Care Quality Commission

Hinchingbrooke Health Care NHS Trust

Hinchingbrooke Hospital

Quality Report

Hinchingbrooke Park
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Date of inspection visit: 20- 21st October 2015.
Unannounced inspections on 26 & 27 October and 5 November 2015
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This report describes our judgement of the quality of care at this hospital. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Ratings

Overall rating for this hospital	Requires improvement
Urgent and emergency services	Inadequate
Medical care (including older people's care)	Requires improvement
Surgery	Requires improvement
End of life care	Requires improvement

Summary of findings

Letter from the Chief Inspector of Hospitals

The Care Quality Commission (CQC) carried out a comprehensive inspection between the 15 and 18 September 2014 at which the trust was rated as inadequate and placed into special measures. The CQC undertook a review of the areas rated as inadequate in January 2015 to ensure the safety of patients. At this inspection we rated most elements as requiring improvement. We undertook a focused inspection to review all areas identified as requiring improvement and inadequate in October 2015 to monitor the trusts progress.

At our previous inspection the trust the trust had been privately managed by an independent company. This company withdrew its management of the trust at the end of March 2015. Since 1 April 2015 the trust has reverted to the traditional management structure of an NHS trust. A new board and new non-executive directors have been appointed. There is a new interim chief executive who replaces the previous chief executive. This has meant a number of changes have occurred at the trust since this time and we found a service in transition on inspection.

The comprehensive inspections result in a trust being assigned a rating of 'outstanding', 'good', 'requires improvement' or 'inadequate'. Each section of the service receives an individual rating, which, in turn, informs an overall trust rating. The inspection found that overall, the trust has a rating of 'Requires Improvement'. However the trust was rated as inadequate in ensuring that patients were protected from avoidable harm in urgent and emergency services.

Our key findings were as follows:

- Due to the structural management changes that had occurred over the past six months we found a service in transition. New systems and process were in place but these had yet to be embedded.
- Staff were caring and compassionate in their care of patients.
- The emergency and medical services required significant improvement to ensure patients were protected from avoidable harm.
- Services for patients at the end of their lives required improvement to ensure that patients received a safe, effective and responsive service that was well led.

We saw several areas of outstanding practice including:

- A member of staff on Apple Tree ward had introduced 'sensory bands' for the ward's dementia patients. These were knitted pockets which would be embellished with buttons and beads etc. There was an example band on display with an explanation within the ward. The intention of these sensory bands was that patients could wear or hold them to give them an immediate focus to explore.
- Good infection prevention and control initiative including different coloured aprons for different ward bays highlighting if staff move out of these areas without removing or changing their apron.
- The chaplaincy service continued to provide an excellent service, supportive of patients, families, carers and staff.
- There was robust implementation of Duty of Candour.

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

Importantly, the trust must:

- Be able to provide assurance that all members of staff are aware of the procedure for and necessity to, report all clinical incidents and near misses in a timely and accurate manner, ensuring these are thoroughly investigated and reported externally where necessary.
- Ensure that all staff responsible for supporting the feeding of patients have had adequate training in relation to the risks associated with various medical conditions.
- Ensure the end of life risk register records all the relevant risks involved in delivering end of life care to patients in the hospital setting.
- Ensure patient outcomes are monitored and audited and the information is used when reviewing the service.

Summary of findings

- Ensure that there is a robust incident and accident reporting system in place and that lessons learnt from investigations of reports are shared with staff to improve patient safety and experience.
- Ensure the service has an effective governance and risk management systems that reflect current risk and is understood by all staff.
- Ensure that environmental risk assessments are undertaken to ensure that mental health patients are safe from ligatures and self-harm within the department.
- Ensure that there is an effective process for monitoring ECGs and observations to ensure the safety of patients.
- Ensure that there is an immediate review of the environment and provision of children's services.
- Ensure that the time to treatment from a clinician in the emergency department is reviewed and times to treatment are improved.
- Ensure that the triage process for ambulance arrivals is received to ensure that the pathway for patients is safely and times of assessment accurately recorded.
- Ensure that infection control practices within the emergency department are improved.
- Ensure that the processes for the checking of equipment in the emergency department is improved and safe for patients.
- Ensure that allergies are recorded on medicines charts.

In addition the trust should:

- Ensure risk assessments on medical wards are fully completed, personalised to the patient and regularly reviewed for any changes.
- Ensure specialist palliative and end of life care patients are assessed and referred promptly to end of life care team.
- Ensure all appropriate paperwork is completed in a timely way and following best practice guidance.
- Ensure that the plan for end of life care is rolled out and embedded across the trust.
- Ensure there is adequate numbers of specialist medical staff.
- Ensure medicines records include all necessary information.
- Review the collection of audit data in relation stroke care to benchmark outcomes.
- Review the provision of nurse staffing at night within the emergency department.
- Review the need to monitor the culture of staff within the emergency department.
- Review the environment to ensure that environment supports good infection control.

On the basis of this inspection I have recommended that Hinchingbrooke Health Care NHS Trust remains in special measures.

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	Inadequate 	We rated urgent and emergency services at Hinchingbrooke Hospital as inadequate overall. Safety of services and leadership were rated as inadequate with effectiveness and responsiveness being rated as requires improvement. The care provided by staff at this service was good. Safety of service was inadequate because we identified 11 patients during the inspection who were at risk of deterioration, which were escalated by the inspection team to ensure that patients were safe. Patients with mental health concerns who attended the department were not cared for in a safe environment, assessed or risk assessed in an appropriate way. Equipment used for patient care including blood sugar monitoring and anaphylaxis boxes were not kept up to date. Time to see a clinical decision maker to receive treatment was consistently above 60 minutes, and the process for triage of ambulance patient was not safe and placed patients at risk through a lack of monitoring. The department was not fully compliant with standards for 'Children and young People in Emergency Care Settings 2012'. However we also found that there was evidenced learning from incidents with detail shared amongst staff through meetings and staff were knowledgeable about what constitutes a safeguarding concern, how to recognise abuse and how they would escalate such concerns appropriately, and medicines management was much improved since the last inspection. During our unannounced inspection we found that at an action plan was in place and improvements made to care and management of deteriorating patients. The service required improvement in being effective because the trust was not adhering to the NICE or CEM protocols for head injuries or acute asthma in all cases. Staff could not all articulate learning from patient cases and local audits when asked and there was no evidence of staff receiving training on the Mental Capacity Act 2005; this data was provided following the inspection. However we also found that there were clear protocols for staff to follow with regards to the management of stroke and

Summary of findings

sepsis. Policies and pathways for the admission of stroke, fractures and chest pain and these were written in line with the national institute for health and care excellence (NICE) and CEM guidelines and food and drink was available to those who were in the department for any length of time.
Services were caring because the feedback received from service users was positive in the majority. We received feedback on site and through comment cards and the majority shared positive experiences of using the service. The friends and family test results were consistently above the England average. We observed positive and caring interactions between staff and patients throughout the inspection. Staff were caring and compassionate when they spent time with patients. Parents and children were very positive about the change and improvement in the level of care and support provided to children in the department.
The service required improvement in being responsive because the trust was not consistently meeting the four hour standard. On review we found that the management and monitoring systems which underpin the flow towards four hours were not being achieved, which meant that the non-achievement of the standard was not only linked to the available bed capacity in the trust. The lack of a separate children's department meant that the service was not responsive in meeting the needs of children. There was no gynaecology pathway for the trust which meant that women who miscarry or suffer an ectopic pregnancy must go to the emergency department though trust policy was for prompt review of patients by the gynaecology team. However we also found that the provision of support including the scrub uniforms for paediatric nurses were very responsive to the needs of children, and themes from complaints were monitored and shared through team meetings and governance meetings.
The service was rated as inadequate in leadership because the risk register, identification or risk and management of risk was not yet embedded within the service. The vision of the local team to improve and develop the service was not in line with the trust's vision for the service following the removal of plans to implement environmental changes. There was a lack of leadership development and training

Summary of findings

for leaders who were running the service locally and the service was not assessing the culture and engagement of staff. However we also found that the culture of the service had significantly improved since the last inspection and there was a positive willingness of staff to want to give good care to patients. The divisional leaders of the service were working cohesively and had a good understanding of how they wanted to improve the service.

Medical care (including older people's care)	**Requires improvement**	Medical services required improvement. Learning from incidents was not consistently shared with staff across the division and there were no formal mortality and morbidity meetings though we were told they were to commence soon. We observed some poor infection control practices in relation to hand hygiene. Not all patients had their allergies recorded on their medicines chart or were assisted in a timely way to take their medicines. Records and risk assessments did not always reflect the needs of patients and were not updated to reflect changing care or needs and mandatory training had variable compliance across the division. Nursing staffing was adequate but not always correctly reflected on public information boards. There were insufficient medical staff in a number of specialties including respiratory and stroke medicine. Medical services effectiveness required improvement. Local audits plans were not clear and there were a number of our of date trust policies. Patient outcomes were not always measured and there was a lack of stroke audit data which we were told was due to a lack of staff to complete. Not all staff had completed competency assessments and some of those who had, had completed them some time before. Whilst nutrition and hydration was managed well for most patients, we saw a number of occasions where patients were not referred to a dietician when they should have been. Seven day services were in place for a number of services but a lack of some senior consultants meant there was insufficient cover in these areas. Pain relief was given in a timely way to most patients and there was effective multidisciplinary working within and without the hospital. We observed

Summary of findings

correctly completed Mental Capacity Act (MCA) assessments but staff knowledge of the MCA was variable in line with mandatory training figures for MCA and Deprivation of Liberty Safeguards.
Caring was good within the medical division. We observed staff interacting in caring and compassionate ways with patients and relatives. Friends and Family Test (FFT) response rates were higher than the England Average and most wards scored highly on the test. Patients we spoke with told us that staff were caring and had kept them involved and up to date with their care and treatment. Information received from comments cards were uniformly positive about the quality of care received.
Medical services were responsive. There was evidence of planning to meet the needs of local people as well as being part of the wider health economy. The division was meeting referral to treatment times (RTT) though has struggled on occasion to meet cancer waiting times. Trust information showed that length of stay had been reduced by one day in the last 7 months with a focus on reducing delayed transfers of care and improving access to investigations and tests.
Most patients had their individual needs met and we saw good practice in relation to dementia care on one ward. However, we saw that patients did not always get mouth care when needed and the commissioning of some allied health professionals meant that some patient's needs may not always be met. Complaints and concerns were addressed locally but it was not clear if learning or outcomes where shared effectively with staff.
Medical services required improvement in terms of being well led. There had been changes to ward managers in a number of wards, the introduction of quality matrons and new governance arrangements which would all take time to fully embed. Other elements of governance including mortality and morbidity meetings and the way in which some root cause analysis (RCA) were completed was either missing or incomplete. There were historic informal agreements in place which had left the service

Summary of findings

vulnerable in some areas such as neurology because of the lack of formal assurance that these services would be provided by a third party, though we were aware the trust was addressing this.
We were concerned about the sustainability of some services due to a lack of key staff and the provision of audit data. Several senior clinical leaders were to leave the trust shortly following our inspection and these posts had yet to be recruited to.
Staff spoke highly about the culture of the service and were positive about the changes that had been made in the preceding year though not all were aware of the strategy for their area or specialty though they were aware of the trusts vision.

Surgery	**Requires improvement**		Surgery services required improvement overall with effective, caring and responsive rated as good and safety and well led rated as requires improvement. Oversight of standards of care and governance was fragmented. There was a structured governance process in place but this was not embedded; good practice in one area was not cascaded. Nurse staffing levels were variable on the wards and consultant presence at ward rounds was not consistent. This meant there was a risk to patient safety due to a lack of senior medical review. Medication management required improvement. Caring was good across the surgical wards and departments. Staff treated patients with dignity and respect and displayed compassion and kindness towards patients and relatives. The service had up to date policies and procedures in place to ensure adherence to national guidance and participated in national audits to monitor performance. Data provided showed that patients received care in a timely manner within national timeframes and there was a proactive approach to discharge planning and involvement of patients and relatives.
End of life care	**Requires improvement**		End of life care required improvements as patients were at risk of not receiving safe, effective or responsive treatment that met their needs. Do not attempt cardio pulmonary resuscitation (DNA CPR) forms were incorrectly completed. In many instances, we found that DNA- CPR decisions had not been discussed with the patient or their relatives/ representatives. Where the reason given for not

Summary of findings

discussing decisions with patients was recorded as the patient lacking capacity, Mental Capacity Act Assessments had not been completed. We reviewed DNACPR during our unannounced inspection and saw improvements in recording and completion.
The palliative care team were over stretched which meant that medical and the generalist nursing staff were not effectively trained in end of life care of the patient in the last days of life. This meant that patients would be at risk of not receiving the level of care they could expect
At the previous inspection in January 2015 we found the trust did not have a risk register for end of life care. The trust had completed a risk assessment in August 2015; however these risks were not recorded on the risk register.
The specialist palliative care (SPC) nurses had been overstretched and had recently recruited two new nurses that were currently undergoing role specific training in palliative care. Staff told us this meant there could be delays in responding to referrals. They were unable to undertake training for medical and nursing staff on the wards. This meant staff were not effectively trained and patients did not receive the level of care they could expect.
However the number of ward staff who had training in advanced communication had increased since the last inspection and this was provided externally.
Concerns were raised by staff about the lack of appropriate training for junior doctors and consultants in end of life care.
The leadership of the SPC nurses was not evident though they worked hard to improve end of life care throughout the hospital. Feedback from nursing and medical staff was that the team were “fantastic and very knowledgeable”.
Since January 2015, SPC nurses had increased the amount of time they were available for consultation. They had joined with community palliative care nurses to provide seven day 9am-5pm face to face support and 24 hour out of hour’s telephone advice and support. Medical and nursing staff told us this had made a difference to patients receiving end of life care throughout the hospital.

Hinchingbrooke Hospital

Detailed findings

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

Detailed findings

Contents

Background to Hinchingbrooke Hospital

Hinchingbrooke Hospital is an established 304 bed general hospital, which provides healthcare services to North Cambridge and Peterborough. The trust provides a comprehensive range of acute and obstetrics services, but does not provide inpatient paediatric care, as this is provided within the location by a different trust.

The average proportion of Black, Asian and minority ethnic (BAME) residents in Cambridgeshire (5.2%) is lower than that of England (14.6%). The deprivation index is lower than the national average, implying that this is not a deprived area. However, Peterborough has a higher BAME population and a higher deprivation index.

Our inspection team

Our inspection team was led by:

Chair: Helen Coe, Director of Operations, Frimley Health NHS Foundation Trust

Head of Hospital Inspections: Fiona Allinson, Head of Hospital Inspection, Care Quality Commission

The team included seven CQC inspectors and two board level executives from CQC. A variety of specialists made up the team including: three consultants, nine nurses and a board level nurse and an expert by experience. (Experts by experience have personal experience of using or caring for someone who uses the type of service that we were inspecting.)

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?

The inspection took place between 20 and 21 October 2015, with unannounced inspections on 26 and 27 of October 2015 and 5 November 2015.

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

We held a listening event on 20 October 2015, when people shared their views and experiences of

Detailed findings

Hinchingbrooke Hospital. Some people who were unable to attend the listening event shared their experiences with us via email or by telephone.

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

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

Facts and data about Hinchingbrooke Hospital

Trust information 2014/2015

Beds (July 2015): 297

· 244 General and acute

· 42 Maternity

· 11 Critical care

Staff (July 2015) 1502.74 WTE

· 187.46 Medical

· 477.35 Nursing

· 837.93 Other

Revenue: £108,966,391

Full Costs: £122,763,210

Surplus (deficit) - £13,796,820

Activity Summary (Acute) 2014/2015

In patients: 38,209

Outpatients attendances: 164,044

Emergency attendances: 43,244

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Inadequate	Requires improvement	Good	Requires improvement	Inadequate	Inadequate
Medical care	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Surgery	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
End of life care	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Urgent and emergency services

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

Information about the service

The emergency department (ED) at Hinchingbrooke Hospital provides a 24 hour, seven day a week service to the local area. Patients present to the department either by walking into the department via the reception area, or arriving by ambulance. The department has facilities for assessment, treatment of minor and major injuries, a resuscitation area, and a children's provision ED service.

There is an acute assessment unit (AAU) within the same directorate, for which patients are admitted for up to 24 hours.

Our inspection included two days in the emergency department as part of an announced inspection, and an unannounced visit on 26 October and 05 November 2015. During our inspection, we spoke with clinical leads from medical and nursing disciplines for the department. We spoke with seven members of the medical team (of various levels of seniority), eleven members of the nursing team (of various levels of seniority), and six members of support and operational staff. The emergency department sees, on average, approximately 120 patients per day.

During our inspection, we spoke with eight patients and six relatives and undertook general observations within all areas of the department. We reviewed the medication administration and patient records for 44 patients in the emergency department.

On average, the emergency department saw around 43,247 patients a year between 2014 and 2015, which equated to around 832 patients a week.

Summary of findings

We rated urgent and emergency services at Hinchingbrooke Hospital as inadequate overall. Safety of services and leadership were rated as inadequate with effectiveness and responsiveness being rated as requires improvement. The care provided by staff at this service was good.

Safety of service was inadequate because we identified 11 patients during the inspection who were at risk of deterioration, which were escalated by the inspection team to ensure that patients were safe. Patients with mental health concerns who attended the department were not cared for in a safe environment, assessed or risk assessed in an appropriate way. Equipment used for patient care including blood sugar monitoring and anaphylaxis boxes were not kept up to date. Time to see a clinical decision maker to receive treatment was consistently above 60 minutes, and the process for triage of ambulance patient was not safe and placed patients at risk through a lack of monitoring. The department was not fully compliant with standards for 'Children and young People in Emergency Care Settings 2012'. However we also found that there was evidenced learning from incidents with detail shared amongst staff through meetings and staff were knowledgeable about what constitutes a safeguarding concern, how to recognise abuse and how they would escalate such concerns appropriately, and medicines management

Urgent and emergency services

was much improved since the last inspection. During our unannounced inspection we found that at an action plan was in place and improvements made to care and management of deteriorating patients.

The service required improvement in being effective because the trust was not adhering to the NICE or CEM protocols for head injuries or acute asthma in all cases. Staff could not all articulate learning from patient cases and local audits when asked and there was no evidence of staff receiving training on the Mental Capacity Act 2005 though this was provided following the inspection. However we also found that there were clear protocols for staff to follow with regards to the management of stroke and sepsis. Policies and pathways for the admission of stroke, fractures and chest pain and these were written in line with the national institute for health and care excellence (NICE) and CEM guidelines and food and drink was available to those who were in the department for any length of time.

Services were caring because the feedback received from service users was positive in the majority. We received feedback on site and through comment cards and the majority shared positive experiences of using the service. The friends and family test results were consistently above the England average. We observed positive and caring interactions between staff and patients throughout the inspection. Staff were caring and compassionate when they spent time with patients. Parents and children were very positive about the change and improvement in the level of care and support provided to children in the department.

The service required improvement in being responsive because the trust was not consistently meeting the four hour standard. On review we found that the management and monitoring systems which underpin the flow towards four hours were not being achieved, which meant that the non-achievement of the standard was not only linked to the available bed capacity in the trust. The lack of a separate children's department meant that the service was not responsive in meeting the needs of children. There was no gynaecology pathway for the trust which meant that women who miscarry or suffer an ectopic pregnancy must go to the emergency department though trust policy was for prompt review of patients by the gynaecology team.

However we also found that the provision of support including the scrub uniforms for paediatric nurses were very responsive to the needs of children, and themes from complaints were monitored and shared through team meetings and governance meetings.

The service was rated as inadequate in leadership because the risk register, identification or risk and management of risk was not yet embedded within the service. The vision of the local team to improve and develop the service was not in line with the trust's vision for the service following the removal of plans to implement environmental changes. There was a lack of leadership development and training for leaders who were running the service locally and the service was not assessing the culture and engagement of staff. However we also found that the culture of the service had significantly improved since the last inspection and there was a positive willingness of staff to want to give good care to patients. The divisional leaders of the service were working cohesively and had a good understanding of how they wanted to improve the service.

Urgent and emergency services

Are urgent and emergency services safe?

Inadequate

Urgent and emergency services were rated as inadequate for being safe because:

- There were concerns regarding cleanliness of the department, cubicles, isolation of infectious patients and hand hygiene techniques.
- The boxes with kit which monitors the blood glucose of a patient, known as a BM box was not always monitored as required. The anaphylaxis box was not checked daily as required.
- The walls along the majors department into the resuscitation department were damaged and where trolleys had hit there walls there were holes in the walls, which required repair.
- The curtains within the cubicle areas were not disposable curtains and there were no recorded dates of when these curtains were put up or when they were last changed. Data provided by the trust following the inspection showed curtain changes were monitored.
- The department had a policy for the care and risk assessment of patients with mental health concerns, however this was out of date and staff in the department were not aware of it.
- There is no dedicated room or bay for patients with mental health concerns who present with health anxieties or in crisis. We observed during the inspection, eight patients who were in the department with mental health concerns. During the inspection two of those patients absconded from the department.
- Of the four patients we observed on the first day of our inspection, none had a formal risk assessment completed on them for the risks of harm to self or others and absconding.
- Staff within the department had not received any specific or detailed training in dealing, identifying or managing patients with mental health conditions.
- The environment meant that the patients with mental health concerns were at risk of self-harm due to items of equipment being inappropriately left out.
- Time to see a clinical decision maker to receive treatment was consistently above 60 minutes.
- The process for triage of ambulance patient was not safe and placed patients at risk through a lack of monitoring.
- We identified 11 patients who were at risk of deterioration during our inspection; we escalated all cases to the senior staff in charge to ensure that the patients received appropriate care.
- The department was not fully compliant with standards for 'Children and young People in Emergency Care Settings 2012'.

However we also found:

- There was evidenced learning from incidents with detail shared amongst staff through meetings.
- Staff were knowledgeable about what constitutes a safeguarding concern, how to recognise abuse and how they would escalate such concerns appropriately.
- Medicines management was much improved since the last inspection.

Incidents

- The service had reported no never events since our last inspection. The service followed the trusts incident reporting policy and has reported 323 incidents in the previous 12 months.
- The incidents reported, in the majority, resulted in no or low harm for impact with the top reported incidents being low staffing levels, patient falls and pressure ulcers.
- Four serious incidents were reported for the service between January 2015 and August 2015 which were linked to sub-optimal care of a deteriorating patient, failure to act on test results and an assault.
- There was evidenced learning from incidents with detail shared amongst staff through meetings, handovers and through online forums. We specifically asked four staff members of nursing staff if they could provide learning from an incident and all could recount an incident where they were provided with feedback and learning. However we asked three doctors about learning from incidents and they were not all clear on what learning had occurred from recent serious incidents.
- Where serious incidents had occurred we reviewed the reports which had recorded that the families and the patients, where appropriate, where informed about the incident and the investigation in accordance with duty of candour requirements.

- The lead consultant described what mechanisms the service had for reviewing and holding mortality and morbidity reviews. Reviews are done at the monthly meetings to identify any patterns trends or learning which would then be shared with staff through local meetings and the main staff notice board.
- We reviewed the information on mortality displayed on the staff notice board, the most recent information displayed about mortality was from July 2015, and listed the key learning points for discussion. Minutes of meetings for October and July 2015 showed detailed discussions about individual cases together with key learning from each case for sharing.

Cleanliness, infection control and hygiene

- At our last inspection there were concerns around the cleanliness of the department identified as well as poor infection control practices observed amongst the staff. During this inspection we observed that the department was mostly visibly clean.
- There were obvious signs of damage to the floors in the main corridor area and in the plaster rooms which meant that it could not be assured that the floors were clean. We discussed the damaged floors with a member of the infection control team who were not aware of the damaged floor and informed us that they would address this with estates to ensure it was repaired.
- The policy when patients who attended the department and were at risk of infection were known was that they were to remain isolated in their cubicle and the cubicles would be deep cleaned prior to the next patient being able to use it.
- During the inspection we observed two cases where patients were at risk of infection, one with shingles, and one with diarrhoea who were isolated to their cubicles; however the cubicles were not thoroughly cleaned between patients.
- We also observed the patient with shingles wandering throughout the department and was not isolated. We raised this with the nurse in charge who immediately went to get the patient back to their cubicle.
- Equipment was visibly clean upon inspection and had been labelled with 'I am clean' labels.
- We observed poor infection control practice amongst the medical staff working in the department. We saw four doctors go between patients throughout their shift without washing their hands and type notes on the computer without washing their hands, wearing gloves and then removing them and not washing their hands and going between cubicles without using hand gels or washing their hands.
- We noted that in the majority the hand hygiene amongst the nursing staff was better than that of the doctors, however three instances of nurses going from a cubicle to obtain an item whilst wearing gloves and then returning to the patient without changing the gloves or using hand gels.
- We observed infection control audits taking place during the course of the inspection. We spoke with the infection control staff about our observations to ensure that the appropriate action could be taken to improve infection control practices.
- We also observed two members of medical staffing not adhering to the uniform policy by wearing jewellery with jewels in and also more than one ring on at any one time.
- Infection control audits from July 2015 identified a 96% compliance with infection control practices and this had also highlighted hand washing therefore further improvements in this area.

Environment and equipment

- The environment design and layout within the major's department area meant that it was not possible to observed all patients closely. The bays all has curtains pulled across them which meant that patients were not observed at all times, nor were the monitors or machines that a patient may have been on.
- We checked the resuscitation equipment in the department and found that all had been checked daily and were stocked in line with resuscitation council guidelines.
- The boxes with kit which monitors the blood glucose of a patient, known as a BM box, were available in three areas of the department. We checked all three and found many gaps in checking of these boxes. Within majors there were 10 dates not checked in September, 18 days not checked in August, 28 days not checked in July, 20 dates not checked in June and 22 days missing in May 2015.
- The anaphylaxis box within the department was checked and found to be stocked, however there were no records that this had been checked daily as required by national recommendations.

- The gas store was located in an inappropriate area near the ambulance entrance. The oxygen cylinders were stored in a cupboard where there were computer servers and wires and the electronic mechanism for the sliding doors which created a fire risk. The cylinders specifically state to store away from electrical items.
- The walls along the majors department into the resuscitation department were damaged and where trolleys had hit there walls there were holes in the walls, which required repair.
- The curtains within the cubicle areas were not disposable curtains and there were no recorded dates of when these curtains were put up or when they were last changed. We were told by the housekeeping staff that they were changed when they were obviously not clean; however there were no records of this. Data provided by the trust following the inspection showed curtain changes were monitored.
- The department was not fully compliant with standards for 'Children and young People in Emergency Care Settings 2012'. We saw that the children's areas were not dedicated only to children and young people. This was raised during our previous inspections and we were informed that there were plans to separate the children's area, however at the time of this inspection staff told us that those plans had been put on hold.
- The children and young people's areas department was not fully compliant with standards for 'Children and Young People in Emergency Care Settings 2012'. We saw that the children's department was not dedicated only to children and young people. There was also a lack of safe play facilities. This meant that children waited in the general A&E waiting area, were triaged in the same system as adults, and were treated in areas where adults were seen.
- At the time of our inspection we observed prisoners from a local prison attending the waiting room and were in the same area as the children which was not safe practice.
- This was raised to the trust as a concern during the previous inspection in September 2014 and January 2015. The trust informed us that they had planned to build a new children's emergency department and building would commence in the summer, however the plans for this did not materialise and the changes had not taken place and this was impacting on the running of children's' services with no long terms solution to meet the needs of the children.
- During the unannounced inspection we identified that on items of equipment, including ECG machines that the times on the machines had not been changed following the clocks changing 38 hours prior to our inspection. This meant that the results did not show the correct time and could have impacted on the care of patients.

Mental Health Care

- The department had a policy for the care and risk assessment of patients with mental health concerns, however this was out of date, and staff in the department were not aware of it.
- There is no dedicated room or bay for patients with mental health concerns who present with health anxieties or in crisis. Patients are placed into an available bay, where they could be observed or into the relative's room.
- We observed during the inspection, eight patients who were in the department with mental health concerns. During the inspection two of those patients absconded from the department. Due to the environmental set up within the department the staff for one patient who absconded, who stated they were feeling suicidal, were not aware that they had absconded until we had made them aware of this.
- The relative's room is not fit to be a room for assessing those with mental health concerns. There is only one entrance/exit point, there were no call bells or alarms in the room which meant that it was not safe to use.
- Of the four patients we observed on the first day of our inspection, none had a formal risk assessment completed on them for the risks of harm to self or others and absconding. We raised this with the senior staff within the department who located the risk assessment form and put it back in use. However this risk assessment form covered the risks of suicide only and was not sufficient to manage risks around care delivery for these patients.
- Staff within the department had not received any specific or detailed training in dealing, identifying or managing patients with mental health conditions or mental health anxiety, which is an area which requires significant improvement.
- We spoke with four staff nurses specifically about the care for those patients with a mental health concerns and all four reported to us that they did not feel safe caring for them in the current environment, without the

right training or support. They also raised concerns about the use of the relative's room to speak with patients as it could place a staff member at risk. This they felt was increased because the trust does not have dedicated security staff on site to support them in the event of a challenging situation.

- There was no formal procedure for asking people or checking their property where a person presented with self-harm. Therefore people could have items with them which could place the patient, staff, and others at risk of harm.
- When we observed two patients who were placed in bays in the minors and children's area. This meant that these patients could be left unattended with children in the same area which was not safe.
- The environment meant that the patients with mental health concerns were at risk of self-harm due to items of equipment being inappropriately left out. For example in the plaster room we observed that the saw, knives, scissors, and others items used for the application and removal of plaster were left out unattended with the door wedged open and could be accessed by anyone.
- The storage area, which was opposite the minor's area cubicles, had cupboards which were not locked. When we looked inside the cupboards we could access scissors, scalpels, and other items which could be used for patients who may be at risk of self-harm.
- Walking through the department we identified a number of areas which could present a risk from ligature points. We asked the senior staff within the department if the environment had been walked through to identify these risks and a risk assessment undertaken. We were told that this had not been risk assessed.
- Staff had systems to request a specialist mental health assessment such as from the local mental health trust, Crisis Resolution and Home Treatment (CRHT) for adults, the Child and Adolescent Mental Health Services (CAMHS) and from older persons services once they assessed the person was medically fit for discharge and their physical health needs were met. We saw referral forms for CRHT.
- We spoke with one CRHT staff member from another trust who told us that they would assess the patients following referral, provide advice if needed or complete an additional risk assessments took place before people with mental health needs were admitted to a ward in the acute trust.

Medicines

- Medicines storage was identified as a concern during previous inspections. With the exception of the resuscitation area on the first day of our inspection the medicines cupboards were all locked and medicines were secure. When the resuscitation area was not in use the cupboards were found to be locked at all times.
- We checked a sample of medicines, including emergency medicines, these were in date and stored at the correct temperature. Controlled drugs stores were also checked and found to be correctly recorded and stored appropriately.
- Fridge temperatures for medicines requiring refrigeration were checked daily to ensure medicines were stored correctly.

Records

- We examined the records of 44 patients during our inspection and identified with the staff that there were challenges on completing the records between paper and electronic systems. The mix between paper and electronic recording on the system led to delays in updates being available for others to review the patient records.
- We identified that there were discrepancies in four cases where the records on the medicines administration chart were not legible after being written by the doctor and also where observations that were recorded were not fully recorded and therefore could not be used.
- Where a patient was identified as being as risk of pressure ulcer development the staff would complete a pressure ulcer risk assessment in the department, prior to transferring the patient to the ward. We observed that this was taking place throughout the inspection.

Safeguarding

- We saw a current safeguarding policy for adults and children, which was accessible on the intranet. The policies were version controlled and the policies reflected national guidance.
- Staff were knowledgeable about what constitutes a safeguarding concern, how to recognise abuse, and how they would escalate such concerns appropriately. The trust had a safeguarding policy which was accessible to staff.

- Training records for the department showed that 100% of medical staff and 88% of nursing staff have received safeguarding adults training at level 1. 92% of medical staff and 97% of nursing staff have received safeguarding children level one training.
- The department had declared a risk on their risk register that there was not a sufficient number of staff trained with level 3 safeguarding children training at only 60% of all staff trained. The named nurse for safeguarding children informed us of their plans to recover this with additional dates being offered to increase training compliance.
- Staff spoken with were clear on the Children's & Adolescent Mental Health Support teams' arrangements. They told us that safeguarding training included an over view of the mental capacity act and consent practices for children.
- Staff we spoke with referred to reporting safeguarding vulnerable adults and children concerns to the local authority and the trust safeguarding lead. We saw evidence of staff appropriately reporting concerns for a child. Leaflets for victims of domestic abuse were available for staff to give out.
- In one case where an adolescent attended the department without a parent present, the safeguarding indicators for the adolescent's situation were missed by the doctor providing care. We discussed this with the lead nurse for the children's service and we were assured that there would be support for further education and learning for this doctor and education for others to reduce the risk of repeated events.

Mandatory training

- Mandatory training was available to all staff who worked in the service. The emergency department staff compliance was 89% for fire training, 89% had been trained in equality, diversity and human rights, 83% had received information governance training. We asked for the up to date training records for all staff across a wider range of subjects other than those provided however these were not provided.
- We spoke with staff in the department who could verbalise that they have received training in Advanced Life Support, and emergency Paediatric Life Support and could show us charts which demonstrated that over 80% of medical and nursing staff had received this training, though no formal records were provided.
- The senior nursing and medical staff working within the department informed us that they had a clear programme to increase the compliance and attendance at training but had seen compliance change due to an increase in staff leaving, new staff joining and demand for the service, which meant that staff were not always released.

Assessing and responding to patient risk

- The trusts policy on early warning scores (EWS), approved in August 2015, states that all adult patients admitted as an in-patient will have a set of physiological observations and a EWS score calculated at least once in 12 hours. The trust informed us that all patients arriving to the department should have at least one set of observations done within 15 minutes.
- Within A&E whilst there were no specific guidelines written down it was their aim to undertaken observations on all patients on an hourly basis, or more if identified as required. However due to the staffing and set up within the department, the completion of a full set of observations was not achievable and we saw was not completed.
- The department has a defined streaming system in place for the patients who arrived into the department on foot through the front door, and once streamed into the appropriate pathway then they will be triaged and then treated.
- We observed 11 specific patients during the course of our inspection where we had to raise concerns about the care they were provided because it placed them at risk of harm.
- For example one patient with chronic obstructive pulmonary disease (COPD) arrived with shortness of breath of 08.52am. Initial assessment was undertaken at 09.00am and they were then seen by doctor 09.26am. The patient had an electrocardiogram (ECG) was undertaken at 09.57am and showed changes requiring intervention but no action was taken to act on ECG results. The early warning score EWS at 08.50 am was scored at 5, but no further checks were done until we escalated the patient at 10.15am. The observations were re-done and the patient now scored a 7 and required immediate medical intervention.
- Another patient who arrived at 12.49pm was acutely unwell and placed into the resuscitation area with suspected sepsis. They were assessed by a nurse at

12.49pm but were not then seen by a doctor until 13.45pm despite observations showing that their early warning score (EWS) was 8 which meant that they required medical support.

- Another patient was recorded as arriving at 1.14pm, being assessed at 1.14pm and seeing a doctor at 1.14pm. First observations however were recorded at 2pm. The patient was admitted with chest pain and their observations showed bradycardia. The echocardiogram (ECG) which was undertaken at 3.24 had not been reviewed by a doctor when we checked at 4.10pm. We escalated the care of this patient to the nurse and doctor in charge who immediately reviewed this patient.
- We examined 11 ECG test results and saw that these had not been reviewed, signed, dated and timed by medical staff in nine cases. There were also no entries on the electronic record system of review of the ECG results. One ECG showed right bundle branch block (RBBBlock), which had not been reviewed for more than one hour after it being taken. When asked, the doctor was not able to provide rationale for delay in review of this ECG.
- We also identified a patient with suspected cauda equina syndrome who was not seen by a doctor for 3 hours and 57 minutes after arrival. The MRI scan was requested 3 hours and 24 minutes after arrival which could have placed the patient at risk of further complications.
- There was no dedicated Rapid Assessment Triage (RAT) team of doctors who triage all priority cases and cases of concern. The department medical staff informed us that they used RAT flexibly and when required, however we were concerned with the lack of consistency when RAT was and was not used, with one medical staff member telling us that they assessed patients by "eyeballing them".
- The ambulance time to initial handover and assessment reported was consistently better than the England average at around 5 minutes. We observed this to be the case during the course of the inspection, handovers from ambulances were taken by the nurse in charge.
- The average time to first assessment, which should be 15 minutes at triage, was showing that the service was performing better than the England average. However there was a lack of clarity on the triage process through the ambulance arrival route. We were informed that triage would happen following handover however we observed that the handover was considered as the triage, which then delayed the time to first assessment and treatment.
- For example one patient who was recorded as arriving by ambulance 8.01pm and observations and first triage were done at 8.45pm, however the system had their triage recorded at 8.01pm which was the handover and therefore not accurate. Another patient arrived at 09.11am and was recorded as being assessed at 09.11am, which was not accurate.
- The average time to treatment from clinicians recorded, which should be within 60 minutes, averaged 150 minutes. We looked at this as part of the inspection and found that the medical staff were not timely in recording on the system when they were seeing patients which was impacting on their overall performance. Whilst the service was not consistently meeting the 60 minute target, the service was potentially selling themselves short and making their performance appear worse than it actually was by not accurately recording the times to treatment accurately.
- There was a lack of clinical observation noted for the waiting room. This area was observed by a receptionist and the occasional nurse walking through, the design of the department meant that there was a lack of clinical oversight in this area.

Nursing staffing

- The nursing vacancy rate had significantly decreased since our last inspection with a 17% nurse vacancy being recorded in July 2015. The senior nursing staff in the department informed us that they believed that those nursing vacancies were in the process of being filled with start dates being scheduled.
- The department had recruited 7.0 WTE paediatric qualified nursing staff since our last inspection. These staff shared working with paediatrics and covering the walk ins through the department so were dual working on adults.
- We spoke with four paediatric nurses who had recently started, all were enthusiastic and knowledgeable and were a real asset to the service. Whilst some had reservations about working with adults, they were embracing it as part of the experience but all were disappointed about the lack of progress with the plans to separate out the children's service in the department.

Urgent and emergency services

- There were insufficient staff nurses on duty at night time with four nurses on duty overnight with one nurse on a twilight shift. We raised this concern with the senior management of the trust who had reviewed and looked to increase the permanent establishment of staffing overnight and alter some twilight shifts to stagger late night finishes to improve staffing at night.
- In the majority there were sufficient levels of nursing staff on duty, with the exception of the nurse in charge role, which due to the challenges of the department meant that they were not able to sustain working in a supernumerary capacity.
- The management and organisation of nursing tasks and patient delegation meant that the nursing establishment was disorganised and required reconfiguring.
- The total vacancy, acuity and dependency and demand of the service meant that there was an 1.5% average use of agency and bank staff on shifts each month. The use and coverage of bank and agency was monitored and managed locally.
- The turnover rates of the nursing and support staff within the department was 11% which is higher than the trusts trajectory of 5%.
- Nursing handovers were done between staff at the beginning and end of each shift. Handovers occurred with nurses allocated to each area handing over to the nurse taking over their area of responsibility. We observed two handovers and observed that it worked well on a local basis.
- The nurse in charge was present on the board round of the medical staff who were handing over patients in the department.

Medical staffing

- The department was staffed by 4 WTE permanent consultants and had one consultant on long term sick which provided them with 3 WTE working consultants. The consultant ratio at 21% is lower than the England average of 23%.
- The department currently has 7 WTE middle grade doctors, with approval being given by the trust to recruit an eighth middle grade doctor. At 43% the use of middle grade staff at the trust is significantly higher than the England average of 13%.
- The department is putting several middle grade staff through a development scheme linked to the College of Emergency Medicine to obtain consultant positions within the hospital within three years.
- The department has only 7% of specialist trainee posts against the England average of 39%, however to ensure that they have cover they utilise middle grade support.
- The department currently has 10 foundation year trainees from Health Education England, which at a rate of 29% is higher than the England average of 24%.
- The current medical vacancy rate within the department is 26% and the vacant shifts were covered by locum medical staff with medical staff coverage on locum being 53% of the medical rota. The turnover rates for medical staff in the department has been 75%.
- Handovers were led by the doctor in charge of each shift and took place at the beginning and end of each shift. We observed the handover and the discussion of each patient which was comprehensive and clear.
- Where the department became busy or problems were identified the doctor in charge would call additional huddles to reprioritise the medical staff to deliver the service.

Major incident awareness and training

- The trust had a major incident policy and plan in place for major events.
- 95% of staff working in the emergency department had received major incident awareness training within the last two years.
- The service had received external training in major incidents which included, CBRN, HAZMAT, loggist and command and control training.
- The service had arrangements, equipment and plans in place to deal with emergency events and decontamination of high risks diseases such as Ebola. Staff within the department had received training in the emergency management of Ebola in 2014.
- The department too part in a formal exercise in July 2014. The exercise was organised and run and a full debrief of events took place with learning outcomes monitored through the directorate clinical governance meetings.

Are urgent and emergency services effective?

Urgent and emergency services

(for example, treatment is effective)

Requires improvement

Urgent and emergency services were rated as requires improvement for being effective. The concerns identified with the effectiveness of the service were considered for a rating of inadequate, however on balance it has been rated as requires improvement because:

- The trust was not adhering to the NICE or CEM protocols for head injuries or acute asthma in all cases.
- We asked the staff what they understood in terms of learning from audits, particularly head injuries, and both medical and nursing staff could not all tell us of an audit they were aware of or learning from the audit on head injuries.
- We had concerns raised to us by five people during the inspection about pain relief and management.
- The severe sepsis and septic shock audit dated October 2015 showed that the trust's performance had declined in five of the six key indicators. There had been improvement between July and September 2015, though two elements remained below target.
- There was no training information available which demonstrated what percentage of staff have received mental capacity act training.

However we also found:

- There was a clear protocol for staff to follow with regards to the management of stroke and sepsis.
- Policies and pathways for the admission of stroke, fractures and chest pain and these were written in line with the national institute for health and care excellence (NICE) and CEM guidelines.
- The department are undertaking a range of audits, as well as partaking in national audits, to learn from cases and improve care.
- The trust compared favourably with national CEM Asthma audit data.
- Food and drink was available to those who were in the department for any length of time.

Evidence-based care and treatment

- There was a clear protocol for staff to follow with regards to the management of stroke and sepsis. The department had introduced the 'Sepsis Six' interventions to treat patients. Sepsis Six is the name given to a bundle of medical therapies designed to reduce the mortality of patients with sepsis. Bundles were also available for neutropenic sepsis.
- We reviewed the notes of four patients who were admitted with a query of sepsis. Of those four patients three were provided with treatment in line with the sepsis pathway recommendations. The patient that was not on the pathway when they should had been was provided with fluids and IV antibiotics of urinary sepsis but the doctor said that the patient was not on the pathway and would not go on the pathway, there was no recorded rationale for this decision despite the course of treatment provided.
- We reviewed the policies and pathways for the admission of stroke, fractures and chest pain and these were written in line with the national institute for health and care excellence (NICE) and College of Emergency Medicine CEM guidelines. NICE and CEM guidance on sepsis, head injury and fracture neck of femur was not always being followed in the department because the care that was being provided was not being recorded.
- The fracture neck of femur pathway between the emergency department and the orthopaedic service required improvement. We reviewed the notes of three patients admitted with a fractured neck of femur. Two of the three patients were on the pathway, however the third was not. One of the three patients had received pain relief within 30 minutes according to the records.
- The trust was not adhering to the CEM or NICE guidelines for acute asthma in the case we reviewed. We reviewed the care of one patient admitted with acute asthma who had a first full set of observations taken 78 minutes after arrival and waited for more than 60 minutes to see a doctor. The only asthma guideline measurement met was the taking of a peak flow reading following arrival. The patient was scoring on the EWS and looked increasingly unwell. We escalated the condition of this patient to the nurse in charge who went to check on the patient and take observations. The patient required critical care outreach support as a result.
- The trust was not adhering to the NICE or CEM protocols for head injury in all cases. We examined the records of two patients who had head injuries and whilst initial

neuro observations were undertaken these were not recorded frequently, in one case the gap between observations was over one hour and the second case was two hours.
- The department are undertaking a range of audits, as well as partaking in national audits, to learn from cases and improve care. The department holds regular meetings for audit and openly invite all staff to attend. We reviewed the meeting minutes of these meetings where a range of local and national audits were discussed.
- We asked the staff what they understood in terms of learning from audits, particularly head injuries, and both medical and nursing staff could not all tell us of an audit they were aware of or learning from the audit on head injuries. Results of this audit were displayed on the staff information board.

Pain relief

- College of Emergency Medicine Pain in Children audit for 2014-15 was not yet available for this inspection.
- We had concerns raised to us by five people during the inspection about pain relief and management. One patient who had renal colic had to wait 88 minutes for pain relief on arrival. A second patient had to wait over two hours for pain relief following arrival. A third patient waited for 130 minutes for pain relief.
- A fourth patient who arrived with a major fracture to their arm was placed in the waiting room and did not receive a full triage pain assessment or pain relief. We escalated the care of this patient and the lack of pain relief after 3 hours 37 minutes.

Nutrition and hydration

- Food and drink was available to those who were in the department for any length of time, and when the department was busy a drinks trolley went through to ensure that patients had sufficient access to fluids.
- Food and drink was also available to relatives who were waiting in the department.

Patient outcomes

- The unplanned re-attendance rate within 7 days was consistently lower than or similar to the standard and approximately 2.5% lower than the England average.
- The consultant sign off audit showed that about 19% of patients were seen by a consultant and 42% of consultants discussed cases with patients which was better than the England average. Only 39% of patients were seen by a doctor ST4 level and above doctor which is worse than expected compared to the England average.
- The CEM sepsis audit showed that of the eleven indicators the trust performed in line with the England average on six of the indicators. The trust scored worse than the England average on five of the indicators including the administration of antibiotics and monitoring of urine output. There had been improvement between July and September 2015, though two elements remained below target.
- The CEM mental health audit showed that of the eight indicators the trust performed similar to expected on six indicators and better than expected on two indicators.
- The trust compared favourably with the CEM asthma audit.
- The severe sepsis and septic shock audit dated October 2015 showed that the trust's performance had declined in five of the six key indicators.

Competent staff

- All medical staff within the emergency team had gone through the revalidation process with the GMC and where actions for improvement were identified through this process this was addressed through regular one to ones with the lead consultant.
- The appraisal rates for the department was 67% for medical staff, 89% of nurses and 100% of support staff and receiving an appraisal within the last 12 months.
- The nursing leaders were aware that the nursing staff were going to be completing their nursing revalidation this year and were implementing support mechanisms for the staff to complete their revalidation process with the NMC (nursing and midwifery council).
- Agency staff working in the department completed a full induction including competency checks prior to being authorised to undertake specific tasks such as the taking of an ECG or administration of medicines.
- Competencies for staff were completed on items of equipment in the resuscitation area including defibrillators and echocardiograms (ECGs), we examined training and competency records for staff who used these items of equipment which supported what we were told.
- The nursing and medical leadership described training and development opportunities for staff within the service. There were opportunities to obtain further

education and qualifications for role specific qualifications advanced nurse practitioners, nurse prescribers but their first key priority was the leadership skills development for nursing staff in the department.
- The medical leadership provided us with an example of training their own consultants through the DREAM programme which was linked to the college of Emergency Medicine for middle grade staff. This course which can take up to three years offers middle grade doctors progression opportunities to go to consultant level. The department had three staff on this scheme for development which was positive.

Multidisciplinary working

- There was a notable level of respect between the different professionals working in the department. Nursing and medical staff were observed to work well together and with open lines of communication.
- The team worked well with the surgeons and medics who attended the department for referrals.
- We spoke with four members of the ambulance service who reported that there was a good working relationship with the staff in the department and that they were happy to attend the service and work with the staff, though they believed that the service was more challenging, in terms of handovers and turnaround times, than it needed to be for least busy service in the East of England.
- Psychiatric and mental health services were available from the mental health trust which covers the Cambridgeshire area. We saw the team engage this service when a referral was made urgently to them for assessment and support.
- The team worked closely with the wards and the site management team and ensured that appropriate patients were referred over to the care of this service when needed.

Seven-day services

- The emergency department is open seven days per week and twenty four hours per day.
- Radiology services currently do not operate seven days per week but on call services were available for emergency cases when needed to support the service.

Access to information

- The records system used within the emergency department was disorganised because the service used a combination of paper records and electronic records. Access to all systems was not a concern as all information required to provide the care to patients was accessible at any time however it could be time consuming to locate when it was not all stored in the same place.
- The three nurses and three doctors we asked about the records system informed us that they were used to the system however access to information in the same area could be improved. The clinical leads for the service when asked also acknowledged that access and streamlining of information could be improved.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- There was no training information available which demonstrated what percentage of staff have received mental capacity act training. Though speaking with four nurses and two doctors in the department they had a clear understanding of the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Data provided by the trust following the inspection showed that 55% of emergency department staff had completed MCA training.
- Staff explained their systems for assessing people's mental capacity to give consent regarding treatment. Staff also referenced assessing children as 'Gillick competent'.
- All patients who arrive in the department over the age of 65 should have a dementia screening undertaken as part of good practice. This department did not undertake screening for Dementia routinely.
- We observed staff explain what they were going to do and asked for the patients consent before they proceeded.

Are urgent and emergency services caring?

Good

Urgent and emergency services were rated as good for caring because:

Urgent and emergency services

- The feedback received from service users was positive in the majority. We received feedback on site and through comment cards and the majority shared positive experiences of using the service.
- The friends and family test results were consistently above the England average.
- We observed positive and caring interactions between staff and patients throughout the inspection. Staff were caring and compassionate when they spent time with patients.
- Parents and children were very positive about the change and improvement in the level of care and support provided to children in the department.

However there were some areas that could be improved because:

- We received feedback from two patients and relatives and eight comment cards back about staff being too busy to provide care and answer their questions.

Compassionate care

- Throughout the inspection we observed examples of care where doctors and nurses were kind and compassionate towards patients and treated them with dignity.
- We observed several examples of staff asking for the persons consent prior to entering their cubicle area, respecting their dignity.
- All doctors we observed approaching patients we observed approached them and started by introducing themselves by name using the "Hello my name is" method.
- Since April 2015 the trust has performed between 92% and 95% on the A&E Friends and Family Test, which is significantly above the England average of 88%.
- We received feedback through comment cards during the inspection, and of the 38 cards received 30 provided us with positive feedback about the service and the staff providing the service.
- Of the eight comment cards which did not provide positive feedback the feedback related to staff being too busy to speak with patients and relatives and explain what was happening, and delays in pain relief being given. The majority of the feedback however was very positive about the care provided by the service.

Understanding and involvement of patients and those close to them

- Families of three children we spoke with felt very engaged in the care of their child from the paediatric teams. The three parents told us that they felt that the service for children had significantly improved in the last year and were positive about this.
- The majority of people we spoke with felt involved about the next steps of care to be provided. However two families felt that they were not engaged in care due to delays in receiving information and updates about their treatment plans. We spoke with the staff in the department about the concerns raised by the two families who went to speak with the patients' and relatives to provide reassurance.

Emotional support

- Clinical nurse specialists were available to provide support to patients in the department and we observed two occasions where the older persons specialist nurse and Parkinson's specialist nurse were consulted to attend the department and speak with patients.
- Whilst no specific counselling services were available patients and staff had access to the chaplaincy service who offered support to patients and staff seven days per week, and they walked through the department at least once per day.

Are urgent and emergency services responsive to people's needs?

(for example, to feedback?)

Requires improvement

Urgent and emergency services were rated as requires improvement for being responsive because:

- The trust was not consistently meeting the four hour standard. On review we found that the management and monitoring systems which under pin the flow towards four hours were not being achieved, which meant that the non-achievement of the standard was not only linked to the available bed capacity in the trust.
- The planning and delivery of services did not meet the needs of children.
- There was no gynaecology pathway for the trust which meant that women who miscarry or suffer an ectopic

pregnancy must go to the emergency department though trust policy was for prompt review by the gynaecology team. Also there were no 'ring fenced' or priority beds for gynaecology patients.
- The trust and the department had a lack of awareness with regards to how busy the department was compared to neighbouring hospitals. In comparison the department has more staff per patient head than other hospitals in the county, yet the performance against the four hour standard as well as time to treatment for a service seeing so few people per day was much lower than expected.

However we also found:

- The provision of support including the scrub uniforms for paediatric nurses were very responsive to the needs of children.
- Themes from complaints were monitored and shared through team meetings and governance meetings.
- The service was working on the relationship to improve access to mental health services for both adults and children.

Service planning and delivery to meet the needs of local people

- During periods of demand we witnessed that the department struggled to cope. There was a lack of clear co-ordination within the teams which caused the flow through the department to become confused. For example, patients placed within minors, majors, children's and mental health was mixed and it was not clear who was responsible for maintaining a responsive flow with the exception of children's which was more organised,
- Despite some minor improvements over the past year, the department had limited space and the design, layout and footprint of the department was restrictive and did not enable the service to be responsive. For example, the cubicles meant that the patients could not be observed and there was no separate children's area.
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Meeting people's individual needs

- The children's service were operationally continuing to work with children and young people's mental health services (CAMHS) to ensure that services for children and young people could be accessed in a more timely way.
- Mental health liaison services were available in the trust Monday to Friday, and an out of hour's service was available at the weekends. Access to mental health services were available through the local mental health trust who would respond to care when needed.
- We observed the staff access the translation service, known as language line, when they were trying to communicate with a patient whose first language was not English. This telephone service was available to the department 24/7.
- There was a named nurse for learning disabilities and staff had received training in understanding learning disabilities and complex needs. The nurse was available Monday to Friday, however information is available to staff on the intranet to support them with a patient who has complex needs if required.
- The trust has a named nurse for dementia and the service had access to this person Monday to Friday where needed for advice and guidance.
- Leaflets on a variety of conditions including back pain and flu as well as choosing the right pathways of care and when to choose emergency care were available to patients in the reception area.
- The leaflets available were in English only although other languages were available where the first language was not English.
- The staff within the children's department wore scrubs which were patterned with known characters from Disney's Frozen or Bambi or superhero's such as Batman and superman, the children we observed all commented on the scrubs when the nurses were with them and this put the children at ease. The thought processes behind the use of the scrub tops as a distraction for the children was outstanding.
- There was no gynaecology pathway for the trust which meant that women who miscarry or suffer an ectopic pregnancy must go to the emergency department. Also there were no 'ring fenced' or priority beds for gynaecology patients.

Access and flow

- The percentage of patients leaving before being seen was consistently lower than the England average of 5% from January to August 2015.
- The trust struggled to meet the 95% target for patients being seen within 4 hours. Between April 2015 and June

Urgent and emergency services

2015 the trust did not meet the target for 11 out of 13 weeks but improved from mid-June onwards. The trust was averaging 75-90% between June and September 2015.

- We looked at the key standards and which supports the delivery of four hours and found that there were delays in time to triage, treatment and assessment which meant that performance against the four hour standard was lower than expected.
- The bed occupancy of the hospital was a factor in delivering the standard. However, with the overall bed occupancy being on average 80% capacity within the hospital is not always a significant factor in the four hour standard not being achieved.
- Median total time in A&E was higher than the England average. On average the median wait time was 27 minutes higher than the England median.
- The performance for the percentage of emergency admissions waiting 4-12 hours to be admitted with a generally higher percentage than the England average. With January, June and July 2015 being the highest reported for the period with 20-45% of patient waiting for between 4 and 12 hours to be admitted.
- The trust has performed in line with the England average over the previous three months with no ambulance handovers being delayed more than 60 minutes, however there were peaks during the year in January, April, June and July where there were periods of performance which was below the England average.

Learning from complaints and concerns

- The department received 71 complaints between August 2014 and August 2015. The most common themes of complaints were the attitude of staff, waiting times, misdiagnosis, and failure of care.
- Complaints and concerns are discussed at each team meeting with staff as well as at divisional governance meetings. We viewed minutes of meetings at all levels which supported that learning from complaints was discussed.

Are urgent and emergency services well-led?

Inadequate

Urgent and emergency services were rated as inadequate for being well led because it was felt that while some progress had been noted there was not yet enough:

- The risk register, identification or risk and management of risk was not yet embedded within the service.
- The risk log did not highlight any of the risks regarding the environment, deteriorating patients or mental health care which we identified during the inspection and raised concerns about to the management of the department and the executive team.
- The vision of the local team to improve and develop the service was not in line with the trust's vision for the service following the removal of plans to implement environmental changes.
- There was a lack of leadership development and training for leaders, both nursing and medical, who were running the service on a shift by shift basis.
- The service was not assessing the culture and engagement of staff. The staff working in the department were not aware of their flow and how busy the service was in comparison with other hospitals in the area.
- The staff in the department viewed the service as busy because they had an increased number of admissions compared with their normal activity.
- The role of the nurse in charge role and a doctor in charge role for each shift, which was implemented the week prior to our inspection, was in in its infancy and required work to improve the model of leadership.
- The department did not undertake any pulse surveys of staff within the emergency department to understand how staff were feeling at any one time.

However we also found:

- The culture of the service, in terms of openness, had begun to improve since the last inspection.
- The divisional leaders of the service were working cohesively and had a good understanding of how they wanted to improve the service.
- The department had implemented a nurse in charge role and a doctor in charge role for each shift.

Urgent and emergency services

Vision and strategy for this service

- The trust does not have a clearly defined vision for the emergency department. Within the department the trust staff were aware of the core values of the trust and were able to describe them.
- The local leaders had a clear vision for the service and had defined plans for the future development and progression of the adult and children's services. Staff told us that they had these plans approved and ready to start building, however the trust executive team had altered the plans for the service, and this meant that the future of the service was no longer clear.

Governance, risk management and quality measurement

- The division had monthly governance meetings to look at risk management, governance and quality issues throughout the service. We examined meeting minutes for the last meeting which demonstrated that issues around governance in the emergency department were discussed.
- The emergency department had a risk log, which had eight risks listed on it with the oldest dating back to March 2014 with the oldest risk related to the undertaking to audits.
- The risk log highlighted the need to update a divisional governance risk register to monitor risk. During the inspection we asked the divisional leaders about the risk register. They informed us that this was now being updated and being developed but was a continuing work in progress.
- The risk log did not highlight any of the risks regarding the environment, deteriorating patients or mental health care which we identified during the inspection.
- The trust wide risk register for August 2015 did not identify any risks relating to the emergency department, the lack of provision of a separate children's area was not identified or seen as a corporate risk.

Leadership of service

- The leadership of the service had improved since our last inspection but required further improvement. The lead clinician, divisional lead nurse, matron, and lead nurse for children worked together cohesively and understood what was needed to make the department improve.
- The service had a matron who covered several services, but they were also the lead nurse for the accident and emergency department, which meant that there was no dedicated lead named nurse for the emergency department.
- Each shift was led by band six nurses who were not all well developed in leadership skills and not all demonstrated good leadership of the service. Two experienced nurses we observed led the service very well but another two were in need of leadership development.
- The department had implemented a nurse in charge role and a doctor in charge role for each shift, which was implemented the week prior to our inspection. We observed that this model of care would work well and showed times of where it did work well, and ambulance crews we spoke with also reported that this was an improvement in the way the department was led. However more work was needed to make this model of leadership more cohesive and embedded.

Culture within the service

- The culture in the department during our last inspection was not open and staff did not feel supported or able to freely speak about concerns. During this inspection we noted that there had been a significant improvement in the culture of the service.
- We spoke with staff who openly told us about what they were most proud of and where they felt improvements were still required, and they did so without fear which was positive.
- There was a willingness to change, make improvements, and upgrade the service to deliver good patient care an all staff spoke positively about how they wanted to make this service a success.

Public engagement

- The service takes part in the Accident & Emergency inpatient survey and also takes part in the A&E friends and family test. There were comments cards and feedback forms available throughout the service to engage the public in providing feedback or ideas for improving the service.
- All patients were given comment cards upon leaving the service to provide feedback specifically about how the service could improve and seek feedback to implement changes where needed.

Urgent and emergency services

Staff engagement

- The department did not undertake any pulse surveys of staff within the emergency department to understand how staff were feeling at any one time. The NHS staff survey returned a result of two positive findings, six negative findings, and 23 indicators which were within expectations.

Innovation, improvement and sustainability

- The department was implementing a front door model of care in the future with the use of therapist support. The aim was to start early intervention and discharge planning before admission and will allow staff to focus on a clear endpoint at the start of the patient's acute journey.
- The clinical leaders were working to improve the recruitment of clinical staff through the use of the DREAM programme supported by the College of Emergency Medicine. This would allow for medical staff to rotate through hospital to increase medical staff cover and gain staff experience and skills prior to being made consultants within the service.

Medical care (including older people's care)

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

Information about the service

The medical division had over 19,000 admissions between January and February 2014 with over half being emergency and the majority of the rest being day case. The largest category of admissions was general medicine with 20% being medical oncology. We visited Apple Tree, Cherry Tree and Walnut Wards as well as the Acute Admissions Unit, Medical Short Stay Unit and the endoscopy unit.

We spoke with 36 members of staff and 25 patients and relatives. We reviewed records, conducted interviews and observed care being given and carried out several Short Observational Framework for Inspection (SOFI) observations of care on two wards.

This was a follow up inspection following concerns identified at our inspections of September 2014 and January 2015.

Summary of findings

Medical services required improvement. Learning from incidents was not consistently shared with staff across the division and there were no formal mortality and morbidity meetings though we were told they were to commence soon. We observed some poor infection control practices in relation to hand hygiene. Not all patients had their allergies recorded on their medicines chart or were assisted in a timely way to take their medicines.

Records and risk assessments did not always reflect the needs of patients and were not updated to reflect changing care or needs and mandatory training had variable compliance across the division. Nursing staffing was adequate but not always correctly reflected on public information boards. There were insufficient medical staff in a number of specialties including respiratory and stroke medicine.

Medical services effectiveness required improvement. Local audits plans were not clear and there were a number of our of date trust policies. Patient outcomes were not always measured and there was a lack of stroke audit data which we were told was due to a lack of staff to complete. Not all staff had completed competency assessments and some of those who had, had completed them some time before. Whilst nutrition and hydration was managed well for most patients, we saw a number of occasions where patients were not

Medical care (including older people's care)

referred to a dietician when they should have been. Seven day services were in place for a number of services but a lack of some senior consultants meant there was insufficient cover in these areas.

Pain relief was given in a timely way to most patients and there was effective multidisciplinary working within and without the hospital. We observed correctly completed Mental Capacity Act (MCA) assessments but staff knowledge of the MCA was variable in line with mandatory training figures for MCA and Deprivation of Liberty Safeguards.

Caring was good within the medical division. We observed staff interacting in caring and compassionate ways with patients and relatives. Friends and Family Test (FFT) response rates were higher than the England Average and most wards scored highly on the test. Patients we spoke with told us that staff were caring and had kept them involved and up to date with their care and treatment. Information received from comments cards were uniformly positive about the quality of care received.

Medical services were responsive. The division was meeting referral to treatment times (RTT) though has struggled on occasion to meet cancer waiting times. Trust information showed that length of stay had been reduced by one day in the last 7 months with a focus on reducing delayed transfers of care and improving access to investigations and tests.

Most patients had their individual needs met and we saw good practice in relation to dementia care on one ward. However, we saw that patients did not always get mouth care when needed and the commissioning of some allied health professionals meant that some patients' needs may not always be met. Complaints and concerns were addressed locally but it was not clear if learning or outcomes where shared effectively with staff.

Medial services required improvement in terms of being well led. There had been changes to ward managers in a number of wards, the introduction of quality matrons and new governance arrangements which would all take time to fully embed. Other elements of governance including mortality and morbidity meetings and the way in which some root cause analysis (RCA) were completed was either missing or incomplete. There were historic informal agreements in place which had left the service vulnerable in some areas such as neurology because of the lack of formal assurance that these services would be provided by a third party, though we were aware the trust was addressing this.

We were concerned about the sustainability of some services due to a lack of key staff and the provision of audit data. Several senior clinical leaders were to leave the trust shortly following our inspection and these posts had yet to be recruited to.

Staff spoke highly about the culture of the service and were positive about the changes that had been made in the preceding year though not all were aware of the strategy for their area or specialty though they were aware of the trusts vision.

Medical care (including older people's care)

Are medical care services safe?

Requires improvement

We rated medical services safety as Requires Improvement. This was because:

- Learning from incidents was not consistently shared with staff across the division and there were no formal mortality and morbidity meetings though we were told they were to commence soon. We could not be sure that all incidents were reported.
- We observed some poor infection control practices in relation to hand hygiene.
- Not all patients had their allergies recorded on their medicines chart or were assisted in a timely way to take their medicines.
- Records and risk assessments did not always reflect the needs of patients and were not updated to reflect changing care or needs.
- Mandatory training had variable compliance across the division.
- Nursing staffing was adequate but not always correctly reflected on public information boards.

However, we also found:

- Staff had a good understanding of safeguarding principles and how to make safeguarding referrals.
- Modified early warning scores were used consistently and patients reviewed in a timely manner when required.

Incidents

- There had been 22 serious incidents reported between May 2014 and April 2015, the largest category with 8 incidents being grade 3 pressure ulcers.
- We reviewed two serious incident reports and found them to be detailed with a full investigation and recommendation for further actions including risk assessing patients routinely and further training.
- Review of the 2014/15 Quality Accounts showed the Trust had a 0.8% occurrence rate of clinical incidents resulting in serious harm or death, which is lower than the national average of 1.0%. Trust data indicated a fall in the number of incidents with harm across the medical wards.
- The Trust has appointed a team of senior managers to provide a high level review of a sample of patient deaths in 2015/16, identifying any cases where further review is required around patient care management. However, there were no regular mortality and morbidity meetings.
- We asked senior medical and nursing staff about mortality and morbidity meetings for the division. We were told that one meeting had occurred but it had not been minuted. They told us that meetings were to be arranged for consultants with invitations to other staff though current best practice is for a wider membership to include senior nursing staff, allied health professionals and pharmacists. An inconsistent approach and absent mortality and morbidity meetings meant that cases were not properly discussed or lessons learnt.
- One nurse we spoke with regularly took charge of the ward and told us that they were not able to report incidents until very recently as they had not been trained. The ward manager we spoke with told us that this had been the case but that the nurse had now had training. The trust used the 'Safeguard' incident reporting system and was to use a different system in the near future.
- 4 members of staff we spoke with told us that they did not routinely get feedback on incidents.
- All staff we spoke with were aware of their responsibilities under Duty of Candour. During our inspection, an incident was identified that may trigger this requirement. We saw that the trust took appropriate action to report the incident and spoke promptly with the patient and relatives and offered an apology and offered a face to face meeting. They kept them up to date throughout the course of our inspection.

Safety thermometer

- Safety thermometer data was displayed on wards but was inconsistent in its visibility.
- For Walnut Ward data for September 2015 showed that hand hygiene, sharps audit and cannula assessment were all at 100% with mandatory training at 95% and environmental audit at 90%.
- Data on Apple Tree Ward showed that here was 100% compliance with harm free care and hand hygiene.
- Data displayed on one ward stated there had been six falls in the preceding month but we were told later this was incorrect and there had only been two falls meaning the data displayed was incorrect.

- However, safety thermometer data displayed looked consistent with data supplied in board papers and to commissioners.

Cleanliness, infection control and hygiene

- Ward and clinical areas were visibly clean. There were separate cleaning rotas available which showed that areas had been cleaned each day or shift. Regular cleaning audits showed greater than 90% compliance for cleanliness.
- Curtains around the beds had the date when they were first used and were changed if dirty, were up longer than a given period or if there was risk of infection.
- We observed equipment being cleaned and sanitised properly between patient uses.
- "I am clean" stickers were affixed to equipment that had been decontaminated and ready for use.
- Staff did not always remove gloves following patient contact. For example, on two occasions a nurse left caring for a patient to get a blood glucometer without removing their gloves. A junior doctor wore gloves following patient contact whilst sorting through blood collecting equipment and was challenged by another member of staff. On another ward we saw a member of staff walking around the ward wearing the same gloves and apron that they wore to treat a patient.
- Compliance with hand hygiene and personal protective equipment usage was for medical wards for the six month period of Feb-July 2015 demonstrated 75% - 100% compliance and this was corroborated with observational studies of the wards in our October 2015 visit. It was noted from the data supplied that Cherry Tree ward did not appear to participate in either June or July's hand hygiene audits. Data supplied following the inspection showed that Cherry Tree Ward did complete hand hygiene audits and scored 100% compliance.
- In the six months before our inspection there was only one reported case of C-Difficile which was on Apple ward in June 2015.
- Patients with an identified infection or potential infection were appropriately identified and cared for in side rooms in line with trust policy and infection prevention and control guidance.
- We observed a member of the Infection Prevention Team whilst on Cherry Tree ward advising relatives of the procedure to follow for visiting a patient in a side room with a suspected infection.

Environment and equipment

- Equipment was properly checked and maintained in line with manufacturers' guidance and recommendations.
- Electrical equipment that required portable appliance testing (PAT) was appropriately tested.
- Emergency equipment including resuscitation equipment was properly checked in line with policy. There were weekly audits completed on the resuscitation trolleys on medical wards and nursing staff told us that the trolley tabs were changed on a Sunday evening. The Critical Care Outreach Team also completed quarterly focused resuscitation trolley audits.
- The environment was well maintained though cluttered on some wards with trolleys and medical equipment.
- On one ward the equipment cupboard was left open despite having a digital lock on the door and contained two ultrasound machines amongst other equipment.
- The layout of side rooms on the wards made it difficult to observe patients, particularly if the door needed to be kept closed. This meant staff had to regularly attend patients to ensure their safety and comfort. The trust had risk assessed patients using side rooms due to these concerns.

Medicines

- Medicines were stored securely with secure access limited to nursing staff. The pharmacy team had recently audited medicine storage which had shown improvement. Controlled Drugs which require special storage and recording were stored following good guidance procedures including daily checks by two nurses on quantities and records. Medicines requiring cool storage were stored appropriately in locked medicine refrigerators. Daily temperature records for the medicine storage room and for the medicine refrigerator documented that medicines were stored within safe temperature ranges.
- The times for medicine administration documented on prescription charts were recorded as 'Breakfast', 'Midday', 'Teatime' and 'Night' and were not time specific. This made it difficult to determine at what exact time medicines had been given to a patient. Whilst for

some medicines this is not critical there are some medicines such as pain relief where it is important to know in order to determine whether a patient can safely be given another dose.

- A clinical pharmacist visited the wards five days a week. We spoke with the pharmacist who was checking patients prescribed medicines. They were involved in patients' individual medicine requirements and helped identify medicine issues which could be dealt with immediately. A nurse told us that there was a good relationship with pharmacy particularly for discharge medicines which were organised using an electronic discharge prescription the day before the patient was discharged.
- We saw appropriate arrangements were in place for recording the administration of medicines. The records showed patients were getting their medicines when they needed them. Checks were undertaken on missed doses every two weeks to ensure patients were being given their medicine or a reason for not giving the medicine was documented. The last audit dated 19 October 2015 reported no missed doses. Any missed doses would be reported as an incident.
- Medicine incidents were recorded onto a dedicated electronic recording system. On Apple Tree ward a nurse we spoke with said that the learning from medicine incidents was not always shared across the trust. For example the ward had undertaken learning from a medicine incident which was positive; however the learning had not been shared across other wards. This had been recognised and a new recording system would help to identify issues to share.
- The trust policy on documenting patients' 'Allergies or Sensitivities' to medicines including 'None Known' on their prescription chart within 24 hours of admission was not always followed in practice. We found that despite reminders displayed on the wards about the importance of documenting patients' allergies that this section on the prescription chart or any additional medicine charts was not always completed following trust policy. We looked at 13 prescription charts and found 3 charts with no allergy information completed and a further 2 charts which although had been completed were not signed or dated. 2 Insulin prescription charts did not have allergies recorded. This information must be documented in order to prevent the potential of a medicine being given in error and causing harm to a patient.
- On two occasions we found medicines by a patient's bedside left unattended or the patient not assisted to take the medicine. We informed staff immediately of this.
- Apple Tree and Walnut wards both had two medication incidents resulting in harm which occurred between April to August 2015.

Records

- Records were stored outside patient bays and additional records at the end of the bed. Notes and records were not always secure and were stored in unlocked trollies in corridors.
- Audit dashboards for records showed variable compliance with June 2015 showing 80% compliance with documentation standards on Walnut Ward.
- We looked at 23 records and found that they were not always reflective pf patients changing needs. In three records we found that a Waterlow risk assessment (used to monitor skin integrity) was not correct as they had not taken into account a pre-existing condition. In another record a patient with a wound had been seen by a specialist nurse but this was not referenced in the care plan and no body map was completed to detail the wound. A further two Waterlow scores had been completed but not dated so it was unclear how relevant the assessment was.
- In a further set of notes, there were numerous wound care plans but not all were dated. They were difficult to navigate, to monitor clinical improvement or why changes to dressings had been made that were not in line with the care plan (primary dressing).
- Two fluid balance charts appeared incorrect and had not been totalled correctly. One showed a high positive balance which we brought to the attention of medical staff who told us they would review but did not believe it to be accurate.
- In three records, the falls risk assessment has been ticked to indicate a full assessment and care plan was required but this had not been completed and two had not been reassessed despite the patient having had a further fall. Trust data indicated a reducing number of falls in 2015.

Medical care (including older people's care)

Safeguarding

- Safeguarding information was available in ward and clinical areas. 11 Staff we spoke with were confident in the process of when to report a safeguarding and what constituted a safeguarding concern.
- July 2015 data showed that the average compliance with having completed this training was 96%, this included; Apple Tree ward, Cherry Tree ward, Walnut Ward, Acute Admissions Unit and Medical Short Stay unit.
- During our inspection we saw that staff had identified potential safeguarding concerns related to a recently admitted patient and took appropriate action to refer as a safeguarding.

Mandatory training

- Mandatory training included immediate life support, moving and handling and infection prevention amongst others. Compliance rates were variable across the division.
- Trust compliance data for Mandatory Training from July 2015 compliance averages across the following medical wards; Apple Tree ward, Cherry Tree ward, Walnut ward, Acute Admission Unit (AAU) and the Medical Short Stay Unit (MSSU) were as follows;

Deprivation of Liberties (DoLS) – 66%

IPT – 81%

Fire Safety – 89%

Information Governance – 86%

Mental Capacity Act – 66%

Moving and Handling - 85%

Prevent training – 34%

Safeguarding Adults – 96%

Safeguarding Children level 1 – 97%

- Individual ward mandatory completion rates for the nine required training elements ranged from 72%, Medical Short Stay Unit to 82%, Apple Tree ward.
- Agency staff completed an induction checklist before commencing work. We saw a completed checklist and spoke to one agency member of staff who confirmed they had completed one prior to starting work on the ward.

Assessing and responding to patient risk

- He trust continued to use the modified early warning score (MEWS) as opposed the recommended National Early Warning Score (NEWS). There was a clear and robust risk assessment for the use of MEWS and justification for its continued use.
- During our inspection we were concerned about one patient. We informed a member of staff about our concerns but no immediate action was taken and immediately following this the patient had an untoward incident. Following the incident the patient was appropriately reviewed and cared for. Before our inspection, a safeguarding was raised in relation to the care of a patient in the same ward also cared for in a side room. We were concerned that learning from a previous incident had not been embedded.
- Data provided by the trust indicated a falling number of falls with harm across medical wards.
- The Critical Care Outreach Team conducted an audit in February 2015 of the Modified Early Warning Score (MEWS) usage across the Trust in both Medical and Surgical areas which was based on the NICE CG50 guidance. This was the fifth audit since November 2009, and demonstrated that there has been year-on-year an upward trend in compliance with the standard of recording MEWS with every set of patient observations and this audit demonstrated a 96% compliance rate. Correct documentation of MEWS scored 93% which was the lowest compliance along with correct recording of oxygen saturation and correct use of algorithm to increase patient observations to hourly occurrences.
- All MEWS scores we reviewed during the inspection had been correctly calculated and escalated where appropriate. Observations were recorded at intervals as determined by the tool and/ or medical review. One patient who was having regular neurology observations following a head injury had them completed on time. However, we saw one patient on acute non-invasive ventilation (NIV) who should have had two hourly observations but there were several occasions where this did not happen and observations were carried out four hourly thought he patient was correctly escalated according to their MEWS.
- Critical care outreach offered a service during the ward until 8pm. There were plans to extend this to midnight dependent on recruiting sufficient staff. Out of hours, support was offered by the clinical site team.

Medical care (including older people's care)

- The Situation Background Assessment Recommendation (SBAR) tool was used for sharing concise and focused clinical information between teams on medical wards. We observed these tools being used as part of the midday huddle meetings which lasted half an hour, involving nursing, and medical staff and prioritised patient care based on clinical need and acuity.
- During the course of our inspection a number of additional staff were used to offer one to one support for patients with complex needs.

Nursing staffing

- There were around 12 registered nurse vacancies across the medical division with no vacancies for health care assistants.
- Wards had planned and actual staffing numbers displayed at the entrance to the ward. On two occasions on Walnut ward we found that the display was incorrect, once as there was one less member of staff than displayed and another as there was an additional registered nurse but one less health care assistant than displayed. There also appeared to be some confusion as to who was responsible for updating the data on the boards with some ward staff unaware.
- Nursing handovers were structured and gave the necessary clinical information to enable safe and effective care of patients between shifts.
- The safer nursing care tool (SNCT) had been used to evaluate staffing number in clinical areas which had seen a change in staffing in some areas.
- The March 2015 version of the monthly 'Safe Staffing Exception Report' written by the Associate Director of Nursing, Midwifery and Quality reported that four wards had been piloting the safer staffing module on e-Rostering to provide patient acuity information at 0800 and 2000 daily. The aim of this was to allow visibility of staffing needs and safe movement of staff within the hospital.
- The closure of the reablement unit had meant that permanent staff had been redeployed to other ward areas increasing their number of trust staff and reducing some agency and bank usage.
- Senior staff told us that, wherever possible, they used agency staff who were familiar with the ward and had worked there previously.
- Staff were able to describe the process used to request additional staff and that most requests were authorised.
- Due to a change in national policy, the trust were planning for recruitment of nurses from overseas including the Philippines.

Medical staffing

- There were more consultants than the England average that made up 39% of the medical staffing. There were significantly less middle grade and registrars at 22% than the England average of 45%. There were more junior doctors at the trust at 40% compared to the England average of 22%.
- There were a number of consultant level vacancies across the division. Senior clinical staff and managers told us that they mitigated this by using long term locum's who knew the hospitals and the processes. There were vacancies for 2 acute medicine consultants and the lead cardiologist was shortly to leave to take up another position. There were also locum consultant staff managing the haematology service.
- There was 1.3 WTE respiratory consultants in place at the trust made up of two consultants who worked between the trust and a neighbouring trust. When on leave or sickness, the respiratory consultant cover could be reduced to three days a week. There was no respiratory cover routinely at weekends. During our inspection patients requiring non-invasive ventilation were cared for on the ward and we were told tracheostomy patients also were cared for on the ward. When no respiratory consultant was available, acute physicians cared for patients. Whilst acute physicians were able to care for respiratory patients in the absence of a respiratory physician, this was insufficient number of respiratory consultants to manage a full respiratory service. The lead stroke consultant was due to retire from the trust shortly after our inspection. The trust had advertised but failed to recruit to this position and senior staff informed us that the majority of stroke care was provided by a neighbouring trust.
- Medical Wards in the Trust had medically led handovers on a twice daily basis at 08:00 and 20:00 which gave appropriate detail and identified any patients who may be outlying on other wards.
- There were consultant led ward rounds daily for patients on medical wards.
- Junior medical staff we spoke with told us that they were well supported at the trust and they had access to good teaching.

Medical care (including older people's care)

Major incident awareness and training

- There was major incident policy in place for the trust and a business continuity plan also in place. Staff we spoke with were not fully aware of the implications for the use of the policy other than they "would get a phone call".
- Staff in the Acute Assessment Unit (AAU) had a good understanding of the major incident policy as the AAU effectively became part of the emergency department in the event of a major incident. A major incident protocol was in place for the management of the unit as part of an emergency department.
- A winter escalation plan was in place and part of a wider health economy plan to manage capacity.

Are medical care services effective?

Requires improvement

Medical services effectiveness required improvement. This was because:

- Local audits plans were not clear and there were a number of our of date trust policies.
- Patient outcomes were not always measured and there was a lack of stroke audit data which we were told was due to a lack of staff available to complete.
- Competency assessments were in place but we found a small number of staff had not completed them for some time.
- That patients did not always get mouth care when needed. Whilst nutrition and hydration was managed well for most patients, we saw a number of occasions where patients were not referred to a dietician or the reason why they had not recorded when they should have been.
- Seven day services were in place for a number of services but a lack of some senior consultants meant there was insufficient cover in these areas.
- We observed correctly completed Mental Capacity Act (MCA) assessments but staff knowledge of the MCA was variable in line with mandatory training figures for MCA and Deprivation of Liberty Safeguards.

However, we also found:

- Pain relief was given in a timely way to most patients and there was effective multidisciplinary working within and without the hospital.
- There was effective multidisciplinary working both with hospital staff and staff in other services.
- The endoscopy service had received JAG accreditation in summer 2015.
- Seven day services were in place for allied health professionals and other staff.

Evidence-based care and treatment

- The Trust has a 2015/16 clinical audit plan but there is no evidence that this had been formally agreed or signed off by a board sub-committee. There was no indication of timeframes for completion of local or national audits within this plan.
- Local care pathways for stroke and cardiology followed best practice and NICE guidance including CG80 though potential conflicts with tis guidance arose from the commissioning of speech and language therapy in stroke services.
- Some local policies were out of date by a significant time period, for example the diabetes procedures available on the trust intranet was due for review in 2006, the incident management policy which has previously been mentioned and was due for review in 2013, as well as some patient information such as stroke leaflets outside Apple Tree ward which were dated 2012, and the Cardio Pulmonary Resuscitation (CPR) patient information sheet v1.1 in the ward area of Apple Tree ward was due for review in December 2012.
- There were a number of clinical incidents reported on medical wards in relation to non-adherence to local policies or procedures, 40 of these had occurred on Apple Tree ward in the last year.
- Staff on both Apple and Cherry Tree wards, discussed how local audits were completed; daily, weekly, bi-monthly and monthly for ward level data, including safety thermometer data, using the electronic audit system, and a member of staff on Cherry Tree ward was able to demonstrate this.
- The National Institute of Health and Clinical Excellence (NICE) guidance states that all patients, on admission, receive an assessment of venous thromboembolism (VTE) and bleeding risk. Trust data showed a compliance rate of 98% with the national average being 96%

Medical care (including older people's care)

Pain relief

- Pain relief was given in a timely way for the majority of patients though one person was distressed at having to wait two hours for pain relief following transfer from the emergency department.
- A specialist acute pain team was available for patients requiring specialist input.
- Analgesia was administered in a number of ways to ensure it was able to meet the patient's needs. This included oral pain relief, via injection or through a pump or syringe driver.
- A pain tool was available to assess patients' pain. There appeared inconsistent use of the tool though we observed staff asking patients if the pain relief had been effective.

Nutrition and hydration

- Patients were assisted with their fluid and nutritional needs. Assistance was given promptly at mealtimes if required with additional staff available to help them. Patients who may need assistance were clearly identified.
- Patients who were not able to gain enough nutrition orally were supported by other forms of nutrition including enteral feeding via a percutaneous endoscopic gastrostomy (PEG) and total parenteral nutrition (TPN). TPN was prepared in pharmacy for administration on the wards. Two medicines charts we reviewed showed that the TPN had been administered promptly.
- Two records we reviewed indicated that a patient should be referred to a dietician on the basis of their risk score. There was no evidence in the notes that this had been done but the patients had been commenced on a food chart that was up to date though in one record a food chart had not been commenced when the assessment indicated it was required and no rationale as to why it was not completed.
- We saw 2 patients who required mouth care who had not been assisted with this by staff. In two further sets of patient records, speech and language therapy staff in their initial assessment commented that the patients had required mouth care but it had not been given. On a further occasion, an outreach nurse identified a patient requiring mouth care who then informed ward staff.

Patient outcomes

- Readmission rates for the trust for elective admissions were better than the England average overall with medical oncology and general medicine having a much lower risk and medical haematology about the same as the England average.
- Readmission rates for non elective (emergency) admissions were slightly better than the England average with gastroenterology being better than the England average.
- SSNAP audit data was inconsistent. Whilst there was a full data set for previous years, there were no or insufficient records for April to June 2015. We were told that since the stroke specialist nurse left in January 2015, administrative staff had completed limited data recording. No comparison could be made on stroke audit data or stroke care benchmarked against other providers. This was particularly concerning given the imminent departure of the lead stroke consultant.
- Myocardial Ischaemia National Audit Project (MINAP) data showed deterioration in performance between 2012/13 and 2013/14 for patients seen by a cardiologist and being admitted to a cardiac ward and a slight improvement in the number of patients being referred for angiography. The 2013/ 14 data showed that the trust performed better than the England average for patients reviewed by a cardiologist but worse than the England average for patients being admitted to a cardiac ward and number of patients being referred for angiography.
- The Joint Advisory Group on GI Endoscopy (JAG) had awarded the endoscopy unit accreditation shortly before our inspection.
- National Diabetes Inpatient Audit (NaDIA) for 2013 showed the trust performed better than the England median in 15 indicators including visit by a specialist team, staff knowledge and medication errors. The trust performed worse than the England average for 5 indicators including foot assessment in 24 hours, meal timing and staff awareness of diabetes.

Competent staff

- Completion of appraisal rates on Apple Tree ward was 50% in September 2015 and 50% for Juniper Ward. Walnut ward appraisal rate was 83% and Cherry Tree at 95%.

Medical care (including older people's care)

- In terms of medical staffing for the period 2014/15 83% of the Trust's 56 Consultants had achieved appraisal sign-off. 16% of Staff Grade, Speciality or Associate Specialist Doctors (11) had achieved appraisal sign off within the Trust's timeframe.
- Appraisal completion rates were requested for medical ward nursing staff, but this data was not supplied by the Trust.
- Clinical nurse educators had been employed to work with staff proactively and also to work in areas where there had been identified concerns.
- There was a full induction programme for staff joining the wards. 2 new staff we spoke with confirmed they had received induction, had a supernumerary period and regular meetings with their manager.
- We saw that a number of competency assessments had been completed on wards such as intravenous and medicines competencies. On one ward a number of these assessments were dated June 2013 with no indication when they should be reviewed.
- One member of staff caring for patients requiring non-invasive ventilation (NIV) told us they has not completed any training for care of acute NIV patients but felt well supported on the ward to care for these patients. They were unsure if they had ever completed a competency assessment for NIV care. We requested information form the trust in relation to staff competencies are received only a policy on NIV.

Multidisciplinary working

- Medical wards had a thirty minute daily 'huddle meeting' which was a mixed nursing and medical staff and allied health professional meeting in the doctor's office to discuss any concerns and plan discharges. This was in addition to the 08:00 and 20:00 handover meetings.
- White board rounds were completed daily by the MDT and this was also attended on occasion by community staff to discuss complex discharges and care.
- There were local and regional weekly MDT's to discuss complex patients and care planning.
- Ward rounds routinely comprised members of the MDT to effectively manage patient pathways and plan discharges.
- During our inspecting we saw community services visiting the ward to assess a patient for discharge. There was clear collaborative working to ensure that clinical needs in the community were met.

Seven-day services

- There were clear on call arrangements for medical staff. Medical and nursing staff we spoke with told us that that there were no problems calling in on call staff.
- There were a number of vacancies for consultant staff and limited cover for some specialties such as respiratory. These patients would be seen by acute physicians in the absence of these consultants who word a seven day rota with approximately one weekend in four. All patients that required consultant review at weekends were seen by the on call team.
- Physiotherapy staff worked seven days providing care to ward patients based on need. There was an on call physiotherapy service for patients requiring chest physiotherapy.
- The discharge planning team worked weekends with effect from April 2015 to facilitate timely discharges which staff told us contributed to the reduction in length of stay.
- There was on call pharmacy and radiology services over the weekend and out of hours. Staff we spoke with told us that all essential investigations and support could be ordered and carried out promptly out of hours.

Access to information

- Staff were able to access medical records as and when required which were available to ward staff.
- Test results including radiology and blood tests were usually received promptly according to the staff. Senior managers had expressed some concern over delays in pathology results though ward staff told us they available via an online system.
- During our inspection a patient with complex needs was admitted from a nearby trust. The patient did not arrive with all the information required to manage their care which meant staff had to work with limited information.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Records showed that patients signed consent forms before procedures were undertaken. Three patients we spoke with told us they had been asked for consent prior to a procedure and where given the necessary information.
- We observed verbal consent being obtained before care and treatment was given.

Medical care (including older people's care)

- Not all staff had received training for MCA and DoLS and mandatory training figures for this were variable across the medical wards but typically less than 75%. We spoke with 8 staff about the MCA. 3 had a good knowledge of the Act and their responsibilities though 5 staff were not always sure of their responsibilities or the implications of the Act.
- We saw one example of the Mental Capacity Act (MCA) being properly applied in relation to a patient requiring an urgent procedure. The MCA 2 had been fully completed with clear input form the multi-disciplinary team. We saw three further examples of MCA being properly considered by medical staff.
- Staff had properly completed two deprivation of liberty safeguards and sought the appropriate permission. There was a clear date for review of the DoLS.

Are medical care services caring?

Good

Caring was good within the medical division because:

- We observed staff interacting in caring and compassionate ways with patients and relatives.
- Friends and Family Test (FFT) response rates were higher than the England Average and most wards scored highly on the test.
- Patients we spoke with told us that staff were caring and had kept them involved and up to date with their care and treatment.
- Information received from comments cards were uniformly positive about the quality of care received. Over 140 comment cards received with 9 naming a medical ward were all positive.

Compassionate care

- Friends and family test (FFT) data for July 2014 to June 2015 showed the trust had a much higher response rate at 61% than the England average of 34%.
- Results showed 100% recommendation for Apple Tree Ward between April and June 2015. For the same three months, responses were mixed but improving with 78% recommending in April 2015 but 100% in June 2015. Walnut Ward had also seen mixed results with 96% recommending the ward in April 2015, 100% in May and 82% in June 2015. The Reablement Unit also saw variation in responses though this area was closed shortly before our inspection as part of a service redesign.
- In March 2015 both Apple Tree and Cherry Tree Wards had a 0% recommendation indicating responses had not been received or data processed.
- The September Board Integrated Report shows that the Friends and Family response rate was low at just 33% across the Trust. Medical ward recommendations in the September Integrated Board report showed 94 – 100% with 98% being the trust performance target. Reablement and Walnut wards were under trust targets.
- Patients we spoke with during the course of the inspection, comment cards and listening event were overwhelmingly positive about the care and treatment they received.
- In the main ward area close to the Nurses' station on Apple Tree ward there was a dementia pledge tree – a poster of a tree which staff had attached their individual pledges to on post it notes.
- We observed a distressed patient on Cherry Tree ward and a registered nurse was trying to persuade her to return back to her bay, the patient made it clear this was not what she wanted. There was a sister from another ward sitting in one of a pair of chairs close to the nurses station who asked the patient to sit in the other chair with her while she waited which visibly calmed the patient.
- A patient who had received care on Apple Tree ward and Woodlands told us, "I spent eight weeks in Apple Tree ward and most of the time staff were very caring and kind, on a few occasions the staff were slow to answer the emergency pull cords but everything else was very good."
- On one occasion a patient required repositioning. The health care assistant achieved this by using the profiling bed but did not explain to the patient that was what was going to happen.
- We carried out three Short Observational Framework for Inspection (SOFI) observations on wards at the trust. We observed positive staff engagement with patients though there were periods of up to 25 minutes when no member of staff entered the bay.

Understanding and involvement of patients and those close to them

Medical care (including older people's care)

- Patients and relatives we spoke with told us that they were involved with their care and making decisions though one person said that despite daily ward rounds, they felt the plan changed each time.
- One person we spoke with told us that the medical team had planned their care and treatment around their other commitments to ensure they were properly cared for whilst supporting their family.
- We observed staff discussing care and discharge arrangements with a patient and their carers. The staff explained what care had been provided and asked the patient if they wanted to be referred to specialist community nursing to support their future care.

Emotional support

- A Chaplaincy volunteer visited Cherry Tree ward and was observed speaking to patients at the time of our visit. The wards were frequently visited by the well regarded chaplaincy team.
- Nurse specialists gave patients contact numbers so that they always had a point of contact when not in hospital.
- We spoke with a senior member of staff who had arranged counselling services for a patient following a difficult period of care.

Are medical care services responsive?

Good

Medical services were responsive because:

- The division was meeting referral to treatment times (RTT) though had struggled on occasion to meet cancer waiting times.
- There were small numbers of medical outliers on non-medical wards.
- Trust information showed that length of stay had been reduced by one day in the last 7 months with a focus on reducing delayed transfers of care and improving access to investigations and tests.
- Most patients had their individual needs met and we saw good practice in relation to dementia care on one ward.

However, we also found:

- The commissioning of some allied health professionals meant that some patients' needs may not always be met.
- Complaints and concerns were addressed locally but it was not clear if learning or outcomes where shared effectively with staff.

Service planning and delivery to meet the needs of local people

- The ambulatory care unit provided care to patients directed there from the emergency department as well as GP referrals. It provided prompt treatment and had a direct impact on the reduction in the length of stay of patients at the trust.
- The division had reconfigured some services and pathways in cancer and patients with suspected heart attacks to improve outcomes and ensure patients received the correct treatment in the most appropriate place.
- The division had a winter plan and contingency arrangements in the event of high demand for care and treatment. A reduction in length of stay had improved the division's ability to respond to increased demand for services.
- Meeting minutes showed that the division was managing delayed transfers of care (DToC) by utilising community beds closer to patients homes when they did not require an acute hospital bed.

Access and flow

- The trust was consistently meeting Referral to Treatment Time (RTT) targets for medicine. Between March 2015 and August 2015 showed both general medicine and gastroenterology were achieving 100% for patients seen within time, with Cardiology also at 100% between the months of May 2015 to July 2015.
- Data for June – August 2015 showed that the trust was reaching 80-89% compliance with the 62 day treatment target for cancer patients, delays were reported as due to radiology provision within the Trust, delays in report returns from the pathology and delayed referral receipt from neighbouring trusts. The trust had an action plan in place to address these issues.
- For the last full year (January to December 2014), length of stay for elective admissions was about the same as the England average at 4.6 days compared to the England average of 4.5 days. Length of stay was better than the England average for clinical haematology and worse than the England average for gastroenterology.
- Length of stay for non elective (emergency) admissions was better overall than the England average at 6 days

compared to the England average 6.8 days. General medicine was better than the England average with respiratory and gastroenterology worse than the England average.

- There were 448 out of hours patient moves completed between April and September 2015 for the trust as a whole with no figures available for medical specialities. Senior staff we spoke with told us there was approximately 1 to 2 bed moves out of hours for medical patients.
- Trust data showed that length of stay had been reduced by one day in the preceding seven months with a focus on reducing delayed transfers of care (DToC) and shortening the time needed to have radiology investigations completed. DToC had been on a downward trajectory since May 2015 with 16 DToC's in September 2015. This was however above the trust target of 10 per month and higher than commissioners targets for DToC. This represented an improvement in performance against 2014/ 15 data when DToC's had stood at 11%.
- Patients referred by their GP to the AAU and ambulatory care would then be transferred to the short stay unit (SSU) if they were expected to be discharged within 72 hours.
- Bed capacity meetings were held three times per day with attendance e by doctors as required.
- There were small numbers of medical outliers on non medical wards. Each patient remained under the care of their consultant and was reviewed daily unless otherwise agreed. Junior medical staff told us they were aware of any patients they might have in other areas of the hospital and a medical handover clearly identified patients on other wards. Juniper ward which had a mixture of surgical and medical patients had a dedicated medical team.

Meeting people's individual needs

- The Trust's Head of Patient Experience conducted a call-bell review in March 2015. This followed our January 2015 inspection where concerns were raised about patient waiting times for call bell responses. The aim was to make sure that patient call bells were responded to within the Trust's review aim of two minutes. The target was met on most wards, but not Cherry Tree or the Medical Short Stay Unit (MSSU), the longest wait was 14 minutes on Cherry Tree ward, the reason given was that staff were completing a drug round at the time. We observed call bells to be answered within two minutes during this inspection.
- A member of staff on Apple Tree ward had introduced 'sensory bands' for the ward's dementia patients. These were knitted pockets which would be embellished with buttons and beads etc. There was an example band on display with an explanation within the ward. The intention of these sensory bands was that patients could wear or hold them to give them an immediate focus to explore. The process was that a risk assessment was to be carried out on each patient before they were provided with a sensory band.
- A specialist nurse for dementia routinely visited wards to support patients living with dementia and the staff caring for them.
- Apple Tree ward held a stock of pressure relieving mattresses for patients at risk of pressure ulcers. Other ward areas told us that they could access equipment including bariatric equipment promptly. We observed a member of staff ordering a mattress and it arrived on the ward within 30 minutes.
- Speech and language therapy were only commissioned to provide care for patients with dysphagia and not dysphasia. This meant patients who had a stroke or required this service could not be sure of receiving it at the trust. Dysphasia is a common symptom following stroke. Only two nurses were trained to undertake basic swallow assessments.
- Physiotherapy staff were only commissioned to provide care for ten days following a stroke. They were then required to apply to continue therapy for individual patients or provide unfunded care.
- Telephone translation services were available and all staff we spoke with were aware of how to access them though we were told they were infrequently used.
- "You say, we did" boards were available on each ward. One showed patients had identified a need for wireless internet and this had been provided. However, there were no dates on the boards and it was not clear how recent the information was.
- Frailty assessments were completed on the wards and older people's specialist nurses provided expert advice and care for older people. They formed part of the multidisciplinary team in planning the care and discharge of older patients.

Medical care (including older people's care)

Learning from complaints and concerns

- All the staff we spoke with were aware of the complaints policy and how to assist people who wished to make a complaint or raise a concern.
- We reviewed the most recent complaint on two wards and found that learning had been clearly identified from the complaints. We spoke with 11 staff, 3 of who told us they did not receive feedback regarding complaints or concerns raised in their area.
- We saw during one shift 'huddle' that a recent complaint was fed back to staff with the outcome of the investigation. A further ward told us they carried out this practice to cascade information to staff.
- Ward meetings on Apple Tree Ward were minuted but we saw little evidence in the minutes of consideration of complaints or concerns identified.

Are medical care services well-led?

Requires improvement

Medial services required improvement in terms of being well led because:

- There had been changes to ward managers in a number of wards, the introduction of quality matrons and new governance arrangements which would all take time to fully embed thought this process had clearly begun.
- Other elements of governance including mortality and morbidity meetings and the way in which some root cause analysis (RCA) were completed was either missing or incomplete.
- There were historic informal agreement in place which had left the service vulnerable in some areas though we were aware the trust was addressing this.
- We were concerned about the sustainability of some services due to a lack of key staff and the provision of audit data. There were vacancies for senior medical leaders that had not been recruited to.

However, we also found:

- Staff spoke highly about the culture of the service and were positive about the changes that had been made in the preceding year though not all were aware of the strategy for their area or specialty though they were aware of the trusts vision.

Vision and strategy for this service

- Senior clinical staff and managers were aware of the strategy for the division and the trust as a whole.
- Staff were able to tell us about the trusts vision but were not sure of a vision or strategy for the division. The trust values and vision were displayed in a number of the clinical areas that we visited.

Governance, risk management and quality measurement

- Senior clinicians and managers were sighted on their main risks including medical staffing, inpatient falls and medication incidents. There was a comprehensive plan in place to address risk of falls and this programme was running during our inspection and action plans in relation to medical staffing and medication incidents. The number of falls was reducing in the months before our inspection.
- There was a lack of patient outcome measurements in some services and a lack of data to benchmark stroke services and patient outcomes because the trust was no longer collecting a full Sentinel Stroke National Audit Programme dataset.
- There were no regular morbidity and mortality meetings within medical services. Senior staff informed us that one meeting had been held but not minuted. There were plans to introduce the meetings imminently and identify appropriate staff to attend.
- The divisional quality matron received a copy of every incident form and attended a monthly risk meeting (the Quality and Risk Meeting) to discuss any issues or 'flags' and identify remedial actions. Minutes showed the items discussed, the outcome and who was responsible for completing the action.
- The Incident Management policy was out of date at the time of inspection with this being flagged in the September Integrated Board Report, with a remedial action plan to update this.
- Clinical incident root cause analysis (RCA) reports were discussed with complaints within Governance minutes, and we were provided with evidence of an associated 'Governance and Risk analysis document (August 2015). It was not clear whether this is shared with all levels of staff, also the incident/complaint descriptions had no reference number to refer back to for additional information and the action plan at the back has no responsible individuals or timeframes for completion,

therefore we cannot be fully assured that when things go wrong a robust system is in place to investigate and take immediate and longer term action to stop a reoccurrence.
- There was an historic informal agreement with a neighbouring trust to provide neurology staff. This had recently been problematic with a growing waiting list. A locum was being considered to reduce the waiting list whilst discussions continued regarding a formalised agreement for neurology services.
- Audit was managed electronically but ward staff didn't yet have access to the dashboard but were sent paper copies instead. On one ward, a member of staff was unable to locate the most recent data/

Leadership of service

- Senior and junior staff told us that there had been a degree of uncertainty in the preceding 12 months following change in management within the and without the organisation. We were told that staff now felt more comfortable about the future.
- Since our last inspection there had been changes in the governance and leadership structure of the medical service. This included the addition of quality matrons in clinical areas. On two of the medical wards, leadership was new and would take time to establish, one of the wards having an interim manager for 4 months prior to the new ward managers appointment.
- The division was soon to lose senior clinical leaders in stroke and cardiology medicine and had not recruited to these posts at the time of our inspection.
- Most staff felt well supported but three staff we spoke with told us that they did not always feel supported in their day to day work, predominately due to staffing concerns.

Culture within the service

- The 'Stop the Line' initiative was to encourage an open culture and give staff the confidence to report when there was cause for concern and ensured a senior manager reviewed the situation. Between October 2014 and October 2015 Trust data showed this initiative had enabled 15 clinical incidents to be reported, (6/15) 40% of these relate to staffing issues.
- A new 'Freedom to speak up' [Whistleblowing] policy was introduced in September 2015, which encourages staff to speak up about concerns.
- Senior staff told us they believed that junior staff felt more empowered to 'Stop the line'. Staff we spoke with told us they had called a stop the line previously.
- 4 staff we spoke with told us they were confident in raising concerns and felt they would be considered fully.

Public engagement

- The trust continued to engage with Healthwatch and other patient groups to improve services at the trust and gain patient feedback.

Staff engagement

- Staff spoke highly of the trust and the area they worked in.
- "Breaking the cycle weeks had been initiated. GP's had been invited into the hospital to understand how the trust worked and was managed. Senior staff described the relationship with GP colleagues to be much closer than previously.
- Walnut ward had a staff concerns box in the staff room to allow people to put in concerns anonymously though none had been received.

Innovation, improvement and sustainability

- The trust had reduced length of stay by a day in seven months by addressing some work practices and improving systems.
- The imminent departure of senior clinical leaders from the medical division, and failure to recruit to the positions, had raised questions as to the viability of stroke services. Absence of specialist nursing or allied health professional staff coupled with an ongoing lack of data provided to national audit centres meant the effectiveness of the service could not be demonstrated.

Surgery

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

Information about the service

Hinchingbrooke Health Care NHS Trust provides a range of surgical services including general surgery, elective and trauma orthopaedics, ear, nose and throat (ENT), urology and ophthalmology.

The service consists of five main surgical wards and two operating theatre suites. Juniper ward is an acute gastrointestinal medicine and general surgery ward, the acute trauma surgical unit (ATSU) is a mixed specialty surgical ward for acute and trauma admissions. Specialties included orthopaedic, gynaecology and urology. Birch ward is the elective orthopaedic surgery ward and the Mulberry suite provides a separate facility for private patients.

The treatment centre accommodates Daisy ward, which has mixed specialty patients including urology, general surgery, gynaecology and orthopaedics.

There are seven theatres in the main hospital and five theatres in the treatment centre.

During this inspection, we visited all five wards within the surgery service and both theatre suites. We spoke with 34 staff, including medical and nursing staff, 12 patients and two relatives. We reviewed 13 sets of medical records and information requested by us prior and during the inspection provided from the Trust.

Summary of findings

Surgery services required improvement overall with effective, caring and responsive rated as good and safety and well led rated as requires improvement.

Oversight of standards of care and governance was fragmented. There was a structured governance process in place but this was not embedded; good practice in one area was not cascaded. Nurse staffing levels were variable on the wards and consultant presence at ward rounds was not consistent. This meant there was a risk to patient safety due to a lack of senior medical review. Medication management required improvement.

Caring was good across the surgical wards and departments. Staff treated patients with dignity and respect and displayed compassion and kindness towards patients and relatives.

The service had up to date policies and procedures in place to ensure adherence to national guidance and participated in national audits to monitor performance. Data provided showed that patients received care in a timely manner within national timeframes and there was a proactive approach to discharge planning and involvement of patients and relatives.

Surgery

Are surgery services safe?

Requires improvement

Safety in surgery was rated as requires improvement because:

- Nurse staffing levels on wards was variable with areas of concern in Juniper ward, the acute trauma surgical unit (ATSU) and Birch ward.
- Mortality and morbidity meetings did not occur across all of the surgical specialities and there was no robust process in place to ensure these meetings took place.
- Consultant attendance at ward rounds was not consistent.
- Medication prescription, administration and recording were inconsistent across the surgical wards.
- There was no robust system in place to ensure improvements occurred regarding the safe management of medicines.

However we also found that:

- Nursing staff on the surgery wards undertook a safety huddle twice a day to review patients' needs and discuss any changes in patients' conditions to enable early identification of any changes.
- The five steps to safer surgery and World Health Organisation (WHO) checklist was utilised and audited in all theatres. All aspects were observed including team briefing, sign in, time out, sign out and debrief.
- We reviewed 13 sets of patient nursing and medical notes. The majority of records were complete and accurate in detail.
- Staff carried out daily checks of resuscitation trolleys and emergency equipment within the surgical wards and theatre's.

Incidents

- There was a new electronic system in place for reporting incidents. Despite the change in system, staff were aware of the process to report incidents and their individual responsibility. This extended to temporary staff; one agency nurse on Juniper ward explained that they had completed an incident form jointly with a substantive member of the team, as they did not have access to the system.
- Nursing staff on each ward were aware of incidents that had occurred locally. There was a variety of methods in use for communication of incidents to ensure dissemination of learning and changes in practice. On Juniper ward there was an incident folder that staff could access. On the acute trauma and surgical unit (ATSU), the notice board in the staff room displayed incident summaries and findings for staff to read. There was also a verbal discussion during the nurse-staffing huddle every two days.
- There had been six serious incidents reported for surgery between August 2014 and April 2015. These incidents had undergone investigations, two had related to patient falls, but there was no overall trend identified. There had been no further serious incidents reported in surgery in the last six months.
- Folders named as 'yellow pages' were in all areas, including theatres, and contained information for staff on incidents and risk assessments to enable ease of access. Staff stated that these had only recently been implemented.
- Mortality and morbidity meetings were not consistent across specialities and there was no formal plan in place to ensure this took place. Meetings had occurred in general surgery and urology specialties only and none had taken place within Orthopaedics. This meant that there was no regular consistent review of recent patient deaths by medical staff, to identify any concerns and potential learnings to improve patient safety. There was no robust process in place to ensure these meetings took place. Medical staff stated that there was a plan to start meetings in Orthopaedics following the recent appointment of a clinical lead but did not know when this would occur. When requested, the trust did not provide any information regarding plans for orthopaedic mortality and morbidity meetings.
- The associate medical director stated that similar meetings for review of any patient deaths, whether they had surgery or not, were to be introduced. At the public board meeting in October 2015, the chair expressed that the mortality and morbidity data must be at 100% to improve patient safety and urged the medical director to ensure that all consultants were committed to this.
- Staff knowledge of duty of candour was variable. Not all staff could describe what duty of candour was whilst others knew that this meant involvement of patients and relatives when incidents occurred but could not provide examples.

Surgery

Safety thermometer

- The NHS Safety Thermometer is an improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care. The safety thermometer records 4 harms: pressure ulcers, falls, urinary tract infections (UTIs) in patients with a catheter and venous thromboembolisms (VTEs). Ward performance data from May 2015 showed that Birch ward, Juniper ward and ATSU had 98 - 100% compliance with catheter care bundle and VTE assessments. In June 2015, Birch maintained this score. The integrated performance and quality report produced data on pressure ulcers collectively across the trust but did not breakdown into individual wards. Ward dashboards were phased in from July 2015.
- The number of patient falls within the surgery wards where nurse-staffing vacancies were high had fluctuated in the six-month period between June 2015 and October 2015. On Juniper ward, there were 12 reported falls, with four occurring in one week. Ten on the ATSU, with three occurring in the same week and eight on Birch ward.
- Electronic dashboards were in place in each surgical ward. The ward matrons could alter the display on these boards accordingly. On Juniper ward, the dashboard did contain some safety thermometer results but this was not the case on other wards. This meant patients and relatives did not have access to data to demonstrate ward performance.

Cleanliness, infection control and hygiene

- The surgical wards were uncluttered and appeared visibly clean. 'I am clean' stickers were visible on equipment such as commodes, blood pressure machines, hoists, walking frames and wheelchairs.
- Side rooms on the surgical wards provided isolation when required to prevent the spread of infection. On Juniper ward there was a notice on the door to inform staff and relatives of the additional precautions that were in place. Personal protective equipment (PPE) such as aprons, visors and gloves were available outside the side room.
- Staff adhered to trust policies and guidance on the use of PPE, and to 'bare below the elbow' guidance, to help prevent the spread of infection. Hand hygiene audits were undertaken throughout the trust. We reviewed these and actions were taken where appropriate to ensure compliance with the trusts policy.
- Fabric curtains were in place around each individual bed space in the ward bay areas. Staff stated that curtain changes took place at regular intervals, and when necessary, but were unsure exactly when changes took place. There was no indication of length of time between laundries on any of the curtains, which meant that there was no way of easily identifying when these were due which could increase the risk of infection.
- Data showed that in the six months between February 2015 and July 2015 there had been no cases of meticillin-resistant staphylococcus aureus (MRSA) within the surgical wards. There had been one case of Clostridium difficile (C. diff) on Juniper ward.

Environment and equipment

- Staff carried out daily checks of resuscitation trolleys and emergency equipment within the surgical wards and theatres. These checks were consistent across all areas, checklists were in place and records were complete.
- There was a system of daily checks of the emergency difficult airway management trolley in theatre but these were not consistent. On review, the equipment checks had taken place approximately once a week. This was brought to the attention of the theatre manager, as this equipment should be available at all times and therefore there was a potential risk to patient safety should there be any discrepancies with the equipment.
- The surgical wards and theatre appeared uncluttered. There was adequate bed space to ensure nursing care and intervention could take place without the need to move excessive amounts of furniture. The theatre had a newly refurbished large storeroom for consumables, which was nearing completion. This had been fitted with mechanically operated moveable shelves, to maximise storage whilst minimising moving and handling risks to staff.
- Throughout the surgical areas, equipment, such as hoists and standing aides were in date for service requirements, which meant that they were suitable for patient use.
- On Juniper ward and the ATSU, it was difficult to identify individual bed spaces and therefore specific patients. The bed numbering altered depending on the bay: in two of the four bays, the numbering went from left to right and then opposite in the other two bays. This meant that there was a potential risk to patient safety if

there was confusion over patient identity. The ward matron in Juniper ward had identified that this was confusing for new staff, temporary staff and relatives and needed addressing but this had yet to take place.
- On Juniper ward, there were kick plates to open the automatic doors to the five-bedded bay areas. These were quite noisy and could be disruptive to patients at night. The ward matron stated that they were seeking quieter alternatives.
- Staff stated that it could be challenging to replace equipment. The sister on Juniper ward had purchased weighing scales personally as the system to order was lengthy.

Medicines

- A pharmacist visited the surgical wards five days a week. They were involved in patients' individual medicine requirements and helped identify and deal with any immediate medicine issues.
- Medication prescription, administration and recording were inconsistent across the surgical wards. There was no robust system in place to ensure improvements occurred regarding the safe management of medicines. ATSU had not completed any missed dose audits. Nursing staff stated that medication errors were reported as an incident although learning from medicine incidents was not always shared across the trust. There had been six medication incidents on ATSU in September 2015. However, there were no details provided regarding learning or identified actions.
- There was a discrepancy with medication for one patient on ATSU. It was unclear as to what pain relief had been administered in the emergency department (ED), as information had not been sent with the patient. This meant that it was difficult to know what additional pain relief was appropriate. One nurse informed the medical team that they had been told verbally via the telephone that paracetamol had been given at 5pm. On review of the drug chart there was an entry for paracetamol, but no signature. The patient had received further analgesia but remained in extreme pain and the inspection team highlighted the case to the ward manager. When information was obtained regarding the pain relief administered in ED, it was evident that the patient had not received paracetamol but an alternative analgesia and therefore the patient's prescription chart was incorrect. This meant that both medical and nursing staff had failed to determine what medicines had been given in order to ensure that the patient was treated safely.
- On Juniper ward, there were issues with regard to the safe prescribing of paracetamol. Doctors prescribed Paracetamol, which can be administered intravenously (IV) or orally (o), on the same prescription with no clear distinction between the two. There is a difference in the prescribed dose for 'IV' and 'o' which should not be interchangeable. This meant that the administrator could decide the frequency and route. We looked at four patients' prescription charts and found paracetamol prescription errors on all four. Nursing staff were recording when the medication had been given but not by which method. This meant that there was a risk of harm to patients from miss-medication.
- Staff were not adhering to the medication safety bulletin, dated August 2011, that provided information on safe paracetamol prescribing. The ward manager and ward pharmacist agreed that this medicine issue needed to be highlighted to prescribing doctors.
- Intravenous fluids were stored securely in rooms accessible via key code access on the surgical wards. In Juniper ward, there was a desk space in the fluid storeroom that provided a quiet space for medical and pharmacy staff to review and prescribe medications without interruptions.
- Juniper ward shared learning from medicine incidents at staff meetings, noticeboard information bulletins and extra training provided to nursing staff on specific medicine issues. For example, there had been extra training given in the use of patient controlled analgesia (PCA) pumps. There was a medicine safety bulletin dated October 2015 available to read on the staff noticeboard.
- Certain medications are required to be stored within specific temperatures to maintain their integrity. A system for daily monitoring of drug fridge temperatures on the wards and in theatres was in place. Checklists included details of the acceptable temperature ranges and actions required should the temperature fall out of this range. However, adherence was not consistent in all areas.
- Recording of fridge temperatures in theatre was inconsistent. In one anaesthetic room, the thermometer had been faulty from mid-September 2015. Despite

recording and documenting the fault daily, staff had undertaken no actions. Therefore, the drugs were in use but without assurance that they had been stored correctly and their integrity was intact.
- Storage and recording of controlled drug administration was adequate across all areas. Controlled drugs were stored in locked double cupboards and the nurse in charge held the keys. Daily stock level checks were in place on the wards and at the end of each operating list in theatres. Staff were aware of the correct procedure for disposal of out of date controlled drugs.

Records

- We reviewed 13 sets of patient nursing and medical notes. The majority of records were complete and accurate in detail.
- Nursing records were in a folder, situated outside the bay areas, and a clipboard attached to each individual patient bed. The clipboard held specific parts of the documentation such as the Modified Early Warning score (MEWS) and fluid charts to encourage immediate completion by staff at the point of care with the patient.
- Medical records were stored on trolleys situated near each nursing station, across the surgical wards. This had a risk of records being unsecure when staff were not at the nurse's station. Staff were aware of the proximity and accessible nature of medical records and took steps to protect confidentiality for example on Daisy ward once notes had been accessed staff closed the trolley lids in a timely manner.
- On ATSU there were written notices on the wall pockets that contained the patients nursing records, reminding individuals that the notes could only be read if they had consent to do so. The sister was planning to review the accessibility of the nursing folders outside the bays for confidentiality reasons. However, this was not a common theme across the other wards, and notices about consent were not in place elsewhere. This meant that there was an inconsistent approach across the wards.
- There was a discrepancy for one patient on ATSU regarding the plan of care. The patient thought that they would be undergoing surgery but in contrast, nursing staff thought the plan was to treat conservatively. On review of the patient's notes there was no clear treatment plan recorded. We informed the nursing team who contacted the medical team to review the patient and communicate the care plan clearly.

Safeguarding

- Safeguarding training is mandatory for all staff. Data provided by the trust showed that for the surgery core service, overall 92% of staff had completed safeguarding adults training level 1 and 97% for safeguarding children level 1.
- Staff were aware of their individual responsibilities in relation to safeguarding concerns and could identify appropriate actions to take to protect patients.

Mandatory training

- Delivery of mandatory training was by a variety of methods including E-learning and face-to-face sessions. Training included fire safety, equality, diversity and human rights training and information governance.
- Training data submitted by the trust showed that the level of training for the surgery core service overall was 88% for equality and diversity training, 74% fire safety and 77% for information governance, as of the end of July 2015. Of the staff groups, the administrative and clerical staff had the highest percentage of completion with the two lowest staff groups being the medical and dental, and nursing and midwifery groups.
- There was no system in place to ensure protected time for training. Staff on ATSU stated that they did not always have time to attend depending on clinical pressures.

The training data showed that the two wards with the least percentage of staff that had completed training were Juniper ward and ATSU.

Assessing and responding to patient risk

- The Modified Early Warning system (MEWS) was in place across the surgical areas to identify any change in patient condition and ensure timely appropriate escalation for deteriorating patients. We reviewed 13 nursing and medical notes and in 12 cases, the MEWS score was completed.
- Nursing staff within theatre recovery, audit the completion of MEWS for patients post-surgery. Results for the three months between July and September 2015 showed that the MEWS score was complete in 85%, 90% and 95% respectively.
- The five steps to safer surgery and World Health Organisation (WHO) checklist was utilised and audited in all theatres. All aspects were observed including team briefing, sign in, time out, sign out and debrief.

- Staff in theatre completed instrumentation checks against tray checklists. However, the recording of this check on the instrument checklist was not consistent. On the 21st October 2015, staff had completed instruments checklists fully in the Orthopaedic theatre but not in the ENT theatre. Checklists were competed by either ticking individual instruments or grouping them together. However, the method of recording on the checklist was not consistent , which could reduce the effectiveness of this safety check.
- On ATSU, a very elderly patient was admitted to a side room, which meant that direct observation could not take place. They were moved into a six-bedded bay following another patient's discharge. It was not clear why the patient acuity had not been assessed prior to the patient's arrival on the ward to ensure that the side room was appropriately allocated to a patient that did not require a high degree of observation from the nursing staff.
- Nursing staff on the surgery wards undertook a safety huddle twice a day to review patients' needs and discuss any changes in patients' conditions to enable early identification of any changes.
- A quality spot check audit of the World Health Organisation (WHO) checklist compliance had taken place in July 2015, reviewing compliance of the team brief and sections one and two of the WHO checklist between May and July 2015. Data showed compliance at 98.5% in May, 99% in June, 98.5% in July against a target of 100%. There were three ongoing themes for non-compliance identified and recommendations outlined.

Nursing staffing

- There was ongoing nurse recruitment across the surgical areas. Data provided by the trust showed that there were a number of nurse vacancies across the surgery service. The three wards highlighted in the August 2015 integrated performance report with the highest vacancy were ATSU at 9.9%, Birch ward at 11% and the highest being Juniper ward at 16.5%. In line with this vacancy data, the turnover on ATSU and Juniper ward in particular was high at 21% and 47% respectively.
- Where nurse vacancies existed, agency and bank staff were utilised to bridge gaps. Levels of agency staff between January and March 2015 averaged at 20% for ASTU, 27% on Birch ward and 27% on Juniper ward. We noted form information provided that all of these wards were areas where there had been concerns with care and a high number of patient falls recorded.
- There was an electronic rota system in place. This system indicated the number of qualified and assistant nursing staff for each shift. However, it did not show the number of nurses planned on each shift and therefore any shortfall could not be clearly seen by patients and visitors.
- The trust used the Shelford safer staffing tool which demonstrated that there was a ratio of one registered nurse to six patients on an early shift, one to seven on a late shift and one nurse to 10 patients on a night shift. In addition to these registered nurses the trust had four health care assistants on an early shift and three on a late and night shift. We reviewed rotas for a number of areas in the surgical services. We saw that in general the numbers planned were in alignment with the Shelford Safer Nursing Tool. However, other data reviewed showed that these numbers were not actually met across the month of September 2015.
- The safer staffing module on E- rostering was in place to provide patient acuity information and allow visibility of staffing needs and safe movement of staff within the hospital. In the safer staffing report of September 2015, Birch, ATSU and Juniper ward were all highlighted as not achieving target nursing levels of 95% in either or both registered nursing or health care assistant categories..
- Nursing numbers at night were adequate and monitored by the site matron each evening with staff relocated to areas of need.

Surgical staffing

- Vacancies for medical staffing were varied dependent on speciality. Data provided by the trust showed the overall vacancy rate at July 2015, as 12.5 % for urology, 15% in general surgery, 15% in ophthalmology and 4.6% within trauma and orthopaedics.
- There was a 1.8% vacancy within anaesthetics. There was no middle grade anaesthetic cover with critical care unit (CCU) training. The resident consultant anaesthetist remained in hospital overnight to mitigate the risk with a one in 13 rota.
- There was no substantive breast consultant. Two locum consultants, a staff grade appointed in February 2015,

and junior doctors provided service cover. Recruitment was ongoing for a substantive consultant and the risk to provision of service was on the corporate risk register and updated in June 2015.
- Data provided regarding the use of locum medical staff between April 2014 and March 2015 showed that there had been a reduction in locum staff in the first three months of 2015. Locum usage matched the vacancy specialties in urology, general surgery and trauma and orthopaedics.
- There was inconsistent consultant attendance to ward handover and ward rounds. Due to commitments within theatres, the consultants generally only attended four out of five ward rounds. This meant that there was not a consistent senior review of all surgical patients.
- There were five whole time equivalent research and development clinicians. Current research topics included ophthalmology and gynaecology.

Major incident awareness and training

- There was a major incident policy in place relating to all services within the trust including surgical services.
- Staff had knowledge regarding what constituted a major incident. They knew where to access the policy on the intranet and stated that staff would redeploy to the areas of most need. Daisy ward is nominated as the base area and patients would be transferred within the main hospital

Are surgery services effective?

Good

Effectiveness of surgery services were rated as good because:

- Staff were aware of policies and procedures.
- The trust performed on average or slightly better in a range of national audits.
- Staff received induction and competency assessments.
- There was good multidisciplinary working, with daily white board meetings and structured handover.

However we also noted that:

- Pain management was not appropriately managed in all patients.
- Actions resulting from audits were not always actioned.

Evidence-based care and treatment

- Policy and procedures were available to staff, including agency staff, on the trust intranet and staff were aware of how to access these for reference.
- Communication of updated policies was via email to all staff. On Daisy ward, staff stated that updates were printed and added to the staff communication book. Staff signed once they had read the update.
- There was a local audit undertaken in May 2015 reviewing the management and care of acute upper gastrointestinal bleeding. The audit encompassed nine patients with data collected from patient records and endoscopy reports for the 12-month period between January 2014 and December 2014. Despite the small patient cohort results showed that the trust adhered to the National Institute for Care and Excellence (NICE guidance cg141) for the management of suspected variceal haemorrhage. Only one patient with a suspected variceal bleed was not offered prophylactic antibiotics at presentation. All patients had an early review by a gastroenterologist and a timely endoscopy.
- The colorectal multidisciplinary team participated with the 2014 national patient cancer survey and reported colorectal outcomes both internally and externally to the clinical commissioning group (CCG). 86% of responses were equal to or above the national average
- The modified early warning system (MEWS) was in place across the surgical areas to monitor acutely ill patients in accordance with NICE (guidance CG50).

Pain relief

- The management and control of pain was inconsistent across the surgical wards. Patients provided mixed feedback regarding the level of management of their pain. Some patients stated that their pain was well controlled and medication given in a timely manner whilst some other patients stated the opposite.
- One patient admitted to the acute trauma and surgical unit (ATSU) from the emergency department (ED) had been in pain for over 24 hours. He was very disappointed with the system in the ED with dealing with pain relief and the lack of recognition of his pain requirements.
- The sister on the post anaesthetic care unit (PACU) was the nominated nurse lead for pain. They provided support and training to all nursing staff and an organised training schedule was in place throughout

2015. This included PCA pump training, epidural pumps, intravenous and oral drug administration and anaphylaxis update training. Data provided showed that training on patient controlled anaesthesia (PCA) had been delivered to staff on all wards.
- Patients undergoing elective joint surgery had their prescription for pain relief pre-populated on the drug chart after review at pre-assessment. This meant that these patients could receive pain relief as quickly as possible and reduced delays that may result from time taken to gain medical review and prescription.

Nutrition and hydration

- The malnutrition-screening tool (MUST) is a five-step screening tool to identify adults at risk of malnutrition. Completion of the MUST score was not consistent. Out of 13 patient records reviewed, only six had the score completed.
- Patients gave mixed reviews of the food provided. Some stated that they felt the food had improved from previous admissions and there was adequate choice provided. One patient stated that their request for a poached egg was met which meant that they were encouraged to eat something light when they had not wanted anything from the regular menu.
- Patients had jugs of water available and nursing staff encouraged patients to drink regularly.

Patient outcomes

- The trust had an audit dashboard tracker in place to monitor progress of local and national audit with specific reference to the appropriate NICE guideline. Completion of this tracker was not consistent with many of the findings from audits not completed and actions not documented.
- The trust participated in a range of national audit including, hip fracture audit, bowel audit, laparotomy audit and lung cancer audit. Data from the National Hip Fracture

Database (NHFD) annual report 2015, showed that the trust performed slightly better compared with the England average in all seven of the indicators.

- The lung cancer audit results showed the trust had performed better that the England average with 100% of cases discussed by the multidisciplinary team (MDT) and received a CT before bronchoscopy.
- In the patient laparotomy audit 2015, the trust had a mixed performance. Data showed that out of 11 indicators used to measure that patients had appropriate care, the trust performed above 70% for three, below 49% for three and average 50-69% for five. The three indicators where the trust scored above 70% were final case ascertainment, arrival in theatre in timescale appropriate to urgency and consultant surgeon present in theatre. The three indicators where the trust scored below 49% were consultant review within 12 hours of emergency admission, pre-operative review by consultant surgeon and anaesthetist and assessment by medicine for care of the older person (MCOP) specialist for patients over the age of 70.
- The relative risk of readmission for emergency (non-elective) admissions was lower than the England average across all specialities. In contrast, the risk of readmission for elective admissions was much higher than the England average across all specialities. This meant that there was a potential that patients were discharged inappropriately (early) following elective surgery.

Competent staff

- Juniper ward is a mixed medical and surgical ward and received a mix of elective and emergency patients. This meant that staff had to have a clinical skill set for both disciplines. Competency packs were in place for staff and included topics such as drug administration.
- There was a practice educator attached to the surgical wards that provided support to new or junior staff. On ATSU, the ward sister stated that the practice educator planned to undertake a training day a month, in November the focus was due to be E-learning and in December documentation.
- Within theatre and recovery, an annual revalidation of staff competencies was in place. This meant that staff knowledge and skills were continually monitored and maintained. On the wards, staff had yearly updates on medical devices to ensure competency.
- Therapy staff stated that supervision sessions were in place every eight weeks for junior physiotherapist staff alongside regular one to one sessions with senior staff.
- Post anaesthetic care unit recovery competencies had been designed by the team and shared across the network and were benchmarked and taken up and used by other local providers.

- Staff appraisal was on an annual rolling programme. Data from the July 2015 oversight report showed that staff appraisal varied considerably across the surgical ward areas. On Birch ward, 95% of staff had received an appraisal, whereas this was only 50% on Juniper ward and 64% on ATSU.
- Induction checklists were in place for temporary staff. There was an attempt to book regular agency staff as they were familiar with the areas, paperwork and systems at the trust, which reduced the risk of compromised patient safety. Temporary staff stated that they felt welcomed and part of the team. This also extended to training opportunities such as infusion pump training.
- Training was available to staff within each specialised area. Birch ward received elective orthopaedic admissions and six staff had completed an orthopaedic module to improve their specialised knowledge.
- The lead consultant for anaesthetics told us that a group of anaesthetists regularly took more than 28 paediatric lists each year. Ten anaesthetists regularly undertake the paediatric lists and provide mentor practice and support to colleagues. Clinicians can record the shared experience and double up in theatre to count towards continued professional development. There is a consultant on call for any paediatric emergency surgery. To increase patient safety there are detailed guidelines for paediatric selection for elective cases.

Multidisciplinary working

- There was a daily white board meeting on the wards to review and plan patient care. On Juniper ward, the meeting included junior medical staff, nursing sister, physiotherapist, a social worker and the discharge planner. This meant there was an opportunity daily for multidisciplinary input and sharing of information to provide a holistic view to patient care.
- Staff on the ward used a structured method for handover, situation, background, assessment and recommendation (SBAR) with the purpose of contributing to effective escalation and increased patient safety.
- On Juniper ward, the medical teams for medicine and surgery worked closely together. The medicine team, based on the ward, reviewed emergency issues with surgical patients and then escalated to the surgery teams. This meant that there were minimal delays.

Seven-day services

- Physiotherapist service was not a seven-day service. There was a full time provision Monday to Friday, with an on call, focused service for patients listed over the weekend. This meant that the physiotherapist might see one patient or be in the hospital all day seeing multiple patients.
- Occupational therapy (OT) provision was Monday to Friday with no cover for evenings or weekends.
- Radiographers provided a seven-day service. Two radiographers were allocated to theatre between 08:45am and 17:15pm, Monday to Friday, to cover the x-ray requirements intraoperatively. This reduced to one radiographer out of hours. At weekends, there were two radiographers on duty, one to cover the wards and one to cover theatres, which meant that the service was available across all areas. Staff recognised that at peak times there could be some delay due to the number of surgical wards covered by one radiographer and were currently looking into an alternative shift system. There were five whole time equivalent vacancies for radiographers at the time of inspection.
- There was a consultant on call at weekends that reviewed all new surgical patients and any post-surgery that required assessment.

Access to information

- Nursing and medical staff had access to documentation and care records for patients in order to provide continuity of care. There were computers on all wards for staff to access and test results were available via the computer system.
- There was a picture archiving and communication system (PACS) in place to view all diagnostic results such as x-rays, computed tomography (CT) and magnetic resonance imaging (MRI). This meant that substantive staff had timely and efficient access to images, interpretations, and related data.
- Locum medical staff and agency nursing staff did not have access to the computer system, which could compromise patient care due to inability to request or review information.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Surgery

- We reviewed four patient records and the consent forms were accurate, clear and appropriately completed in all cases. All included the intended operation clearly stated, no abbreviations and signed and dated by both the surgeon and patient.
- It had been recorded at pre-assessment that one patient was extremely anxious. On the morning of surgery, the consultant had altered the intended surgery by including a diagnostic laryngoscopy. This was to alleviate the need for a potential separate procedure. The operating list was amended and the team informed of the plan during the team brief. On review of the notes, the additional procedure had been included on the patient consent.
- Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLs) training data showed that completion varied across the surgery division. Results were 83% for ENT, 65% for trauma and orthopaedics 61% for theatres and the lowest was 56% in general surgery.
- There was no protected training time and one member of staff stated that it was not always possible to attend training due to clinical commitments and that their MCA and DoLs training had been cancelled twice.
- Staff were aware of their responsibility in regard to assessing a patient's capacity and understanding. They could describe the process that they would follow to escalate any concerns to the named lead for safeguarding of vulnerable adults or mental health link nurse.

Are surgery services caring?

Good

Caring was rated as good across the surgical wards and departments because:

- Friends and Family Test (FFT) results for the surgical wards showed consistently positive responses with figures in September 2015 demonstrating a 95% rate of patients who would recommend the surgical services to others.
- Staff treated patients with dignity and respect and displayed compassion and kindness towards patients and relatives.
- Patients and relatives felt involved in decisions and care planning.
- We received 35 comment cards relating to surgical services most of which expressed a positive experience for patients and their relatives.

Compassionate care

- Nursing care was consistently compassionate, respectful, and maintained patient dignity. One patient described staff on Birch ward as "very respectful" and another said staff maintained patient dignity by "saying 'knock knock' at the curtain before coming in".
- We spoke with12 patients and feedback on the care received was positive. The majority of patients stated that staff responded to call bells in a timely manner. Trust data for call bell response time had a response target greater than 90%. Between May 2015 and July 2015, neither Juniper ward nor ATSU recorded data. Results for September 2015 showed 100% for Juniper and Birch ward but this was 80% for ATSU.
- Both nursing and medical staff were courteous and friendly to patients. A patient on Birch ward described staff as "absolutely brilliant". A patient on Daisy ward described staff as "very friendly" and described one of the plastic surgery consultants as "fabulous".
- Nursing handover took place at the entrance to the multiple bedded bays, which helped to maintain confidentiality whilst nurses were discussing individual patient care plans.
- Consideration regarding confidentiality during verbal discussions was less consistent on Daisy ward. A patient identified that patients in the waiting area could overhear the reception desk. The patient was concerned about the lack of confidentiality during the booking-in process.
- The Friends and Family Test (FFT) results from July 2014 to June 2015 supported the patients' experiences expressed during inspection. Response rates were 45% between July 2014 and June 2015; compared with the national average of 37%. Over 94% of patients consistently recommended Birch ward, Daisy ward and the ATSU to friends and family between July 2014 and June 2015, according to the FFT results. All five surgical wards scored above 94% on average during the same period and 95% in September 2015.
- We received 35 comment cards relating to surgical services most of which expressed a positive experience for patients and their relatives. Some of the negative comments included the noise at night.

Surgery

Understanding and involvement of patients and those close to them

- One relative on Birch ward described staff as "absolutely brilliant", and explained that they had waited in the patient's room until they came back from theatre and that all care and treatment was explained "very well".
- A relative on Juniper ward stated, "The little things make the difference." They explained that their mother liked a light left on a night. The night staff were informed at handover and this was accommodated.
- On Juniper ward there was a feedback folder containing compliments and complaints from patients and relatives. It was kept in the staff room and easily accessible to all staff to promote continual learning.
- Introduction of flexible and extended visiting times had occurred on Juniper ward the week prior to inspection to aide communication with relatives. Visiting time was 10am to 8pm, with a rest period of an hour between 1pm and 2pm. A poster explaining the new hours and requesting feedback from relatives was on display. The ward matron asked staff to quieten conversations around the ward reception desk between 1pm and 2pm due to "rest" hour.
- Patients did not always feel fully informed about their care on the Acute Trauma Surgical Unit (ATSU). The use of medical terminology left one patient uncertain of their care plan. Two patients struggled to understand staff with strong accents. One patient had to explain a procedure to another patient due to misunderstandings derived from accent and language barriers.
- One patient on ATSU had been fasted for a general anaesthetic expecting to go for surgery. However, the documentation recorded stated that he was admitted for pain management and was for non-invasive management, sling and review at fracture clinic.
- On Daisy ward, the patient rooms were individual "pods" which were spacious however, these could be quite isolating. There was no day room available and direct view of others and the nursing staff was not possible.

Emotional support

- There were clinical nurse specialists within the surgery service that supported the ward staff and gave advice and care to patients and relatives.
- There was an active chaplaincy service throughout the trust that provided pastoral, religious and emotional support to patients, relatives and staff. The chaplains regularly visited the surgical wards and had a separate telephone number for urgent messages.
- There was a Hip club that provided advice and support to patients undergoing joint replacement. Sessions lasted two to three hours and included information regarding the procedure, expectations, aftercare and support group. This meant that patients had the opportunity before surgery to discuss any concerns.

Are surgery services responsive?

Good

Surgery services were rated as good for responsive because:

- The trust consistently performed above the England average for admitted referral to treatment (RTT) times.
- The percentage of cancelled operations was lower than the England average.
- There was a proactive approach to discharge planning.
- Staff provided responsive care for patients with learning disabilities.
- Staff engaged with relatives following complaints to enable improvement.

However, out of hours ward transfers occurred frequently.

Service planning and delivery to meet the needs of local people

- There was no interventional radiology service; this was due to staff retirement, which resulted in a prolonged patient pathway, as patients had to transfer to another local provider. This was on the corporate risk register in February 2015, due to the risk of delay of patient diagnosis. An agreed pathway was in place with support from another local provider and appointment of locum radiologist.
- The mulberry suite consists of a clinic area and ward for the provision of private health care. This included the complete patient pathway with consultation, surgery and post-operative follow up appointments. The area was utilised for NHS patients when bed capacity within the trust was limited.

Access and flow

Surgery

- Data for admitted referral to treatment (RTT) times between January 2014 and June 2015 showed that the trust consistently performed above the England average. The RTT for admitted pathway patients, where treatment has ended with admission to hospital either as inpatient or day case, had been above 90% for all specialties. This meant that a large number of patients were receiving treatment following diagnosis as soon as possible or within the recommended 18 weeks target. The two specialties with the highest number of patients seen were urology at 98.6%, plastic surgery at 97.8%.
- The percentage of patients whose operation was cancelled and were not treated within 28 days was generally lower than the England average but was higher in quarter two, 2014 to 2015.
- There were 92 operations cancelled on the day of surgery for non-clinical reasons between April 2015 and September 2015. Reasons varied, the highest number, at 50 out of the 92, was due to consultant unavailability and the two main specialties affected were general surgery and ophthalmology.
- There was a proactive approach to reducing delayed transfer of care (DTOC) across the surgical areas. Discharge planning assistants were in place on the surgery wards. Their aim was to assist with the discharge process and help reduce discharge delays.
- Regular meetings included a DTOC meeting every Tuesday, attended by a social worker, team meeting every Thursday and a Matrons length of stay (LoS) meeting. One assistant stated that it was a challenge to liaise with everyone and that certain processes needed to be tightened, such as discharge summaries, medications to take home and ongoing care packages.
- Despite the measures, delays still occurred although to a lesser extent within surgical services. we spoke with three patients on the acute trauma surgical unit (ATSU) who stated that they had been waiting over three hours for discharge. One patient said that they were waiting for medications.
- From January 2015, there was a pilot study in place to provide physiotherapy support within the emergency department. This front of house approach meant that therapist assessment could begin prior to admission to help prevent avoidable admissions. The team had been able to provide equipment and access visits to patients home.
- Daisy Ward is located within the treatment centre and cares for patients undergoing day surgery orelective surgery and procedures. The ward is open Monday to Friday; with any patients requiring a longer length of stay transferred to Birch ward.
- Ward transfers occurred frequently out of hours. Data showed that between April 2015 and September 2015, the number of transfers between 10pm and 6am averaged at 74. The worst month had been April with 101 transfers; this number had reduced to 71 in September.
- The trust had 46 surgical outliers during the period April to September 2015. This number fluctuated and was significantly less than medical outliers as the trust flexed its elective surgical capacity to meet available beds. During our inspection we did not find any surgical patient outlying on a medical ward.
- Due to high utilisation of the five theatres in the treatment centre, a large number of patients were transferred to main theatres for their operations. This meant that there were logistical issues of transporting equipment and patients between the two areas. The number of patients affected in the months between June 2015 and September 2015 were 232 in June 225 in July, 168 in August and 206 in September . Utilisation data for these five theatres ranged between 87% and 104% in August and 89% to 102% in September.
- There was a guideline in place for care of ventilated patients in the post-anaesthetic care unit (PACU). Staff stated that this had not occurred within the last twelve months, as critical care unit (CCU) beds were usually available.

Meeting people's individual needs

- The trust had a learning disability liaison nurse that provided support to the wards. On Juniper ward the sister had requested a review by the specialist nurse for a patient and this took place within 24 hours of the request. A slightly quieter environment was provided by the allocation of a side room and their relative was able to stay overnight with them for additional support and was involved in their review. A full patient passport was completed which meant that staff were fully informed of the patient's needs. The liaison nurse also verbally provided information directly to the ward sister to ensure clarity of specific information.

Surgery

- There was a translation service available for staff to access and this could be booked for elective patients when staff knew that this might be required beforehand. At short notice, a telephone service was available.
- Admission paperwork included a dementia-screening questionnaire for all patients over the age of 75 to enable staff to assess individual needs at point of admission. There was an older peoples' specialist nurse available to support staff with assessment and needs of patients living with dementia.
- The post anaesthetic care team had identified the need to be able to contact relatives, specifically parents but also carers or relatives of any patient with learning needs. They had fundraised and provided bleeps so that relatives would be contactable as soon as their family member arrived in recovery.

Learning from complaints and concerns

- There was a variety of methods used to inform staff of patient complaints. On Juniper ward there was a feedback folder containing compliments and complaints from patients and relatives. It was kept in the staff room and easily accessible to all staff to promote continual learning.
- On ATSU there were comments added to the information board with examples of "you said, we did" provided. One example was that the ward was noisy at night and the resolution had been to offer patients earplugs.
- On Juniper ward staff were proactive in engaging with relatives. The ward matron had contacted a family following a complaint regarding several aspects of care and provided updated information regarding changes and had asked them to attend the next team-building day to talk directly with the team about their experience.

Are surgery services well-led?

Requires improvement

Surgery services were rated as requires improvement because:

- There was an inconsistent approach to governance meetings, including Morbidity and Mortality meetings, with wide variation with documentation.
- Robust local risk assessment was not in place and management of risks was inconsistent.
- The divisional risk register was not up to date.
- Quality measurements and initiatives were not shared across the service. This included improvements from medicines management audits inconsistent attendance by senior medical staff at ward rounds and monitoring of actual verses planned nurse staffing numbers.

However,

- Nursing leadership at a local level was good.
- There was an open culture and staff were comfortable in raising concerns.

Vision and strategy for this service

- There was a vision and strategy for the hospital. There were information posters in all of the surgical ward areas and theatre outlying the trust vision and values.
- The values for the hospital were to provide safe, confidential and timely care. Ensure staff feel valued and have the opportunity for development and for the hospital to be the hospital of choice for patients.
- Staff could state that the vision was for the hospital to be "a top ten" hospital. This included patient experience, outcomes, and engagement of staff.

Governance, risk management and quality measurement

- There was a governance structure in place. Monthly meetings occur with structured topics such as incident reviews, complaints and patient advisory liaison service (PALS). Documentation from all meetings was not consistent. The theatre governance meetings included a review of previous months' minutes and nominated individual with responsibilities for action points. In contrast, the gastro-intestinal and general surgery meetings had no incident outcomes, no actions required and no comparison data from previous months. This meant that there was limited opportunity to identify themes and actions required. We also found that morbidity and mortality meetings were not consistently undertaken across the directorate.
- There was no consistent management of risks and staff knowledge of the divisional risk register was minimal. The ward sister on the acute trauma surgical unit (ATSU) was not aware of the divisional risk register and had no local register of any risks identified.

- The divisional risk register was not updated regularly. There were some risks dating back to June 2014 (urology rota, no cover for annual leave or sickness) and September 2014 (lack of junior doctors on juniper ward) with no update or date to the mitigation taken.
- Local risk assessments were not robust. Staff had some awareness of risks for their own ward areas but the review of these was not always consistent. Three out of 15 risk assessments on ATSU were out of date for review. On Juniper ward, there was a list of risks identified but this was not an active document. This had not been dated, there were no actions identified or predicated dates for completion to ensure that risks were managed and reduced effectively.
- Sharing of quality measurements was not in place, with areas of good practice happening in isolation. For example, on Juniper ward, the sister had introduced shift records, which included any changes or significant situations that occurred; such as staffing changes or incidents. This allowed staff to refer back should they need to. This was not in place in any other of the ward areas. This meant there was less opportunity to identify common themes and reduce risks that may be occurring in multiple areas.

Leadership of service

- There was a defined surgical divisional structure. There had been recent appointments within the current team, which meant that team dynamics were in their infancy and the new structure was still fragile. The associate director of operations was an interim appointment and led alongside the medical director and associate director of nursing. There were three operation managers in post and five surgical directorates.
- Nursing leadership at a local level was good with the majority of staff confirming that their line manager and matron were approachable, responsive and involved staff in the ward development. It was felt that the director of nursing had an open door policy. Band seven staff received regular supervision and monthly one to one sessions with their line manager.
- Some staff in theatre stated that there were limited opportunities for advancement, which could be a contributing factor to staff moving elsewhere. Training opportunities were limited, one example being the advanced life support training. One member of the team stated that they had received this but only as an adhoc opportunity and there was no clear structure for development in place.
- Ward meetings were not consistent across all areas. Staff on ATSU said monthly team meetings did not always take place and the last one had been in August 2015.

Culture within the service

- There was an open culture within the surgery service and staff stated that they were comfortable with raising concerns. There was a whistleblowing policy and staff knew of the 'speak out safely' campaign and the stop the line initiative encouraged all staff to raise concerns.
- Staff in general felt more positive with the recent change back to the NHS. They felt that they had been informed with the changes that had taken place and were enthusiastic about the future. Ward staff felt that there were more training opportunities since Circle were no longer managing the trust.
- Agency and temporary staff felt included in the team and were encouraged to participate with all training opportunities.

Public and staff engagement

- Some staff did state that not all changes and communications reached all staff. Clinical staff had difficulty in getting time to access email communications. One nurse stated that they read information in their own time at home. One of which was a recent email regarding the Safer Nursing Care Tool (SAFER), which helps nurses decide on safe nurse staffing for acute wards based on patients' level of sickness and dependency, but they did not understand what this was. Another member of staff said they had heard about Safer but only as a rumour and was uncertain as to what this was.

Innovation, improvement and sustainability

- The team within the post anaesthetic care unit had a proactive approach to fund raising and participated regularly in sporting challenges to raise money. For example, they had purchased bleeps for parents and relatives from such an event.
- A new ear, nose and throat (ENT) and audiology department opened officially on 8th May 2015.

End of life care

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

Information about the service

There was no dedicated ward for patients at the end of life, therefore patients received end of life care on individual wards at Hinchingbrooke Hospital. The team consisted of three specialist nurses covering 3.2 whole time equivalent and two palliative care consultants; one had commenced employment in July 2015, covering one full time equivalent post. Two of the three specialist palliative care nurses were new into post. The trust was also commissioned to provide specialist palliative care nursing to patients in the community though we did not inspect this service.

The team received referrals and supported generalist nurses in the delivery of end of life care, last days of life care and management of complex needs end of life care for patients on the wards. They were available Monday to Sunday, 9am-5pm, although out of hour's weekend and evening cover was available via telephone. Holidays and out-of-hours consultant support was provided by the on-call medical consultant.

The specialist palliative care nurses and consultants provided advice and support for all patients with complex palliative care needs including patients with cancer. There were 519 deaths at the hospital between April 2014 and March 2015. IN the year 2013 to 2014 the split between cancer patients and those patients without cancer was 56:44. We were not provided these figures for the previous year.

We visited six wards where end of life care was provided; these were MSSU, ATSU, Apple Tree, Walnut, Juniper and Cherry Tree Wards. We visited the bereavement centre, where relatives collected death certificates and received information about bereavement services. We also visited the chapel of rest; and the mortuary. During our inspection, we looked at 26 patient records. We spoke with eight patients and their relatives, and 43 members of staff which included nursing and medical staff, specialist palliative care nurses and health care assistants. We also spoke with mortuary technicians, the chaplain, and staff in the bereavement centre.

We observed interactions between patients, their relative/representative and staff. We considered the environment and looked at 26 care records. Before our inspection; we reviewed performance information we requested from the hospital.

End of life care

Summary of findings

End of life care required improvements as patients were at risk of not receiving safe, effective or responsive treatment that met their needs.

Do not attempt cardio pulmonary resuscitation (DNA CPR) forms were incorrectly completed. In many instances, we found that DNA- CPR decisions had not been discussed with the patient or their relatives/ representatives. Where the reason given for not discussing decisions with patients was recorded as the patient lacking capacity, Mental Capacity Act Assessments had not been completed. We reviewed DNACPR during our unannounced inspection and saw improvements in recording and completion.

The palliative care team were over stretched which meant that medical and the generalist nursing staff were not effectively trained in end of life care of the patient in the last days of life. This meant that patients would be at risk of not receiving the level of care they could expect

At the previous inspection in January 2015 we found the trust did not have a risk register for end of life care. The trust had completed a risk assessment in August 2015; however these risks were not recorded on the risk register.

The specialist palliative care (SPC) nurses had been overstretched and had recently recruited two new nurses that were currently undergoing role specific training in palliative care. Staff told us this meant there could be delays in responding to referrals. They were unable to undertake training for medical and nursing staff on the wards. This meant staff were not effectively trained and patients did not receive the level of care they could expect.

However the number of ward staff who had training in advanced communication had increased since the last inspection and this was provided externally. Concerns were raised by staff about the lack of appropriate training for junior doctors and consultants in end of life care.

The leadership of the SPC nurses was not evident though they worked hard to improve end of life care throughout the hospital. Feedback from nursing and medical staff was that the team were “fantastic and very knowledgeable”.

Since January 2015, SPC nurses had increased the amount of time they were available for consultation. They had joined with community palliative care nurses to provide seven day 9am-5pm face to face support and 24 hour out of hour’s telephone advice and support. Medical and nursing staff told us this had made a difference to patients receiving end of life care throughout the hospital.

End of life care

Are end of life care services safe?

Requires improvement

We have rated safety of end of life care as requiring improvement.

- At our September 2014 inspection we found that staff had not received training in specialist end of life care. At this inspection we also found that there had been no implementation of the roll-out education to equip staff on the wards to provide end of life care that protected patients from avoidable harm.
- Incidents were not always reported in line with trust policy and staff were not clear about what should be reported as an incident. There was a system for reporting incidents, but it was not always being used in a consistent manner.
- Feedback to staff regarding the actions taken from incidents was not robust.
- Patient care records were inconsistently completed and decisions taken about the resuscitation status of the patient were not accurately completed in a number of records.

However we also found some good practice including:

- Patients cared for in a clean and hygienic environment.
- Most staff had received safeguarding training and were familiar with reporting systems.

Incidents

- There had been no never events (serious, largely preventable patient safety incidents that should not occur if proper preventative measures are taken) between January and August 2015. There had been one near miss involving lack of electrical power systems in the mortuary in June 2015.
- There were 25 incidents recorded for "palliative and mortuary" care between January and August 2015. For example we saw one incident where a fast track discharge had been delayed and the patient died in hospital. The specialist palliative care nurses (SPC) told us that not all patients were identified quickly enough by ward and medical staff as needing referral to the end of life care team. This meant some patients would not have had any choice about where they died.
- Incidents were not always reported in line with trust policy. We saw an incident recorded in March 2015 where nursing staff had reported a delay in referral to the specialist palliative care team. Most generalist nursing staff told us they did not report these situations as incidents therefore the trust would not be aware how many patients this affected.
- Most generalist nursing staff knew about the electronic reporting system to report incidents. They told us there was no formal training on how to use the electronic incident-reporting system. As a result, it was clear that staff had different opinions on which incidents should be reported and what category they should use. One member of staff told us they had told there manager a year ago they did not know how to use the incident reporting system but no training had been arranged for them. The trust "Incident and Reporting" policy (2011) states " the department/ward manager should ensure that their staff have the skills and recourses to complete incident forms and monitor levels of reporting as a way of monitoring the effectiveness of the local incident system". This process had not been followed. Whilst this example was raised by nursing staff on a general ward it is an example whereby lack of understanding and training about incident reporting impacts on patients at the end of life.
- Nurses in the SPC team told us they often picked up issues with Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) forms which were incorrectly completed. Trust policy stated that "…all staff must report any…incident including near misses on either the trust's paper or electronic incident report form… this, "provides a clear process for staff to follow in relation to investigating incidents and implementing learning to improve safety". Staff had not followed the trust policy and reported these as incidents. However they had asked the doctors to correctly complete the forms. This meant that patients were at risk of receiving inappropriate or unsafe care due to incidents not reported and no learning shared.
- One member of staff told us they had reported concerns about patient care to the sister on the ward. This incident had not been recorded on the trust system. This meant that data provided in relation to incidents would not provide a reliable oversight of types of incidents occurring in end of life care.

End of life care

- The specialist palliative care nurses told us they reported some incidents. For example, if a patient had been injured or inappropriate or poor standards of care had been observed.
- Some nursing staff told us that they did get feedback about incidents that happened on their ward. On some wards they used the daily "huddle", (short meetings) to highlight any concerns or issues from incidents relevant for the ward.

Cleanliness, infection control and hygiene

- We saw the latest environmental infection control audit for the mortuary completed in February 2015. The trust scored 86% out of 100. Areas highlighted as requiring improvement included ceiling tiles in different locations within the mortuary that required repair which were dirty. Seating in the waiting room that was clean but not wipe able. Information on any actions as a result of the audit were not available. This meant we were not assured that improvements had taken place since the audit.
- We saw that staff in the mortuary had sufficient access to personal protective equipment (PPE) and there were adequate hand-washing facilities. We saw that the mortuary was visibly clean at the time of our inspection.
- We observed that staff complied with the trust policy of being bare below the elbow and wearing minimal jewellery.

Environment and equipment

- Staff provided person centred care, For example recognising religious preferences. An example was in the mortuary where we saw they had marked on the floor the direction of "Mecca".
- Equipment required to care for patients at the end of their life was available when it was needed. Ambulatory syringe drivers (for patients who required a continuous infusion of medication to control their symptoms) were not kept on the wards. Staff told us they could be accessed from the equipment library as required. Equipment met the current NHS Patient Safety guidance. This meant that patients were protected from harm when a syringe driver was used because the syringe drivers were tamperproof and had the recommended alarm features.
- Patients had the equipment they required to support their care safely in their own home.

Medicines

- The trust had a comprehensive anticipatory prescribing policy. We were told by staff that patients who required end of life care were prescribed anticipatory medicines. (Anticipatory medicines are medicines that are prescribed in case they are required.)
- The palliative care team gave advice on anticipatory prescribing when it was required. They told us that medication could be accessed in a timely manner for patients who had expressed a preference to die at home.
- Patients who expressed a preference to die at home had access to medicines to support them at the end of life.
- There was guidance for medical staff regarding anticipatory prescribing to ensure effective control of symptoms such as pain relief and nausea.
- We saw that anticipatory medicines were prescribed when they were required.
- The National Care of the Dying Audit May 2014 showed that over half of the patients treated by the trust were receiving PRN (as required) medication for the five key symptoms that may develop during the dying phase.

Records

- We looked at 26 records for patients who were at the end of their lives. We found that these were not consistently completed. Some records were very detailed and recorded information given to relatives and the patient whilst others did not. This inconsistency was found in patients records on the same ward. On Cherry Tree ward one Do Not Attempt Resuscitation form had recorded "I have mentioned to the patient that CPR may fail" written on the section around discussion with the patient. Whilst this patient had capacity to make decisions it was unclear what information they had been given prior to agreeing with the medical decision. However, we found that some patient records contained robust and explicit notes of discussion with the family and patients around decision made in this respect.
- Following the withdrawal of the Liverpool Care Pathway, the SPC team had introduced a care in "the last days of life" tool. This was a holistic tool which included an initial medical assessment and nursing assessment. Staff we spoke with on the wards were aware of the tool; however they were not always fully completed. For example; we saw in three records for end of life patients where medical staff had not completed the "managing

symptoms" section. This meant there was no written plan in place for prescribed medicines to manage the patient's symptoms. Staff told us this was the doctor's responsibility to complete.

- We saw that six out of 26 records for patients requiring palliative care had no ceiling of care recorded. (This is a document that describes what not to do so as not to put patients through unnecessary procedures.) It is used in hospitals to provide continuity of care and good communication and should always include symptom relief. We found three end of life care records had incomplete nursing assessment and care plan documentation. This meant there was an inconsistent approach to recording and a lack of person centred planning for palliative and end of life care patients across the wards.
- We reviewed DNACPR during our unannounced inspection and saw improvements in recording and completion.

Safeguarding

Specific training data relating to the specialist palliative care team (SPC) care team was not available. However trust wide adults and children's safeguarding training compliance targets for July 2015 were 94% for Safeguarding vulnerable adults and 96% for Safeguarding Children Level 1.

- Staff were aware of their role and responsibilities and how to raise and escalate concerns in relation to abuse or neglect for vulnerable adults and children.
- We saw there were safeguarding policies in place and clear procedures to follow if staff had concerns. Staff explained to us the process they would follow.
- Staff were aware of the trust's whistleblowing policy and knew how to raise a concern.
- Safeguarding training was included as part of the mandatory training package. All staff we spoke with told us they had completed some training in either safeguarding adults or children.

Mandatory training

- National Care of the Dying Audit (May 2014) scored trusts out of 20 for the continuing education, training and audit of staff in care of the dying. 18% of participating organisations, including this trust, scored zero compared to an England average of seven.
- In January 2015, staff told us end of life care training had not been included as part of the trusts mandatory training programme. However, the SPC team had told us that end of life care was going to be mandatory for all new starters, as of September 2014. On this inspection we found this was not yet in place. The clinical lead told us they were in the process of recruiting suitably trained staff to deliver this training and the post was out to advert with interviews planned in early November 2015.
- The trust was continuing to deliver one hour of end of life training on induction for new nonclinical staff. The lead consultant told us this was not yet mandatory for clinical staff on induction.
- The SPC team told us that they would like to provide more training but they also realised this was difficult due to under-resourcing within the team. They hoped that when the new specialist practitioner was recruited they would take on this role in the team. The lead consultant confirmed this would be one of their roles.
- Staff in the bereavement and mortuary departments had access to additional training. For example, post mortem consent training.
- The SPC team told us they were up to date with their mandatory training. We were unable to confirm this as trust data did not separate the specialist palliative care team training.
- Information Governance training was included in the trust's mandatory training programme.

Assessing and responding to patient risk

- The SPC team told us they reviewed referrals, and urgent referrals were usually seen the same day. Most ward nursing staff confirmed the team normally responded very quickly.
- The SPC completed regular ward rounds and kept a list of all the patients on the different wards who were referred. We shadowed specialist palliative care staff as they completed ward rounds.

Nursing staffing

- There were three specialist palliative care nurses covering 3.2 full time equivalents. This was made of 2.6 band 7 specialist nurses and 0.6 band 6 specialist nurse.
- Additional resource was provided to manage community patients ensuring the hospital based specialist nurses focussed on inpatients.

Medical staffing

End of life care

- The overall care of each patient was managed by the consultant who led on the care for each patient's condition.
- There was one full time specialist palliative care consultant and one day a week support from the clinical lead for end of life care from the interim deputy medical director. When the specialist palliative care consultant was not available, for example on annual leave, there was a rota to cover at this level.

Major incident awareness and training

- The mortuary technicians told us that they had a contingency plan in the event that the mortuary became full. The trust had an informal agreement with another hospital and with a local undertaker. Staff gave examples when they would use this plan; however there was no written emergency response plan that detailed what should happen. Staff told us they had additional cooling blankets for emergency use if needed and would be reliant on the other services having storage capacity, should they not have enough space.

Are end of life care services effective?

Requires improvement

We have rated the effectiveness of end of life care services as requiring improvement.

- The trust had an end of life action plan in response to the outcome of the last inspection. This stated that education and training were needed "to provide ward staff with skills to recognise and respond to the dying patient". There had been minimal progression during the past year. Communication with patient and families in respect of breaking bad news was poor due to the lack of competency and confidence in staff having these discussions.
- Staff did not always refer patients to the specialist palliative care team in a timely manner. The palliative care team told us there were often problems with medical staff not responding quickly enough when making decisions about when patients should be referred.
- The trusts bereavement policy referred to the Liverpool Care Pathway despite this policy being updated in September 2014. This pathway needed to be replaced. The trust had rolled out a replacement for the Liverpool Care Pathway, the Amber care bundle, however nursing and medical staff were slow to recognise when patients should be on this programme due to limited training available. This meant that patients did not receive timely effective care.

However we also found that

- Nursing and medical staff told us that the specialist palliative care team were very knowledgeable and supportive and responded quickly when asked for advice and support.
- The implementation of a 24 hour support line had enhanced patient care.
- When the Amber Care Bundle had been completed and referral to the specialist palliative care team had taken place the patient we saw evidence of good review by the specialist palliative care team.

Evidence-based care and treatment

- In January 2105, staff told us a number of initiatives were being rolled out throughout the trust to support NICE guidance. One initiative was delivering training to ward staff on the "Amber care bundle". This is a tool that facilitates decision-making about patients whose condition is deteriorating, and are clinically unstable, with an uncertain outcome. It provided a systematic approach to manage the care of hospital patients who were facing an uncertain recovery, and who were at risk of dying in the next one to two months. However, delivering the training had proven difficult because the SPC team were relying on a bank nurse to deliver training one day a week.
- We found the trust had been slow in progressing actions they had identified in January 2015 as issues. Nursing staff told us there was a lack of understanding about the process and they often had to "prompt" doctors to consider the Amber care bundle as an option for patients but timely decisions were often not made by medical staff.
- Nursing staff recognised that not everyone on the Amber care bundle needed to be referred to the specialist palliative care team. Those that needed to were often delayed and patients waited longer than they needed for specialist support. For example, nursing staff had identified a patient who they felt should be on the Amber care bundle. They had discussed this with

the SPC team who had agreed. This conversation had been written in the patients records however it took over two weeks for the amber care bundle to be started by doctors.

- In another example a patent had been recorded in notes as not on the Amber care bundle but at the end of life. It had taken ten days for them to be referred to the SPC team. The last days of life care plan had been partially completed 8 days later. This was a total of 18 days after it had been recorded the patient was end of life, however no details in "assessment of symptoms" section in the last days of life care plan had been recorded .This showed there had been delays in referring to the SPC after the decision had been made that the patient was end of life. The end of life care plan was incomplete with important information about the patient's symptoms and pain relief missing.
- Nursing staff gave us examples of three patients currently on wards who they felt should have been referred to the end of life team who had not been. One member of staff told us patients could not be referred as they had not yet been assessed for the amber care bundle, even though it had been recorded in the notes they needed to. This meant they did not meet the criteria for referral to the SPC team.
- These examples, along with others we saw, and information from ward staff confirmed there was a lack of evidence that there was an effective process for ensuring end of life patients were referred promptly. Of the 26 palliative and end of life care records we looked at more than half had incomplete or missing assessment and care plan information.
- The SPC team based the care they provided on the National Institute of Care and Excellence (NICE) (Quality Standard 13), End of Life Care for Adults. This quality standard defines best practice in end of life care for adults. The trust had some local guidelines and policies in place that were up to date and based on the NICE guidance.
- The trust "End of Life Care Policy" had been reviewed following the last inspection in January 2015. We saw it referred to the trust guidelines for "Last offices, ward and bereavement care procedures for the deceased patient" which was dated August 2010. The policy said it should be reviewed in 2011 but no review had taken place. The procedures applied to qualified and unqualified nursing staff, medical staff, hospital chaplaincy staff, portering and mortuary staff. The policy was out of date. It also had the incorrect telephone number for the Bereavement Office.
- Poor communication by doctors was highlighted as a concern by three relatives we spoke with and one patient. Nursing staff on wards also highlighted this.

Pain relief

- There were guidelines in the "last days of life care plan" for prescribing pain relief in end of life care. We found three "last days of life" care plans where this information was not recorded.
- Nursing and medical staff told us that they would contact the specialist palliative care team for advice about appropriate pain relief, if required.
- The specialist palliative care nurses were being supported to complete additional training to become nurse prescribers. One specialist palliative nurse told us that the doctors were very responsive at prescribing their instructions. Audit results for nurse prescribers practice were not available as the trust did not collect this information.

Nutrition and hydration

- We reviewed 10 records and saw that malnutrition universal screening tool (MUST) scores were used for patients. Staff told us once patients had been referred to the SPC nurses for end of life care these were no longer completed. This meant that we could not be assured that patients at the end of their lives received any assessment as to their nutritional needs.
- Nutrition and hydration needs were included in patient's care plan. Three nursing staff told us that when patients moved off the amber care bundle and onto the "last days of life" care plan, all individual nutrition and hydration charts were ended. This meant staff were not monitoring or recording if patient's nutritional needs were being met.
- The National Care of the Dying Audit (May 2014) results showed that the trust was identified as being above the England national average at reviewing patient's nutrition and hydration requirements at the end of life. The England national average for reviewing patient's nutritional requirements was 41% and the trust scored 53%, the England average for reviewing patient's hydration requirements was 50% and the trust scored 70%.

End of life care

Patient outcomes

- The trust participated in the National Care of the Dying Audit (May 2014). The results reflected what we found in that referrals to the specialist team were often delayed, education and audit were poor and a formal feedback process for relatives was not yet in place.
- We saw results of two Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) audits carried out by the trust in March and June 2015. It was unclear how many records had been audited as this information was not recorded and there was no update on what actions had been put in place to address the findings. Data responses had not been analysed, and one of the questions within part two of the DNACPR form had been changed for the June audit. Responses did not state whether findings were compliant with current legislation and guidance. This meant the data collected could not be relied on to represent the current situation with regard to appropriate completion of DNACPR documentation.
- There was limited information in care plans. DNACPR forms were completed, but seven out of eight did not have a clear explanation of reasons for DNACPR decision written on the form.
- Seven out of nine DNACPR forms did not have a discussion with patient or relatives documented or reason why not discussed. Therefore it was difficult to ascertain whether DNA CPR discussions had taken place with patients or their relatives/representatives. We also found that these issues were not addressed on any risk register.
- The trust undertook audits of DNACPR forms. The audit from July- September 2015 showed that they had found six DNACPR orders that gave reason for no discussion as" family not available" Patients had remained in hospital for seven days with no further evidence of discussion. The audit did not identify where patients were located or health condition which meant we were unable to determine if any of the patients required end of life care.
- We saw the results of one informal palliative care spot check audit completed by the SPC nurses in October 2015. This was a small sample of approximately 25 nursing staff across nine wards. Staff were asked six questions that included; did they know how to refer to the palliative care team? 18 staff answered correctly and six incorrectly across the wards. In response to "where would staff find the last days of life paperwork", 17 staff answered correctly and seven incorrectly. All staff questioned knew how to keep relatives of patients informed. SPC nurses told us they had not shared this information with their managers yet. They said this highlighted work still to be done with all staff across the trust.
- There has been no audit of the effectiveness of the SPC team, however all the nursing and medical staff we spoke with on the wards were aware of the team and knew how they could contact them if needed.
- There has been no audit of the advanced care plan in the last 12 months.
- There had been no re-audits following implementation of the end of life steering group work plan. The plan had been updated in June 2015 and some deadlines extended into 2016.
- Preferred place of death was being audited, as it was a Commission for Quality and Innovation (CQUIN) for end of life care. (CQUINs are frameworks to improve quality of service and better outcomes for patients). A quality audit of patients preferred place of death had been undertaken in December 2013. Of the 27 patients included in the audit, 89% had expressed a preference for their place of death; 88% of these patients died in their preferred place. We asked the trust for current audit information but this information was not available as they did not collect it.

Competent staff

- We were unable to gather specific information on appraisal rates for bereavement team/ porters and mortuary staff, however trust wide appraisal rates in July 2015 were 78%. They had not met their target of 80% for four of the seven months.
- Trust wide figures showed that essential clinical skills training for Mental Capacity Assessment (MCA) & Deprivation of Liberties (DoLS) were 60% in September 2015 against a target of 90%. This was much lower than the target. Figures for the previous four months showed minimal improvement. One consultant we spoke with told us they knew doctors needed to complete training but it was not a priority due to the heavy workload on the wards.
- The deputy medical director acknowledged there was a "lack of training for junior doctors and that they needed "communication training". The spot check audit undertaken in October 2015 demonstrated that most

staff felt unable to have the conversation with patients to tell them that they were dying. We saw no evidence of any plan in place to address the shortfall in meeting the target or when they expected to reach target.

- Training locums had no training on the amber care bundle or end of life pathway. The palliative care team had raised concerns informally regarding the care and communication for a patient at end of life from the junior locum medical staff on Juniper ward. The matron was aware that this was a learning need and was going to discuss with the appropriate consultant.
- With the exception of the specialist palliative care team, three of the ward nursing staff we spoke with had received training or support with their communication skills, to enable them to be more confident in having discussions with patients about their end of life care.
- SPC nurses had attended the advanced communications course and alongside all cancer specialist nurses and consultants in the field of cancer, been trained to level 2 in psychological assessment. Two of the three hospital SPC nurses were new in post and had not yet completed the additional training.
- Nurses did not receive clinical supervision. This meant there was no monitoring of their practice. The trust staff guide for supervision described it as a formal process, but there was no implementation of the process.
- The trust were targeting "quality end of life care for all training" (QUELCA) for ward matrons and deputy sisters on specific wards. Nursing staff that had completed this course had spent five days at St John's Hospice. The aim of the QELCA programme was to empower generalist nurses to return to their area of work equipped to make a difference to the experience of patients dying in hospitals". Nurses who had completed this course then acted as champions in ward areas. We spoke with two matrons who had completed the course and found it "very good". The trust target for staff completing QELCA training was five staff every two months. We saw that from January – September 2015, 14 nursing staff had completed the course. The trust had set a target to train 25 staff over the course of the year.
- Nursing staff on the wards highlighted that training in end of life care was something that was needed for everyone and not just senior nursing staff.
- There were four staff within the bereavement team. One member of staff had completed "gold standard" bereavement training – train the trainer (2 day course BSA (social aspects of death or dying) and CRUSE (bereavement care) in 2014. Another had completed Counselling and Psychotherapy Central Awarding Body (CPCAB) registered therapeutic counselling level 4 diploma in counselling in 2014, and "supporting parents through baby loss and death of a child".
- We saw the bereavement team staff had attended a number of other relevant courses that enabled them to provide support, care and a professional service for patients at the end of life.

Multidisciplinary working

- Spiritual and religious support was available from the chaplaincy team.
- There were regular multidisciplinary team (MDT) meetings to discuss patient care needs on the wards. We observed one MDT meeting and observed staff worked collaboratively together.
- The specialist palliative care team had good links with palliative care services in the community. For example, they had worked together with the community palliative care nurses to organise a rota that provided 24 hour specialist palliative care support and advice across the hospital as well as community.
- Experienced community palliative care nurses were supporting the hospital team whilst the two new specialist palliative care nurses completed their induction and training.
- The trust used an electronic recording system to enable the recording and sharing of people's care preferences and key details about their care. This ensured care was co-ordinated and delivered in the right place, by the right person, at the right time. However, this did not record whether patients were on the last days of life or the Amber care bundle. This meant they could not identify patients that needed referral to the SPC team electronically. Referrals were written on paper or faxed.
- Staff told us that they knew they could get support from the specialist palliative care team if required. .All of the medical and nursing staff we spoke with told us the SPC team were always supportive, shared their knowledge and expertise and gave good advice.

Seven-day services

- The specialist palliative care team were available for face to face consultations in the hospital Monday to Sunday from 9am to 5pm.

End of life care

- 24 hour telephone cover was available for medical and nursing staff. Hospital and community palliative care nurses were on a rota to cover out of hours. 24 hour cover had commenced in September 2015. At the time of our inspection it had been in place for three weeks.
- The chaplaincy service provided 24 hour, on-call support seven days a week for staff, patients and their representatives.
- The bereavement care services office was open Monday-Friday, 9.30-4.00pm (except bank holiday). Appointments were available from 9-30-1pm.

Access to information

- All SPCT staff had access to information that the trust held in order to assist in the planning of care for individual patients.
- Records written by the SPCT were available in the patients' notes for staff caring for the patient to read.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We found that whilst most staff had received training in relation to the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS), assessments had not always been appropriately undertaken when it was noted a patient lacked capacity as a reason for not discussing DNACPR decisions with them. For example four out of seven records did not have the patient's mental capacity clearly documented.
- We saw training records that evidenced staff had undertaken training in the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (DoLS). Training levels were below trust trajectory in the two months before our inspection. Information provided following our inspection indicated that the trust was meeting trajectory.
- We were not confident that the process of gaining consent for patients unable to give consent due to their health condition was fully embedded within the trust. In one example, we were told about a family that had not known their relative had a DNACPR even though they had regularly spoken with the doctors and nursing staff. Nursing staff told us this had not been recorded as an incident.

Are end of life care services caring?

Good

We rated the end of life care services Good because:

- Patients and their representatives were generally positive about the care they received.
- Chaplaincy staff were visible within the trust, and the chaplain told us that they could access religious representatives from all denominations as required. Staff around the trust spoke highly of the support provided by the chaplaincy team.
- Staff in the bereavement office and the mortuary demonstrated compassion and respect, while preserving the dignity and privacy of patients after death. We saw that the caring approach we observed from the mortuary and bereavement staff was outstanding.

However we found that:

- Patients were not always treated with dignity and respect. Their needs were not always compassionately met.
- We could not ascertain that patients and their families were involved in making decisions about their end of life care.

Compassionate care

- We saw the trust had a policy around care of the deceased patient, including last offices and protocol for removal of deceased patients from wards.
- Patients told us that they were generally happy with the care they received. One patient told us they could find no fault with the nurses on the wards. However, another patient told us care at night was not as good, as bells took a long time to be answered and they had not got their medication when they wanted it.
- During the inspection we observed interactions between staff and patients. Although we saw that most patients were treated with dignity and respect, this was not consistent throughout the trust. For example, we saw one patient who was unable to reach a drink as the jug of water and glass were placed too far away on the bedside. We asked a nurse to help the patient with a drink and they returned with a lidded beaker to enable

the patient to drink. This meant that staff whose job it was to put out fresh water had not recognised they needed help to drink and staff had not noticed the water was too far away.

- Within 2014 National Care of the Dying Audit. The trust scored better than the England for the indicator, 'health professional's discussions with both the patients and their relatives/friends regarding their recognition the patient is dying'.
- During our inspection we visited the mortuary and spoke with the mortuary manager and technicians. Staff gave examples of where they had demonstrated compassion and respect. For example, staff explained how they preserved the dignity and privacy of patients following death.
- We visited the bereavement office, spoke with one of the bereavement officer's chaplaincy staff, and observed an interaction between relatives and staff. We saw that staff demonstrated compassion and respect for patients and their families.
- The mortuary staff we spoke with assured us they rarely had any concerns relating to the way in which patients were treated at ward level following their death. If they did have concerns, for example, patients not being appropriately dressed when they came down from the ward then they reported them as incidents. We saw two incident reports that confirmed this.
- We received five feedback cared that related to end of life care specifically. Most relatives completing these comment cards felt that their loved one had been cared for with compassion and had had their dignity respected at this time.

Understanding and involvement of patients and those close to them

- We saw guidance evidence that following bereavement family could view deceased relatives out of hours.
- We could not ascertain that patients and their families were involved in making decisions about their end of life care. We looked at nine end of life patient records throughout the wards we inspected, and saw that on seven occasion's discussions were not recorded that these had taken place with the patient or, where the patient lacked capacity, their family.
- The National Care of the Dying Audit (May 2014), results showed the trust scored 92% which was better than the England national average of 75% in relation to health professional's discussions with both the patient and their relatives/friends regarding their recognition that the patient was dying.
- The survey also identified the trust as being better than the England national average which was 64% for communication regarding the patient's plan of care for the dying phase.

Emotional support

- A counselling service was available for patients and family.
- The chaplaincy service had a pool of 15 lay and ordained volunteers who were able to support families in the hospital and in the community.
- The chaplaincy staff offered bereavement support to relatives, as well as spiritual support to patients and families. This service was stretched to ensure that a service could be provided 24 hours a day.
- Hospital staff told us they could call on chaplaincy services whenever it was needed and support would be available.
- The chaplaincy team also offered pastoral, emotional and spiritual support to all staff throughout the trust. For example; they took part in the "improving life group".-This group had been set up for staff to help them achieve a good work/life balance
- Although specialist palliative care nurses were trained in advanced communication to ensure sensitive discussions could take place, most staff at ward level, including doctors were not. This meant that when the specialist palliative care team were not available, patients, and their relatives/representatives may not have been given the opportunity to be involved in communication and decisions about treatment and care to the extent that the dying person wants.

Are end of life care services responsive?

Requires improvement

We rated the responsiveness of end of life care services as requiring improvement.

- Services were not planned, organised or delivered in a way that met every patient's needs. Services at the end

of patient's lives were not always responsive to the individual needs. There was no evidence that patients were consulted or achieved their preferred place of death.

- Some patients were not able to access services in a timely way for a specialist assessment. The referral criteria was vague, and the palliative care team, nursing and medical staff told us that patients were sometimes referred too late. For example there was no process to identify patients requiring end of life palliative care when admitted via the accident and emergency department. This meant that patients did not always receive the end of life care they needed in a timely way.
- Patients' care pathways were adversely affected by delays in completing appropriate assessment paperwork
- The specialist palliative care team were busy and had been understaffed for most of the past year. They had worked hard to ensure that every person received the best end of life care where possible.

However we also found that:

- Patients that were referred to the specialist palliative care team were seen according to their needs. The specialist palliative care team told us that they would always try to see urgent referrals the same day.
- The chaplaincy and bereavement services were very responsive. Relatives had access to information and advice. The trust had a dedicated bereavement office, where three bereavement officers supported families through the formal processes following a patient's death.

Service planning and delivery to meet the needs of local people

- Patients requiring end of life care were cared for throughout the trust. There were no designated beds or wards for patients who required end of life care.
- The specialist palliative care team numbers had increased in response to the need to cover seven day working. An audit of the increase in referrals to the team was completed in June 2015 to support the business case for more staff. This had been approved by the board.

Meeting people's individual needs

- The specialist palliative care team told us patients at ward level were not always referred to them in a timely manner. This could compromise the patient's opportunity to make decisions relating to end of life care, and their preferred place of care and death.
- Patients were transferred between wards on a regular basis. In one example we saw a patient had moved wards three times. The nurse in charge on the ward was not aware the patient was at the end of their life and had been referred to the palliative care team.
- In another example we saw records that stated a patient should have been assessed for the Amber care bundle as they were in the last two months of life. Medical staff had recorded this should have started. However the lead nurse for the patient was not aware that had been recommended and the patient had not been referred to the palliative care team.
- Staff told us that they always tried to care for patients requiring end of life care in side rooms, but this was often not possible due to other priorities. During our inspection we saw two patients who were at the end of their life in a bay. One told us they preferred to be in a bay and the other would like to have had a side room but one was not available.
- The chapel in the hospital recognised people of all faiths. The hospital's chaplain told us they had excellent links with pastoral care from 15 lay staff.
- We did not see any patients whereby English was not their first language but staff told us that translation services were available within the hospital.
- Staff in the bereavement office told us that they had numerous resources available to support people of all ages and faiths following the death of a patient. We saw they had numerous different books for children of all ages who were bereaved.
- Chaplaincy staff were visible within the trust, and the chaplain told us that they could access religious representatives from all denominations as required and they also supported people who preferred not to follow a particular faith.
- There was a dedicated room within the bereavement office where relatives could be seen in private.
- Free parking was available for visitors to the bereavement office. Information given to relatives included a booklet called "guidance following bereavement".

End of life care

- Visits for viewing the deceased patient were available 9-30am - 2-30pm, Monday-Friday. Viewing was also available outside normal working hours but would need to be arranged in advance. We saw the mortuary protocol for requests for viewing of deceased patients when out of hours. The mortuary facilities included a waiting room, viewing room and garden.
- Counselling services were available from the bereavement team for up to six months after a patient's death.
- Staff told us they could access policy information and guidance on the intranet.
- The trust provided information and a contact number for palliative care services on its website. This included specialist advice and information about managing symptoms. Information on emotional support for patients and their families. Spiritual support for people of all faiths or no faith and information on organisations who may be able to offer further support.

Access and flow

- We saw a copy of the rapid discharge pathway and spoke with one patient who was being discharged home using this pathway.
- Staff at ward level referred patient's requiring specialist palliative care and support. Not all staff were clear about the referral criteria for the specialist palliative care team. The specialist palliative care team and medical and nursing staff told us that patients were sometimes referred too late. We saw evidence of this on three of the wards we inspected. This meant that patients may not always receive the palliative support they required in a timely manner.
- The specialist palliative care team completed daily ward rounds. We accompanied the team on a ward round; patients were located on six different wards. We observed that the team were involved in decisions about patient's end of life care, including offering advice and support around relief of symptoms and appropriate pain relief.

Learning from complaints and concerns

- The specialist palliative care team told us that they rarely received complaints relating to end of life care. When complaints were raised, they were mainly about communication and lack of information**.** Staff were not able to provide us with any examples where learning had taken place as a result of complaints relating to end of life care.

Are end of life care services well-led?

Requires improvement

We rated that end of life care required improvement on the way it was led at a local level.

- The trust vision and values were not well developed within end of life care. Although the specialist palliative care team had a vision and strategy for end of life care within the trust, this had not been formalised or shared throughout the trust. Staff in ward areas were not aware of the vision and values for end of life care.
- Arrangements for governance and performance management did not always operate effectively. This meant they were not ensuring compliance with national guidelines for audit in palliative and end of life care.
- Not all leaders had the necessary experience knowledge and capacity to lead effectively. Specialist palliative care nurses had been without dedicated leadership for some time. This meant they had made decisions and managed the service as they thought best within their limited resources.
- There was a limited approach to obtaining the views of patients who use services. Where changes were made the impact was not monitored. An example of this is the lack of monitoring of the patients preferred place of death. The trust had no figures in respect of how many patients achieved their preferred place of death.

However we also noted that:

- Since the appointment of a lead consultant in May 2015 the service had begun to have an effective leader. Progress was being made with the new appointment of staff and although audit was still not well developed the local specialist palliative care team understood what the vision of the service was.
- The service was able to identify incidents relating to the palliative care service.
- Although not formally audited the team were able to identify the impact they had on patient care. Some audits of the understanding of ward staff of end of life care had recently been undertaken.

End of life care

Vision and strategy for this service

- Although the specialist palliative care team had a vision and values for end of life care, they were not formalised, and had not been embedded amongst all staff who were delivering end of life care at ward level throughout the trust. This had been partly due to under-resourcing within the palliative care team.
- Following the previous inspection the palliative care team had identified gaps in the service and prepared a business case to develop a sustainable palliative care service with 24-hour access by December 2014. However, on our inspection in October 2015, we found the trust had only just started access to 24 hour support and advice three weeks previously.
- Other objectives recorded on the "work plan" had not been achieved or started. For example; In December 2014, the specialist palliative care team had attempted to rollout the Amber care bundle across four wards. This had proven difficult because the team were relying on a bank nurse to deliver training once a week. The business case had requested an Amber care bundle facilitator and a palliative care discharge planner to cover a seven day working week.
- The decision to place patients on the Amber bundle was a medical decision made by doctors. Doctors and ward sisters we spoke with told us there was confusion about the timeframe and decision making process. For example; we saw records of two patients that had been identified as meeting the criteria however the assessment had not started.
- Specialist palliative care nurses told us they often only got referrals for patients who had been on the Amber care bundle at the very last minute when they were close to the end of life. Not all patients on the Amber care bundle required support from specialist palliative care nurses. For those patients that did, delays in referring meant they would not have had access to the specialist services from palliative care nurses in a timely way. This meant they would not have had any choice about their place of death.
- Where changes had been made improvements were not always identified or action taken and the impact on patients and the quality of care were not fully understood.

Governance, risk management and quality measurement

- Not all risks for end of life care and specialist palliative care team issues had been addressed and were recorded on the risk register. For example; priority issues on the end of life work plan were not on the risk register. The SPC team told us they did not know what was on the risk register as they had never seen it.
- Measures were not in place to manage all the risks identified on the work plan. For example, ensuring compliance with national guidelines for audit in palliative and end of life care.
- Nursing and medical staff we spoke with on the wards where the Amber care bundle had been implemented were not clear what timeframe they should use when patients should go on the amber bundle. Records we saw showed that once a medical decision had been made it could take a week or more before the care plan was completed by the doctors.
- Senior managers did not know how many patients were on the Amber care bundle and how many should have been referred to the palliative care nurses as these records were not kept.
- On one ward the nurse in charge told us they did not have anyone on the Amber care bundle. We looked at one record which demonstrated they did. Upon review the information was not shared during a nurse handover.
- There were no systems to check the quality of the specialist palliative care team input. Staff told us no audits had been completed on the outcomes of their interventions. However, they gave us examples that demonstrated how their intervention had made a difference to a patient's end of life care. For example; same day response to a referral for effective pain relief for a dying patient.
- The electronic care records did not identify patients who were on the Amber care bundle or last days of life care plan. Specialist palliative care nurses were reliant on referrals to identify those patients who might need their services. The trust had no way of identifying patients coming in as an emergency who might be at the end of life.
- The "work plan" had an action to "pursue use of system one" end of life template on the electronic records. This had been identified in January 2015. The planned start/ review date was December 2015. Notes in minutes from board meetings stated this deadline had been changed

and was now 2016. The trust did not have any other system in place to identify patients who came in as an emergency that might need referral to specialist palliative care nurses.

- We were given three examples on the wards where patients had not been referred to the palliative care team in a timely manner. Staff told us they did not record these situations as incidents and they had no other place where these issues could be discussed. As staff did not report these situations as incidents this meant risks were not managed effectively and improvements were not always identified.

Leadership of service

- Staff felt that since the appointment of a new lead consultant in May 2015 communication with senior managers was starting to improve and things were beginning to happen. They told us that previously it had taken a long time to get concerns discussed and actions taken when they highlighted issues that impacted on patients.
- Specialist palliative care nurses had their own triage and referral criteria. Most nurses on the wards told us they did not know what the exact referral criteria was for palliative care but they could contact them about any patient who might fit their criteria and they would offer advice and discuss whether it was a suitable referral for the team.
- Specialist palliative care nurses had worked hard to raise the profile of palliative care services in the hospital. The trust had undertaken no audits to see whether training in end of life care delivered by SPC nurses was effective. This meant they did not know if the training was improving care for patients at the end of their life.
- Specialist palliative care nurses did not know who their lead on the board was. They could not tell us the roles and responsibilities of the interim deputy medical director who had started in July 2015. The lead for the service was a substantive palliative care consultant.
- The specialist palliative care nurses been without any full time dedicated leadership for a long period and received limited management support. This meant they had made decisions and managed the service as they thought best within their limited resources.
- Specialist palliative care nurses did not know if there was a strategy for end of life care. They knew about the end of life steering group but not the full details about what was on the work plan. This was important as most of the actions on the work plan needed the involvement of the specialist palliative care team. The team were experienced and made decisions that were often not shared throughout the trust. For example, they had decided to complete some local audits but had not shared the outcome with their lead consultant. This meant leaders were not informed with what was happening. There was a lack of clarity about authority to make decisions and accountability.

Culture within the service

- Specialist palliative care nurses told us they worked well together and there was shared respect between the different roles and responsibilities within the palliative care team in the hospital and community service.
- Staff felt unhappy as they did not feel they service they gave to patients was good enough and they had no capacity to increase their involvement. Two new specialist palliative care nurses had recently started and interviews for a nurse practitioner/trainer were taking place in November 2015 and they felt that would make a difference.
- The interim senior manager had a number of roles and responsibilities that meant they had been unable to give their full support to the team. Staff said that the recruitment of a dedicated consultant for palliative and end of life care was a positive change and this had led to a more collaborative approach within the team. Staff told us things were improving and once new staff were trained they could begin to look forward to improving services for end of life patients.
- We saw an action plan from the trust wide staff survey that had identified 24 actions for the trust including actions to improve communication. These were in progress but not evaluated. Communication issues were a common theme raised by many staff including specialist palliative care nurses.
- Throughout the inspection, all staff were welcoming and willing to speak with us.

Public and Staff engagement

- The trust gained people's views about services in a number of ways. They requested generic feedback from "friends and family test questionnaires. These were available in locations throughout the hospital. However they were not specific to end of life care.

End of life care

- At our inspection in January 2015, there was a plan to develop a bereavement survey to engage the public in providing feedback to improve services for end of life care, this had not progressed any further. The "end of life steering group work plan", stated this would not start until October 2015. This meant the trust were not compliant with national guidelines for audit in palliative and end of life care.
- We did not find evidence that the trust participated in 'dying matters' week. This is a week, (held nationally in May) where there is the opportunity to raise awareness of the importance of talking about dying, death and bereavement.

Innovation, improvement and sustainability

- We were unable to gather enough relevant information to make a view on how the impact on quality and sustainability was assessed and monitored when considering developments to services or efficiency changes.

Outstanding practice and areas for improvement

Outstanding practice

- A member of staff on Apple Tree ward had introduced 'sensory bands' for the ward's dementia patients. These were knitted pockets which would be embellished with buttons and beads etc. There was an example band on display with an explanation within the ward. The intention of these sensory bands was that patients could wear or hold them to give them an immediate focus to explore.
- Good infection prevention and control initiative including different coloured aprons for different ward bays highlighting if staff move out of these areas without removing or changing their apron.
- The chaplaincy service continued to provide an excellent service, supportive of patients, families, carers and staff.
- There was robust implementation of Duty of Candour.

Areas for improvement

Action the hospital MUST take to improve

Importantly, the trust must:

- Be able to provide assurance that all members of staff are aware of the procedure for and necessity to, report all clinical incidents and near misses in a timely and accurate manner, ensuring these are thoroughly investigated and reported externally where necessary.
- Ensure that all staff responsible for supporting the feeding of patients have had adequate training in relation to the risks associated with various medical conditions
- Ensure the end of life risk register records all the relevant risks involved in delivering end of life care to patients in the hospital setting.
- Ensure patient outcomes are monitored and audited and the information is used when reviewing the service.
- Ensure that mortality and morbidity meetings occur across all of the surgical specialities with a robust monitoring process in place.
- Ensure services have an effective governance and risk management systems that reflect current risk and is understood by all staff.
- Ensure that environmental risk assessments are undertaken to ensure that mental health patients are safe from ligatures and self-harm within the department.
- Ensure that there is an effective process for monitoring ECGs and observations to ensure the safety of patients.
- Ensure that there is an immediate review of the environment and provision of children's services.
- Ensure that the time to treatment from a clinician in the emergency department is reviewed and times to treatment are improved.
- Ensure that the triage process for ambulance arrivals is received to ensure that the pathway for patients is safely and times of assessment accurately recorded.
- Ensure that infection control practices within the emergency department are improved.
- Ensure that the processes for the checking of equipment in the emergency department is improved and safe for patients.
- Ensure that allergies are recorded on medicines charts.

Action the hospital SHOULD take to improve

In addition the trust should:

- Ensure risk assessments on medical wards are fully completed, personalised to the patient and regularly reviewed for any changes.
- Ensure local risk assessments on surgical wards are in place, with a consistent management approach and aligned to the surgical divisional risk register.
- Ensure consultant participation at ward rounds is consistent across the surgery service
- Ensure that the plan for end of life care is rolled out and embedded across the trust.
- Ensure quality measures and good practice are shared across the surgical wards.
- Ensure specialist palliative and end of life care patients are assessed and referred promptly to end of life care team.

Outstanding practice and areas for improvement

- Ensure all appropriate paperwork is completed in a timely way and following best practice guidance.
- Ensure there is adequate numbers of specialist medical staff.
- Ensure medicines records include all necessary information.
- Review the collection of audit data in relation stroke care to benchmark outcomes.
- Review access and flow within surgery with the aim to reduce out of hours ward transfers.
- Review the provision of nurse staffing at night within the emergency department.
- Review the need to monitor the culture of staff within the emergency department.
- Review the environment to ensure that environment supports good infection control.