- This meant the service met their operational standard, and responded to referrals in a timely way over the last 12 month period. As a result of the audit the service were looking at how to support ward teams in early recognition of end of fife as part of the work-programme going forward.
- All ward staff we spoke with could identify the SPCT clinical nurse specialists and consultant. The service reported there were 11 patients within the hospital on an end of life care plan on 31 January 2017. There were no patients waiting more than 24 hours to be assessed at the time of the inspection.
- The SPCT clinical nurse specialists picked up referrals and phone messages for the SPCT each time they went back to the office. The SPCT held a bleep and urgent referrals could be made by bleeping the SPCT. Staff told us and we saw patients who required end of life care were identified at daily ward rounds. Once identified, the ward team would refer the patient for specialist care.
- NGH had achieved the CQUIN in quarter one, two and three (April to December 2016), however, the service had identified a number of themes for improvement related to the non- achievement of preferred place of death. These included poor prognostication (predicting the prognosis) resulting in unexpectedly rapid patient deterioration, a lack of advance care planning and late referral to specialist palliative care team. From the data for quarter three (October to December 2016), 60% of patients had achieved their preferred place of death. From the trust's quarterly CQUIN progress report for this period (October to December 2016), the trust had identified further improvements were required to ensure all patients referred to the SPCT had a preferred place of death clearly recorded in their patient notes. All areas for improvement were being addressed through training and service leads were monitoring the progress of the action plan in place.
- The SPCT had carried out an audit in January 2017, looking at the information between February 2016 and January 2017 on whether a patient's preferred place of death had been recorded for individual patients. Care records of patients known to the SPCT, who had died at the hospital were reviewed. The team were not always able to identify the percentage of patients who died in their preferred place of death as this was not always recorded. The audit identified a number of themes for improvement. For example, delayed referrals to the SPCT, a lack of advance care planning and a number of patients who were discharged from hospital without any advance care planning having been undertaken (for some patients with complex respiratory disease). It also noted that a number of patients who experienced delayed referrals to the SPCT were then too ill for discharge planning to be successful. The audit showed that a number of patients with respiratory disease had been discharged from hospital, with an exacerbation of their illness, within a few months or weeks of their final admission. There was no evidence of any advance care planning or discussion about preferred place of death prior to their final admission. This was being monitored via an ongoing action plan. The audit also showed that

a number of patients who experienced delayed referral to the SPCT were then too ill for discharge planning to be successful. This was also being monitored via an action plan.

- The hospital worked with local services to enable the rapid discharge process to support patients to be discharged at an appropriate time and when all necessary care arrangements were in place. This included transferring to their normal residence or to a hospice from hospital. Whilst the hospital did collect information on the numbers of patients who were rapidly discharged (from regional data), however, it was not systematically used within the whole SPCT to drive improvements. Between 31 January 2016 to 1 February 2017, there were 68 recorded hospital to hospice transfers. Some of these transfers were for complex specialist assessment and symptom control. Nineteen patients specifically identified hospice as their preferred place of care or preferred place of death. Two patients (10%) were transferred on the same day as seen by SPCT. Ten patients (52%) were transferred within 24 hours of assessment by the SPCT. Four patients (21%) were transferred within 48 hours of assessment by the SPCT. Three patients (15%) waited three days for transfer as the hospices did not accept week-end transfers. Two patients died at the hospice on the day of transfer. Collecting this information, the service was able to assess if these patients' wishes had been met. The service was in the process of reviewing this information to assess effectiveness of the service.
- Between 1 February 2016 and 31 January 2017, the SPCT identified 23 patients on the caseload whose care plan included 'Rapid discharge' from hospital to home (or nursing home). Of these patients: nine patients (40%) were discharged the same day (4 from urgent Care EAU or A&E). Seven patients (31%) were discharged within 24 hours. Six patients (26%) were discharged within 48 hours of their request to leave hospital. The service told us the term 'rapid' varied from within the hours of a working day, to within three days of referral depending on the place of discharge and on the time a referral to the team is made and received.
- Porters told us that they were able to respond promptly to requests to transfer deceased patients to the mortuary. This was usually within 15 minutes and they were able to prioritise accordingly. We spoke with ward staff who told us they did not have concerns about response times.

Learning from complaints and concerns

- There was an effective complaint system in place. Staff were able to tell us how they would support patients and relatives to raise a concern.
- Relatives we spoke with told us they knew how to make a complaint or raise concerns if it was necessary.
- There had been no complaints specifically about end of life care team, the mortuary or the bereavement team from December 2015 and November 2016.
- The SPCT lead told us they were provided with complaints from other services, where the patients had received end of life care. The SPCT had access to the investigations and identified learning. The SPCT reviewed these incidents and complaints and discussed within their MDT, to see if improvements to services could be made and to identify needs for future end of life care training they provided to hospital staff to ensure lessons were learnt. For example, we saw the tissue viability team had met the lead nurse for specialist palliative care and end of life care to address concerns about the repositioning of patients who were at the end of life that had been raised at the share and learn meetings
- The mortuary manager, the bereavement team manager and SPCT lead told us how they would deal with complaints, but told us that this rarely happened with palliative care services. They told us that managers investigated complaints and incidents from other departments so that an independent view was taken.
- We saw letters and cards of thanks from relatives and carers addressed to the SPCT, bereavement team, mortuary team and the chaplain in their offices. The teams did not record the number of compliments they received.
- The service worked with their patient advice and liaison service (PALS) teams to develop a process for capturing the experience of families of those receiving end of life care in the hospital, when they collected the death certificate. This was called the "real time right time" survey. It was launched in the autumn of 2016 following a positive pilot in the summer of 2016. The service had documented end of life care feedback from bereaved relatives, friends and carers since the beginning of June 2016. The feedback was been given freely in conversation with bereavement service staff as the service felt they should not be prompting families at such a difficult time.

End of life care

Are end of life care services well-led?

Good

We rated well-led as good because:

- The trust had an executive board representative for end of life care that provided representation and accountability for end of life care at board level.
- Leadership of the SPCT was well defined and leaders were knowledgeable about quality issues and priorities. They understood what the challenges were and took action to address them.
- The trust had a three-year end of life care strategy. The strategy was realistic to achieve the priorities and deliver good quality care and clearly linked to the trust's vision and values.
- There was an effective governance framework to support the delivery of the strategy and quality care. Learning from audits and performance outcomes was used to drive improvements in the service. The risk register was generally reflective of risks.
- Specialist palliative care team (SPCT) and ward staff we spoke with told us end of life care was a high priority for the trust. Staff we spoke with told us of their commitment to provide safe and caring services, and spoke positively about the care they delivered.
- The service had piloted, evaluated and fully implemented an end of life companion volunteer scheme for dying patients who may not have any visitors. The service had support from the local community in caring for patient at the end of their life.

However:

- The trust did not have a non-executive board representative for end of life care at the time of the inspection but were recruiting to this position.
- Whilst the service collected information on the percentage of patients who died in their preferred location through a local commissioning for quality and innovation (CQUIN) for end of life care for 2016 to 2017 which the trust board was aware of, this information was not being consistently used to drive improvements for patient care and choice throughout the SPCT. Not all staff in the SPCT were aware this information was being collected and how it was used to make improvements.

Leadership of service

- Staff we spoke with told us that there was good leadership of the SPCT. The team was led by the end of life project lead, who had been appointed in July 2016.
- Since the last inspection, the trust had employed a full time palliative care consultant. They had commenced their post in January 2017. Despite only being in post a number of weeks, they had begun to establish their role in the team and they were working with the end of life project lead to identify service needs. All of the ward staff we spoke with knew who the leads were for end of life care.
- The director of nursing, midwifery and patient services was the executive lead for end of life care: they provided representation and accountability for end of life care (EOLC) at board level.
- The non-executive director post was vacant at the time of inspection. The trust was in the process of identifying a suitable candidate but they were unable to identify a timescale for this at the time of inspection.
- All staff we spoke with were aware of who their immediate managers were and were aware of the roles of the senior management team.
- Staff we spoke with felt the service leads had the capacity, capability, and experience to lead effectively.
- Managers were visible and approachable. Staff knew who they could ask for support when their line managers were not at the hospital.
- The chaplain, mortuary team and bereavement service told us that they felt supported and listened to by their line management.
- Whilst there was a drive to collect and use performance information to make improvements in the service at trust board level and with local managers, not all staff in the SPCT were fully aware of these plans and actions.

Vision and strategy for this service

- The hospital had a clear vision and set of values, focused on providing safe, effective and quality care. The vision was 'to provide the best possible care for all our patients'. The values were to put patient safety above all else, aspire to excellence, reflect, learn and improve, and respect and support each other. All staff in the SPCT were aware of these values.
- SPCT and ward staff told us end of life care was a high priority for the trust. The hospital had a three-year strategy for end of life care for adults for 2017 to 2019 to achieve its priorities and deliver good quality care. The strategy set out the trust's commitment to support the

provision of safe, responsive, effective, compassionate and well-led care for patients recognised to be in the last year of life. This included those whose recovery was uncertain and those who were in the last days and hours of life.

- The strategy reflected the vision and values of the trust to provide the best possible care to patients, as there was only one chance to get end of life care right. There were three strategic objectives. These were a focus on quality and safety, to exceed patient expectations and to enable excellence through 'our people' (the staff). This was monitored through the services operational group and strategy group.
- The strategy set out the aims and objectives for the SPCT, prompted the SPCT to carry out surveys and audits to identify where they needed to make improvements and provide training to improve knowledge and skills. The SPCT felt engaged and involved in the strategy, saying it had provided them with a clear vision to improve and develop end of life care.
- The vision, values and strategic objectives were developed by the SPCT, and key members of trust staff including the chaplaincy team, the bereavement team and the board. The strategy had been guided by national guidance, the results of the most recent National Care of the Dying Audit 2015, published in March 2016, and the findings from the 2014 CQC inspection.
- The strategy for end of life care across Northamptonshire 2014 to 2019 had identified a need to deliver electronic palliative care co-ordination system (EPaCCS) for the county but at the time of inspection this had not been achieved and there was no date provided for completion of this task.
- Ward staff we spoke with were aware of the strategy and the demonstrated they understood what the vision and values were and their role in achieving it.
- While the strategy did not specifically look at end of life care for the frail elderly, people living with dementia and people with long term conditions, it aimed to apply to all adult inpatient service staff who were involved in planning and delivering care for patients (and those important to them) at the end of life. It incorporated the care of patients whose needs were met by ward multidisciplinary teams, as well as with the provision of specialist support, for example, that provided by the Macmillan specialist palliative care and end of life team, nurse specialists, the chaplaincy and services that provided care following discharge.
- Progress against delivering the strategy was monitored and reviewed regularly at the service operational group, who met twice a quarter. The strategy group met once a quarter and provided a review of the actions carried out by the operational group. The strategy group provided updates to the clinical quality effectiveness group, who reported directly to the board. Link nurses across the wards disseminated information to ward staff. Staff we spoke with on the wards stated they felt engaged in providing end of life care on the wards and were well supported by the SPCT and end of life care teams.
- The trust's lead nurse, the visiting consultant and the trust's director of strategy sat on the countywide (Northamptonshire) end of life care strategy group.

Governance, risk management and quality measurement

- There was an effective governance framework to support the delivery of the strategy and quality care. Staff were clear about their roles and were able to demonstrate they understood what they are accountable for.
- The service had an operational group, which meet twice a quarter that was attended by clinicians and ward based staff. The service also had an end of life care strategy group, which met once a quarter. This group provided a forum to address complaints and queries raised relating to end of life care, through the patient advisory and liaison service (PALS) and the bereavement service. The group investigated and reported on incidents in line with trust policy. Numbers and themes of any incidents and complaints were reported and monitored. This group also provided a review of the actions carried out by the operational group. The strategy group provided updates to the clinical quality effectiveness group who reported directly to the board.
- EOLC services received coverage in board meetings and in other relevant meetings that reported to the board. For example, we reviewed the minutes of board meetings for November 2016, where EOLC was discussed. We saw a report that provided a quarterly update regarding end of life care service across the trust. The report identified the service had been successfully in the appointment of a whole time

equivalent (WTE) consultant in palliative medicine and monitored the number of patients who were imminently dying who had a care plan in place. They had discussed an internal audit of the dying person's care plan, which demonstrated evidence of senior medical review and discussion with patients and/or family. They had also discussed that there was a lack of evidence related to priorities and preferences for end of life care and last offices. The board monitored the total number of deaths that had been identified on the end of life care register

- The service's risk register was generally reflective of the risks to the delivery of safe and quality care and treatment. Items that were on the risk register were being managed and we saw evidence of mitigating actions andissues being monitored.
- Not all risks were on the risk register. For example, the door seal to one of the storage units in the mortuary and staff also informed us that the bariatric trolley used to bring deceased patients from the wards to the mortuary was not fit for purpose. There was some evidence of clinical and internal audit, which was used to monitor quality and systems to identify where action should be taken. The service had some local audits in place to measure the effectiveness and outcomes of the service, for example an opioid prescribing audit and SPCT seven-day working clinical activity monitoring. Whilst the hospital was not collating information about the percentage of patients who were discharged home within 24 hours, the service had access to this information from an external source. The service had taken part in the National Care of the Dying Audit of Hospitals (NCDAH) 2014 to 2015. The service planned to take part in future NCDAH audits.
- The service collected information on the percentage of patients who died in their preferred location through a local commissioning for quality and innovation (CQUIN) for end of life care for 2016 to 2017. The trust's board were aware of this information, however, awareness about how this performance information was being used to drive improvements in the service was variable among staff working in the SPCT. Not all team members were aware this information was being collected or being used to drive improvements in patient care and choice.
- The hospital had an action plan in place to improve the collection of information for all patients who died in their preferred location and the percentage of patients that had achieved discharge to their preferred place within 24 hours. This action plan was being reviewed and monitoring by senior staff in the end of life care service and we saw evidence of this in the end of life care team meeting minutes. However, this was not on the risk register at the time of the inspection. Whilst staff in the SPCT team knew the value of collecting this information and they said they were planning to start collecting this in the coming year.

Culture within the service

- Staff told us they felt respected and valued by the hospital managers, patients and those close to them. Staff felt able to raise any concerns with managers and that they would be listened to. Staff were aware of the hospital's whistleblowing policy.
- Staff we spoke with told us of their commitment to provide safe and caring services, and spoke positively about the care they delivered.
- Staff felt that sufficient priority was given to the EOLC service as a whole. All staff we spoke with felt provision of good end of life care was vital.
- We did not see any evidence of formal team meetings or supervision within the mortuary team. However, staff told us, this was because it was a small team, performance issues, concerns, complaints and general communications were discussed informally. Staff within the mortuary felt supported and did not voice any concerns about their management arrangements.

Public engagement

- The service sought patients' views and experiences. Information gathered was acted on to shape and improve the services and culture. The trust worked with their PALS teams to develop a process for capturing the experience of families of those receiving end of life care in the hospital, when they collected the death certificate. This was called the "real time right time" survey.
- The service used the Friends and Family Test (FFT) as a feedback tool for patients although, these did not specifically identify end of life care results. The FFT is an important feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience.

- The service collected bereaved carer's feedback when they visited the bereavement suite after a death. The service told this was felt to be a more personal approach compared to sending out surveys.

Staff engagement

- The SPCT held regular formal team meetings where information and learning from safety and quality audits could be shared.
- The trust carried out surveys on staff satisfaction, although these did not specifically identify end of life care results.
- Staff within the SPCT had been involved in the development of the end of life care strategic objectives.

Innovation, improvement and sustainability

- There were a number of innovations the service was proud of.
- The SPCT screened of all adult patients identified as approaching the end of their lives for complex needs and symptom issues. Patients were then added to the hospital's end of life register, where they were to be monitored and supported by services to meet their needs.
- The emergency department had developed information and an education document for staff providing EOLC in the emergency department. It was called the 'JIGSAW' and was accessible for all staff on the intranet. Staff we spoke with were complimentary of the document and had found a useful resource.
- A clinical nurse specialist had carried out a research project into patients with heart failure for which they were awarded an Master of Science is a master's degree (MSc). The results of this were disseminated across the Trust.
- The trust had published an article inside a national journal on the commissioning for quality and innovation (CQUIN) in end of life care provision. The need for communication skills training for staff had been clearly demonstrated through the end of life care CQUIN. The service had put in a successful bid to Health Education East Midlands (HEEM) for funding for training, and the county lead nurses for EOLC education were developing a collaboration that included social care, to take the training agenda forward.
- There had been a number of innovative approaches to the underpinning and embedding the use of the amber care bundle, for example, an amber care patient information booklet. The service had implemented case-note stickers to support ward staff in preventing inappropriate patient bed moves for dying patient.
- In 2015, the end of life strategy group supported a six-month project to evaluate the benefits of utilising volunteers to sit with dying patients. The aim of the pilot was to provide companionship for those with identified needs at the end of life, reduce distress, minimise the risk of patients dying alone, improve the patient and carer experience and provide practical support. An evaluation of the project identified the companion volunteers had delivered an innovative, compassionate and caring service for patients who were dying and their loved ones. The scheme was valued by ward staff and supported them in the delivery of responsive end of life care. The end of life strategy group endorsed the continuation of the project and more work was being undertaken to raise the profile of the scheme.

Outstanding practice and areas for improvement

Outstanding practice

- The geriatric emergency medicine service (GEMS) was outstanding in terms of providing awareness of and responding to the needs of patients within this group and developing a service that provided a multi-agency approach at the front door.
- Physician associate programmes were being developed to provide a larger group of decision-making clinicians and provide developmental opportunities for staff.
- The emergency department (ED) worked with external organisations to develop an on-site psychiatric liaison service within the ED, 24 hours a day, seven days a week.
- The ED was actively working with local educational institutions to develop courses that were specific to areas that were difficult to recruit to such as geriatric and paediatric emergency medicine and the ED had a robust leadership development programme in place.
- In the Sentinel Stroke National Audit Program (SSNAP) the hospital was rated as band A overall (A being the best and E the worst), in the April to June 2016 audit, which indicated a world-class stroke service.
- We visited patients being cared for in two out of the three care homes that the hospital used to place patients that were fit for discharge and awaiting their return back to the community. There was a weekly consultant led ward round once a week for these patients and a hospital doctor also visited both homes on three other days of the week. We reviewed 10 patients' records and saw in all there was excellent level of clinical oversight and detailed records of all input from the service's doctors.
- Staff were focused on continually improving the quality of care and the patient experience. For example, we saw evidence that the service was committed to improving the care of elderly patients, such as those living with dementia. Colour-coded bays were evident on some of the wards we visited and finger food boxes had been introduced, which made it easier for patients to eat when they wanted and helped them to maintain independence. Directorate leads told us of plans that were being developed in collaboration with primary care and community services to support the care of elderly patients at home.
- The end of life care service had piloted, evaluated and fully implemented an end of life companion volunteer scheme for dying patients who may not have any visitors. The service had support from the local community in caring for patient at the end of their life.
- The ED had developed an end of life care room that was situated adjacent to the resuscitation area. The room had been decorated with pastel colours and was close to a kitchenette and separate family quiet room. There was signage outside of the room to indicate when it was occupied to minimise the risk of patients and their loved ones being disturbed. Staff had received specific training in communicating with patients and their loved ones in these situations and had access to useful support and information via their dedicated intranet page. There was a specific pathway and guidance for managing these situations when the patient was a child or young person. The ED had developed a specific continuation of care record for patients who were in the end of life care room; this included ensuring that they had received consultation and timely review for symptom control.
- 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.

Areas for improvement

Action the hospital SHOULD take to improve

- To continue to work to improve performance in meeting the national four hour performance measure.
- To review the planned daily consultant cover in the emergency department as it did not meet the national recommendations of 16 hours per day.

Outstanding practice and areas for improvement

- To monitor the security and ensure access to medical care entrances is secured to reduce the risk of unauthorised access and vulnerable patients leaving unaccompanied.
- To monitor compliance with guidelines for documenting monitoring of invasive devices including peripheral vascular devices and urinary catheters.
- To review the potential impact to patients requiring cardiology procedures by use of the Heart Centre as an escalation area.
- Review systems so that patients have their venous thromboembolism (VTE) re-assessment 24 hours after admission.
- Review systems so that patients with hip fracture have a perioperative medical assessment within 72 hours of admission.
- Review systems so that patients whose operations are cancelled on the day of surgery are rebooked to be treated within 28 days.
- Monitor that medication is stored at the correct temperature in all rooms and fridges.
- To monitor the systems for denaturing controlled drugs.
- Consider sharing outcomes of national audits with all surgical staff to improve patient outcomes.
- Continue to monitor the time to initial clinical assessment in the emergency department so patients receive this assessment within 15 minutes.
- To monitor how patient's mental capacity assessments underpinning decisions about cardiopulmonary resuscitation is being evidenced in patients' records for end of life care decisions.
- To review the provision of information leaflets for the most commonly used languages in the area.
- Review the facilities in the chapel so it is inclusive to those of other faiths.
- To review systems for collecting information on the percentage of patients who are discharged to their preferred place of death and the number pf patients who are discharged to their preferred place within 24 hours.
- To monitor that records are stored securely preventing unauthorised people accessing patient records.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Nursing care Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Paragraph (2) Providers must make sure that staff who obtain the consent of people who use the service are familiar with the principles and codes of conduct associated with the Mental Capacity Act 2005, and are able to apply those when appropriate, for any of the people they are caring for. The regulation was not being met because decisions had been made about patient's capacity where there was no evidence of assessments used in the decision making progress or information documented in progress notes. This meant that staff who obtained consent of people who use the service did not follow the principles and codes of conduct associated with the Mental Capacity Act 2005.) We looked at 32 DNACPR forms across all ward areas. In 18 cases we saw that decisions had been made about patient's capacity where there was no evidence of assessments used in the decision making progress or information documented in progress notes.