Care Quality Commission

Peterborough and Stamford Hospitals NHS Foundation Trust

Peterborough City Hospital

Quality Report

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

Ratings

Overall rating for this hospital	**Requires improvement**
Accident and emergency	**Requires improvement**
Medical care	**Requires improvement**
Surgery	**Good**
Intensive/critical care	**Good**
Maternity and family planning	**Good**
Children's care	**Good**
End of life care	**Good**
Outpatients	**Good**

Summary of findings

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Overall summary

Peterborough City Hospital has 611 beds and is a new building funded under the private finance initiative. It became fully operational only from December 2010, combining services previously supported on three separate sites. It is managed by and is the main site for Peterborough and Stamford Hospitals NHS Foundation Trust. It provides acute health services to patients from Peterborough, Cambridgeshire South Lincolnshire, North-East Northamptonshire and Rutland.

We found that the services at the Peterborough City Hospital site met the needs of most of the patients attending. The accident and emergency (A&E) department was a busy unit as road links to the hospital were good and patients from surrounding counties used this unit. The hospital had good links with its five surrounding local authorities and patients were sent to the most appropriate hospital for treatment if this could not be provided by Peterborough City Hospital. The hospital provided medical and surgical services to the expanding population of Peterborough and the surrounding area. The increases in house building meant that the population was expanding and at times of increased demand the hospital struggled to cope with these pressures.

Staffing

The hospital was in the process of reviewing the number of staff on every ward and was using the Safer Nursing Tool recommended by the NHS Institute for Innovation and Improvement. The initial review found that most wards were already functioning at the required level of staffing but a few wards needed further assessment of patient acuity. At our announced inspection we found that most wards were appropriately staffed but we heard that night times were a particular problem with regard to reduced staffing. We returned for our unannounced inspection during the late evening and found that the staffing was appropriate to meet the needs of the patients on all but one of the medical wards, where a member of staff had called in unwell. This was mitigated as a student nurse was on duty. While this meant that staff were busy, patients remained safe during this night visit.

Cleanliness and infection control.

The hospital was found to be clean and infection was prevented and controlled through good use of cleaning schedules and monitoring systems. Each ward and department had audits displayed of the numbers of infections that had occurred and staff were aware of the need for good hand hygiene in preventing the spread of infections. However, we found that a number of hand gel dispensers were empty and that on occasion people had to walk through several sets of doors to find a dispenser that had antibacterial hand gel in it.

Summary of findings

The five questions we ask about hospitals and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

Services at the hospital are mostly safe because the hospital has systems in place to raise concerns and incidents and staff are aware of how to do this. Incidents are reviewed and lessons learned shared with staff. However services for children within the A&E department do not meet national guidance and whilst the trust has plans in place to address this these are not yet in place.

There are processes in place to ensure that the hospital is clean and infection is prevented or controlled. The infection rates at the hospital are low and these are monitored by ward and department. Across the hospital, hand gels were not always available; however, access to alternative supplies could be found.

The number of falls at the hospital were above the national average and have reduced by 4%. The trust has increased awareness of the risk and monitoring. The hospital has a large number of single rooms and open spaces that make it difficult for those with limited mobility to move around. Staff are aware of the issue and use warning systems such as highlighting patients at risk and crash mats to reduce harm from a fall.

Are services effective?

Requires improvement

The hospital uses national guidance in all areas of the hospital to improve patient care. This includes guidance from the National Institute for Health and Care Excellence as well as from other specialist bodies such as the royal colleges. Outcomes for patients are good and are in line with national expectations.

The trust has not taken part in 2 national clinical audits for which it was eligible during 2013/14. Further monitoring is required so that the trust can monitor performance against national performance and improve outcomes for patients. Pain relief at the end of life should be reviewed as patients told us of delays in receiving pain relief.

The hospital monitors a range of measures to ensure that patients receive good care. These include the monitoring of national initiatives such as the Safety Thermometer and local monitoring of call bell response times. Staff are aware of the findings of this monitoring and act upon any deficits in order to improve care.

Are services caring?

Good

We heard from patients and families that the staff were very caring and that they involved family members in the care of loved ones. At the listening event,

Summary of findings

people told us that, while there may have been some issues with the care received, most staff were indeed caring. Patients felt that they understood what was happening to them and we saw a good example of how the hospital prepares people undergoing joint replacement surgery before their operation.

Staff respected patients' privacy and dignity and were aware of those who were vulnerable. We saw some good examples of how staff treated patients with sensitivity and respect. We also witnessed some less good experiences for patients, but these were in the minority and acted upon when we reported them.

Staff in the oncology wards and in maternity were especially sensitive to patients and their families when giving them bad news. This was done with tact and diplomacy. The mortuary staff provided an exceptional service to the recently bereaved.

Are services responsive to people's needs?

Requires improvement

While most patients received care that met their needs once they had been admitted to the appropriate ward areas, there was a number who did not. The capacity issue meant that patients sometimes had to be admitted onto a ward that had a bed available rather than onto a ward that met the needs of the patient. The trust continues to struggle to meet the four-hour wait target in the A&E department and target times for referral to treatment, which means that, although patients are seen, they are not always admitted in a timely manner.

The hospital was in line with national expectations for the number of cancelled operations. It used cancelled planned theatre sessions for unplanned surgery. Action has been taken to address the backlog of complaints but more work is needed in this area to address complaints swiftly and to learn lessons from them. The trust is working with the local Healthwatch to improve the experience of patients who make complaints.

The trust has taken action to address some areas of mental health within the hospital; this work should be extended to include children's and young people's services. In addition the trust has implemented a number of initiatives that improve the care given to vulnerable patients, including those with dementia or learning disabilities. In children's services the trust should review the services for adolescents so that this group of patients have an improved experience.

Are services well-led?

Good

Most staff felt supported by their immediate line managers and were aware of the values of the trust. They knew how the governance systems worked and were able to report incidents. A few staff from across the hospital raised concerns with the inspection team that they felt unsupported in raising issues as they were not confident that action would be taken. Most of the incidents cited related to perceived lack of support by their line manager and confusion about where else to turn. The hospital has recently introduced a new system of reporting concerns.

Summary of findings

The recent staff survey showed marked improvements on the survey undertaken in 2012, with areas such as opportunities for career promotion and percentage of staff receiving training above the national acute trust averages. Areas such as staff suffering work-related stress and working extra hours were below the national averages, showing a positive change for staff at the hospital.

Summary of findings

What we found about each of the main services in the hospital

Accident and emergency

Requires improvement

Most patients felt that they had received safe care, although we were told about some examples where patients had been left waiting for support or about information that had not been communicated well. The layout of the department meant that patients' privacy was respected and that they could be observed easily by staff.

The emergency department had failed to meet some national targets, for example the length of time spent in the department as well as the re-attendance rate. However, it was performing better for other aspects of the patient experience, for example infection control.

There was a clear pathway for each patient attending the emergency department according to their clinical need. We were told that this worked well when there was sufficient capacity throughout the trust. However, when the department and the wider hospital were busy, the patient flow did not always work as planned and one unit specifically aimed at improving the pathway and flow of patients was not being used effectively due to constant bed pressures. A governance structure had been introduced to develop plans to improve patient flow and to help achieve targets.

We found that staffing sometimes fell below the expected numbers and that some weeks were worse than others. We were told about a recruitment campaign to improve the vacancy rate, relieve pressure on staff and reduce the use of bank and agency nurses.

Staff working within the department generally felt well supported by management and thought that they worked in an open and transparent environment.

Medical care (including older people's care)

Requires improvement

We found that, while staff had effective handovers and access to the appropriate guidance available to care for people safely, a large proportion (40.7%) of safety incidents reported were from the medical care specialties. These incidents related to patient falls, pressure area care and infection control. Some staff and patients told us that they felt staffing levels were unsafe at night and at weekends and we saw that there were significant nursing vacancies in some ward areas.. However at our unannounced evening visit on 10 March 2014 we found there to be sufficient staffing on the three medical wards visited.

We found that targets set nationally and locally for patients were not always met. This included the transfer of patients to specific wards and effective discharge planning. The respiratory ward was not carrying out one national

Summary of findings

clinical audit (BTS emergency oxygen). National audits from the previous year were removed from the list for 2013/14. The stroke unit was under-resourced at consultant level. The cardiac unit did not have cardiologist cover during the weekend.

The interactions we observed between staff and patients were all positive and supportive and the staff responded to patients' needs, including for emotional support. Patients and visitors told us that staff were caring and kind at all times. However, we did see instances when staff were too busy to respond appropriately to calls for assistance and the call bell reports showed that over 20% of call bells were not responded to within five minutes. Ward managers monitored complaints and incidents and looked at themes; we saw evidence that actions had been put in place as required to address the areas of concern.

Governance arrangements were in place across the medical care service but not all clinical audits as recommend by the National Institute for Health and Care Excellence (NICE) were being carried out across all wards. Each ward followed trust wide processes for monitoring incidents and accidents and significant areas of risk were placed on the hospital's risk register. Junior staff told us that there was a lack of effective change management and leadership and that key messages were not effectively cascaded down the organisation.

Surgery

Good

Services in the surgical department were safe for patients. Services were provided in a clean and hygienic environment in line with recognised guidance, which helped protect patients from the risk of infection, including hospital-acquired infections.

We saw staff who were caring; the patients we spoke with complimented staff on their caring approach and professionalism.

Shortages of beds resulted in some patients being admitted to an inappropriate environment, particularly in the planned surgery orthopaedic ward. Patients' operations were often cancelled or delayed due to lack of capacity. The operating theatre time available, due to cancelled elective surgery, was utilised by performing emergency surgery and thus minimising the need to attend to cases out of hours. Gaps in staffing were met using bank (overtime) and agency staff, but such staff were not always available. The trust has a recruitment programme; however, staff reported to us that there were delays recruiting and replacing staff.

Action plans were written as a result of reported incidents; however, there was no robust system in place to facilitate learning from incidents or complaints. We saw that appropriate equipment checks and maintenance were carried out. However, there was a lack of storage space throughout all the surgical wards.

Most of the staff we spoke with felt supported by their managers. A minority reported to us that they would be afraid to raise concerns and they feared

Summary of findings

being victimised. However, most staff we spoke with said that they would challenge a senior member of staff for wrongdoing, either directly or via a senior colleague. Staff training and appraisals were carried out to ensure that staff were competent and had knowledge of best practice to effectively care for and treat patients. A clinical governance framework was also in place.

We found that staff were responsive to people's individual needs; however, staff told us that there were often delays in patients' discharge from the hospital.

Intensive/critical care

Good

Critical care patients received safe, responsive and effective care services. The service was provided by sufficient specialist staff in a spacious and clean environment. Admissions to the unit were organised so that they were appropriate and took place without delay.

We saw that people received care and treatment according to national guidelines. There were always sufficient staffing numbers to meet patient needs. Consultant-led one-to-one nursing, or two-to-one nursing, was provided according to each patient's assessed level of need. The staffing ratio was planned so that it was sufficient to meet the needs of critical care patients.

Staff training and appraisals were carried out to ensure that staff were competent, were aware of best practice, and were effective in caring for and treating patients. Care delivered within the unit and to patients on other wards by the outreach team was observed to be person-centred and compassionate.

Patients were supported to make decisions about their care where possible, and relatives were included in their family member's care planning. There was an unacceptable level of delayed discharges from the critical care unit. There was effective leadership at all levels within the critical care service.

Maternity and family planning

Good

Women we spoke with were generally positive about their experiences. Each person said that they had been very well informed throughout their pregnancy and that staff had been attentive to their needs and demonstrated a caring attitude. There was, however, a small number of negative comments about how quickly staff responded to queries or questions people may have had. Staff we spoke with were positive about the running of the service and there were clear lines of responsibility.

We saw how the service identified, responded to and acted upon things that had gone wrong to ensure that the service remained safe.

Effective practices were in place and these were continually monitored and reviewed to ensure that the service met the needs of the women it cared for. The service was staffed in line with recommended ratios; however, concerns were raised about the level of staffing within the antenatal clinic.

Summary of findings

While overall the service was well led, we found that there was confusion within the senior team about how and where the staff should report quality issues. Also, there was no clear strategy or vision for the maternity service. We found that the service had not analysed information to determine how it could improve the running of the available maternity helpline.

Children's care

Good

Children's and young people's services were provided in a clean and hygienic environment in line with recognised guidance, which helped protect patients from the risk of infection, including hospital-acquired infections.

Children's care and treatment followed best practice guidance and monthly audits were carried out regarding patient safety, patient experience and the environment.

Parents we spoke with told us that they felt that their child received good-quality care and that they were informed about any treatment required.

We found that staff were responsive to people's individual needs; however, staff were unaware of the trusts guidance for staff on the ward areas when they needed to make a decision concerning same-sex accommodation. There was also limited support from the child and adolescent mental health services out of hours.

There was leadership at all levels within children's and young people's services and staff felt well supported by their managers. A clinical governance framework was also in place.

End of life care

Good

The trust has a strong focus on end of life care. The trust has used CQUINs (Commissioning for Quality and Innovation targets agreed with the local commissioning groups) to develop and improve the service provided to patients at the end of their life. The trust is clear with regard to the actions required to review and replace the Liverpool Care Pathway. This is one of the CQUINs and the Amber Care Bundle (a defined pathway of care for people within 2-3 months of the end of their life) is being piloted on two wards. The action plan demonstrates that it will then be rolled out across the trust to meet the Department of Health's guideline timeframe of July 2014.

The palliative care team was very committed and provided a service seven days a week. The team was alerted immediately to any admission of a terminally ill patient. There was very good multi-agency working and close working with both the community team and the local hospice.

Staff were clear about 'do not resuscitate' policies and documents viewed were appropriately signed. Equipment was available and clean, appropriate checks had been made, and staff understood how to use the equipment. The experience of pain relief for patients was patchy with some patients waiting a long time for pain relief. This area needs addressing by the hospital.

Summary of findings

The care provided to those who had died was excellent and led by a very passionate bereavement centre manager. In addition, the chaplaincy service and the faith centre provided support to both patients, families and friends and staff of all faiths and cultural backgrounds.

Outpatients

Good

Outpatients services were safe, and staff were well trained and knowledgeable. All staff understood the principles of safeguarding for children and adults and knew how to refer concerns.

The trust had responded positively to concerns about the booking office and call centre. A review of these departments had resulted in more staff being employed and systems refined; this has led to a more effective service. The trust has had 12 patients wait longer than the 13 week target, however this is in proportion to 103,152 new attendances in the year to date. Some outpatient clinics run over but 'did not attend' rates have dramatically decreased as a result of the appointment 'chase and alert' system.

Summary of findings

What people who use the hospital say

Since April 2013, patients have been asked whether they would recommend hospital wards to their friends and family if they required similar care or treatment. The results of this have been used to formulate the NHS Friends and Family tests for accident and emergency (A&E) and inpatient admissions. The hospital is similar to other hospitals in England with respect to the response rate for inpatients and has a higher level of A&E responses. The tests indicate that most patients are extremely likely or likely to recommend the hospital to their family and friends. The national in patient score in December 2013 was 72 as was the hospitals inpatient score. For A&E the national score was 56 and the hospitals inpatient score was 62.

The CQC's Adult Inpatient Survey 2012 showed that the trust is performing within expected levels for all 10 areas of questioning. Compared with the previous year, the hospital scored lower on only two issues: sharing same-sex accommodation and waiting times in response to call bells. The trust has begun monitoring call bell response times as part of its monitoring systems at the hospital. This shows that around 85% of call bells are responded to within 5 minutes.

The Cancer Patient Experience Survey is designed to monitor national progress on cancer care. A total of 152 acute hospital NHS trusts took part in the 2012/13 survey, which comprised a number of questions relating to 13 different cancer groups. There were 69 questions where the trust had a sufficient number of survey respondents on which to base findings, and Peterborough and Stamford Hospitals NHS Foundation Trust was rated by patients as being in the top 20% of all trusts nationally for eight of the 69 questions.

We met a number of people at the listening event held on 27 February 2014 and received feedback from the local Healthwatch. In general, people were positive about their experiences at the trust and the activities of the local Healthwatch also provided positive comments about the hospital. However, people told us that the trust could improve its complaint handling, response to call bells, and care and dignity for patients. We undertook a review of complaints using representatives from the Patients Association; they have recommended some areas of improvement for the trust.

Areas for improvement

Action the hospital SHOULD take to improve

- The trust should ensure that A&E staff are clear on the checking procedure in respect of whether a child is on the child protection register.
- The hospital should roll out intentional rounding to all areas including A&E.
- The hospital should continue to support all staff in raising concerns.
- The hospital should enhance joint working with the Mental Health Trust to ensure a better service for patients.
- The hospital should review admissions to inappropriate wards.
- Equipment should be stored in designated spaces to reduce the risk of trip hazards.
- The trust should review the accommodation and services available for adolescents to improve their patient experience.
- The trust should review pain relief for those patients at the end of their life.
- The trust should ensure that services for children within the A&E department meet national guidance.

Good practice

Our inspection team highlighted the following areas of good practice:

Summary of findings

Joint School

The hospital has a joint school for patients who are having knee or hip replacement surgery. This is run jointly with medical, nursing, physiotherapists and occupational therapy staff. This promotes pre planning for discharge by patients and increases their awareness of the surgery.

Debrief session

The maternity unit offers debrief sessions for women following the delivery of their baby. This allows women to voice any concerns or queries following a difficult birth. It provides reassurance for women and advice on future pregnancies.

Mortuary and bereavement services

The mortuary team provided excellent sensitive services. The services offered by the bereavement centre and mortuary were considered to be very good, as was their extended use to patients families in the longer term. The service was working with Peterborough Cruse to run counselling sessions in the evening.

Ventilator-associated pneumonia infection control

In 2013, the critical care team of intensive care consultants at Peterborough City Hospital shared a national award relating to healthcare-acquired infections (HAIs) for its work on and intervention in ventilator-associated pneumonia; this had reduced infection rates and saved the trust money.

Peterborough City Hospital

Detailed Findings

Services we looked at:
Accident and emergency; Medical care (including older people's care); Surgery; Intensive/critical care; Maternity and family planning; Children's care; End of life care; Outpatients

Our inspection team

Our inspection team was led by:

Mark Pugh, Executive Medical Director, Isle of Wight NHS Trust, and Fiona Allinson, Head of Hospital Inspections, CQC.

Background to Peterborough City Hospital

Peterborough City Hospital has 611 beds and provides medical and surgical services to Peterborough and the surrounding counties. Peterborough City Hospital is a new building funded under the private finance initiative and became fully operational only in December 2010, combining services previously supported on three separate sites.

Why we carried out this inspection

We inspected this hospital as part of our in-depth hospital inspection programme. We chose this hospital because it represented a variation in hospital care according to our new intelligent monitoring model. This looks at a wide range of data, including patient and staff surveys, hospital performance information and the views of the public and local partner organisations. Using this model, Peterborough and Stamford Hospitals NHS Foundation Trust was considered to be a low risk service.

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 team always inspects the following core services at each inspection:

- accident and emergency (A&E)
- medical care (including older people's care)
- surgery
- intensive/critical care
- maternity and family planning
- services for children and young people
- end of life care
- outpatients.

Before visiting, we reviewed a range of information we hold about the hospital and asked other organisations to share

Detailed Findings

what they knew about it. We carried out an announced visit on 4 and 5 March 2014. During the visit, we held focus groups with a range of staff in the hospital, including nurses, doctors, physiotherapists, occupational therapists and pharmacists. We talked with patients and staff from all areas of the hospital. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' personal care or treatment records. We held a listening event where patients and members of the public shared their views and experiences of the location. An unannounced visit was carried out on 10 March 2014 to review the ward and A&E areas.

Requires improvement

Accident and emergency

Safe	Requires improvement
Effective	Not sufficient evidence to rate
Caring	Good
Responsive	Requires improvement
Well-led	Good

Information about the service

The emergency department was built to accommodate up to 90,000 attendances each year. Since the new site opened, the emergency department has seen a dramatic increase in attendance compared with numbers at the previous location: 22% growth has been observed over three winters in emergency adult admissions. The total number of patients attending the emergency department between April 2013 and February 2014 was 82,185.

The trust anticipates that the number of patients attending the emergency department will continue to increase as the population is growing at twice the national rate. This includes a significant increase in the number of people aged over 81.

The emergency centre is a separate unit that forms part of the emergency and medicine directorate.

The emergency department was made up of minor injuries (minors), major injuries (majors), rapid assessment and resuscitation area. Next to the emergency department is a clinical observation decision unit (CODU) and an emergency short-stay unit (ESSU). Patients attending the accident and emergency department should expect to be assessed and admitted, transferred or discharged within a four-hour period. If an immediate decision cannot be reached or where a prolonged period of diagnostics or observations are required, a patient may be transferred to the CODU for up to 24 hours (under the care of the emergency department consultants) or to the emergency medical unit (EMU), which is part of the medical specialty, for up to 48 hours.

The trust did not have a designated paediatric emergency department; however, there was a separate paediatric bed within the resuscitation unit (staffed as required), and two beds within the paediatric GP assessment unit (Jungle) that were staffed between the hours of 9am and 9.30pm. If children were seen outside these hours or more than two children had been admitted during a given period, they were accommodated within the main emergency department. The trust had plans in place to open a dedicated paediatric emergency area within the emergency department in July 2014.

Requires improvement

Accident and emergency

Summary of findings

Most patients felt that they had received safe care, although we were told about some examples where patients had been left waiting for support or about information that had not been communicated well. The layout of the department meant that patients' privacy was respected but that they could be observed easily by staff.

The emergency department had failed to meet some national targets, for example the length of time spent in the department as well as the re-attendance rate. However, it was performing better for other aspects of the patient experience, for example infection control.

There was a clear pathway for each patient attending the emergency department according to their clinical need. We were told that this worked well when there was sufficient capacity throughout the trust. However, when the department and the wider hospital were busy, the patient flow did not always work as planned and one unit specifically aimed at improving the pathway and flow of patients was not being used effectively due to constant bed pressures. A governance structure had been introduced to develop plans to improve patient flow and to help achieve targets.

We found that staffing sometimes fell below the expected numbers and that some weeks were worse than others. We were told about a recruitment campaign to improve the vacancy rate, relieve pressure on staff and reduce the use of bank and agency nurses.

Staff working within the department generally felt well supported by management and thought that they worked in an open and transparent environment.

Are accident and emergency services safe?

Requires improvement

Safety in the past

The emergency department had systems in place for recording and monitoring performance. A dashboard was used to rate performance against key indicators and performance was colour-coded as red, amber or green to enable management to see at a glance those areas that required improvement.

During a 13 month period from July 2012 to July 2013, there was a total of 302 incidents reported to the National Reporting and Learning System by the hospital: these included seven "moderate harm" incidents. Other incidents reported during this period were categorised as minor or insignificant or as having had no adverse outcome. Patients either admitted with a pressure sore or acquiring a pressure sore within the first 72 hours of admission accounted for the highest number of incidents (in approximately half of these, there was an indicator that the patient had been admitted with the sore). These are reported by the Trust but attributed to the community. Patients experiencing a delay in their treatment comprised the second highest number of incidents.

Other patient safety indicators were monitored, for example the Modified Early Warning System (MEWS) and the Paediatric Early Warning System (PEWS). These are tools designed to help nurses monitor whether a patient may be experiencing a sudden decline, and they aim to improve patients' clinical care. We saw that compliance with using the monitoring tool for adults had not been met for quarter 3 but had been met in January 2014. Overall achievement was much lower for paediatric patients: the target had been met for October 2013 but not since.

Learning and improvement

Incidents were reported using an online tool. The staff we spoke with told us that they reported incidents they may have been involved in or witnessed. Staff told us that they were confident in using the system and were encouraged to report incidents as they occurred.

Accident and emergency

The staff we spoke with told us that they had learned from incidents once the investigation into the incident had been completed. Staff told us that they received feedback directly from the matron about some of the incidents they had reported; we saw examples of this.

We were told that lessons from serious incidents were shared and communicated through various meetings within the department, the directorate or the trust, depending on the nature of the incident. We were told that incidents relevant to the emergency department were discussed at staff briefing meetings and senior nurses meetings; we were shown examples of minutes from these.

We reviewed the investigation into a serious incident that had occurred in 2013. The report detailed a chronology of events, considered the learning points and listed recommendations in response to the findings. The investigation was supported by an action plan, and the plan indicated that actions for completion by the emergency department had been implemented.

Systems, processes and practices

We observed that the design and layout of the department were conducive to providing care to patients in accordance with their needs. The department was visibly clean on the day of our inspection and the department scored highly in cleaning and hand-washing audits.

Staff had access to IT systems that enabled them to track patients, report incidents and access policies, among other things. We were told by staff that equipment was always available and well maintained. We observed that the resuscitation trollies contained all the required equipment.

The hospital had systems in place to ensure that safeguarding concerns were shared with the relevant local authorities' safeguarding team. A dual system was in operation to share concerns: if a member of staff suspected that a child or vulnerable adult may have been subject to abuse, they would make a direct referral to the relevant safeguarding team. If they had concerns about a child's general welfare, they could complete a 'cause for concern' form; we saw examples of this happening. In addition to the above reporting arrangements, children under the age of five were routinely checked to establish whether they were on the local authorities' child protection register. However, responsibilities for making checks had changed recently and staff were not clear about who was responsible for making them. The records we reviewed for children under five who had attended the emergency department had not been checked against the child protection register in accordance with the hospital's policy.

Monitoring safety and responding to risk

Staffing was monitored throughout the day and a daily staffing sheet was used to record staff allocations. Shortfalls were addressed by the nurse in charge in the first instance and bank and agency cover obtained as required. If cover could not be sourced, this was escalated to the lead nurse and subsequently to the directorate operational lead for that area. The situation would then be assessed and staff moved within the department according to demand and associated risk.

The department was fully staffed for healthcare assistants but had a vacancy rate of approximately 10% for nursing staff. Approximately 7% of nurses were also on maternity leave. This meant that the department frequently relied on bank and agency nurses to provide cover. We were told that recruitment of nurses for the emergency department was ongoing and that new initiatives were being considered to reduce the number of vacancies; these included the recruitment of nurses from abroad which was currently taking place.

The trust had seen a dramatic improvement in consultant posts being filled within the department during the past 18 months. The lead clinician had developed a recruitment campaign and we were informed that six consultants were currently in post with a seventh post having been successfully filled. The deanery had advised the department that it needed an additional two consultant posts and a business case was being prepared to request these.

The staff we spoke with had mixed opinions about whether the department was adequately staffed. Some staff thought that the department could become very busy and that they did not always have sufficient staff on duty. Other staff told us that there were adequate staffing arrangements in place. During our visits we found that the department was busy but adequately staffed.

We saw that the number of 'safe staffing level' incidents reported had increased from two in quarter 1 to 11 in

Accident and emergency

quarter 3, with the highest number of 'safe staffing level' incidents reported in November 2013. We were informed by the matron that if a member of staff reported a staffing shortfall it did not always mean that the department was unsafe: this was because cover may have been sourced after the staffing incident had been reported.

We reviewed the nursing rotas for November and December 2013 and found that, according to the rotas, there was a shortfall in staff for most shifts in November. December was much improved, with almost all of the shifts having the required number of nurses and healthcare assistants in accordance with the department's agreed levels.

We spoke with staff about safeguarding policies and procedures. The staff we spoke with all talked confidently about how to recognise the different types of abuse and what they would do if they suspected that a vulnerable person may have been subject to some form of abuse.

We observed patient handovers and found that suitable information was transferred between staff during handovers.

Anticipation and planning

The trust had an internal major incident plan, developed in accordance with the Civil Contingencies Act 2004. The plan set out internal responsibilities and links with external services; each delegated role was supported by a separate action card that specified individual responsibilities. The hospital was also a training centre for major incidents and took part in practical exercises every three years as well as annual theoretical exercises. The most recent practical exercise was undertaken in November 2013, after which an action plan was developed to make improvements for future exercises or eventualities.

During the preceding 12 months, one major incident had occurred. An incident report had been written following the event, detailing the timing of events and actions taken. An operational debrief had taken place and perceived strengths and weaknesses had been documented.

The emergency department had a separate escalation policy to cope with a large influx of patients, as well as for dealing with relocation issues in the event that a particular area within the department could not be used. The plans set out clear lines of responsibility and actions to follow.

A proportion of the staff working in the emergency department was currently funded and employed by the military. This arrangement was due to cease in July 2014 and the trust was aware of the need to increase its number of staff and fund these positions. We were told that the staffing levels within the emergency department would remain the same and that there was a trust-wide plan to provide for this.

Are accident and emergency services effective?

(for example, treatment is effective)

Not sufficient evidence to rate

Evidence-based guidance

A clinical audit plan had been developed that would run over a three-year cycle; 2013/14 was to be year one. The audit plan for the current year included four audits: three had not yet started as there had been a delay in receiving guidance from the College of Emergency Medicine. An audit on transient loss of consciousness had been completed; this was to establish whether guidance set by the National Institute for Health and Care Excellence (NICE) had been followed.Results were awaited at the time of our visit.

A further four audits were scheduled for years two and three of the audit plan. Two audits, as well as a clinical audit plan, had been agreed for August 2013. The hospital had an urgent care action plan that reflected external audits of issues within the department. The trust had invited the national Emergency Care Intensive Support Team (ECIST) to review its systems and processes in the A&E department to help improvements continue and to assist in achieving the 4 hour targets set f or treatment for patients.

The emergency department had developed fast-track pathways for a number of specialist areas, including diabetes, nutrition, cardiac arrhythmia and neutropenic

sepsis. We reviewed a sample of patient files against selected protocols and found that patients had been treated promptly and in accordance with the correct protocols.

Monitoring and improvement of outcomes

The emergency department monitored trust-wide targets, some of which were set nationally and others through local agreement: these included targets relating to infection rates, the number of falls, the number of incidents and complaints.

Data for the above was collated monthly and summarised on a balanced scorecard. Performance was reviewed and discussed at meetings in accordance with the committee structure. Operational staff within the department were kept informed through the team briefings.

Staffing

We were told that staff had annual appraisals. The staff we spoke to told us that they felt supported by management and found their appraisal a helpful process. We were shown evidence that 66% of staff within the directorate had completed their appraisal for the year.

Staff had mixed views about the training they had completed. Staff talked confidently about safeguarding arrangements but had less knowledge of other aspects of patient care, for example caring for people with dementia.

We reviewed training records and found mixed results across mandatory training subjects. We saw that some mandatory training sessions had high attendance and completion rates: for example, safeguarding children training had been well attended by all staffing groups. Other mandatory training sessions, for example adult basic life support, had been completed by 39% of medical staff but by 93% of other staff working within the emergency department. Medical staff undertaken Advanced Life Support training which includes Basic Life Support at induction.Training in moving and handling had not been attended by any medical staff; equality, diversity and human rights also had a low attendance rate among the medical staff but had been well attended by other staff.

Staff we spoke with were aware of the Mental Capacity Act and associated deprivation of liberty safeguards; most staff told us that they had completed training in this area. Staff responses were mixed about whether they had completed training on supporting people with dementia.

Multidisciplinary working and support

We observed handovers between shifts and found that information shared between staff changing shifts was adequate to ensure patient safety.

The mental health crisis team was contacted for adult patients who attended the emergency department due to mental health needs. This service is run by the local mental health trust. The crisis team attended once the patient had been stabilised. We were told that there was frequently a delay in the crisis team attending, and that this may impact on the patient's well-being. We reviewed a sample of patient notes and saw that staff from the emergency department had informed the crisis team of patients in their care but the crisis team had not responded promptly.

Children and young people who attended the emergency department with mental health needs were supported by the child and adolescent mental health (CAMHS) team. This service is run by the local mental health trust. We were told that this service was only available during office hours and that there was frequently a delay in the CAMH team responding. This was supported by patient notes and through a conversation with one patient's relative. We were told that the emergency department would admit the child or young person until they had been seen by the CAMH team.

Are accident and emergency services caring?

Good

Compassion, dignity and empathy

Patients in the majors department were accommodated either in side rooms or in beds that were semi-partitioned; this was sufficient to protect their privacy and dignity while enabling staff to observe the patients easily.Staff told us that curtains were always pulled round patients when they received personal care or discussed information. A number of beds on the

emergency department were in side rooms, while other beds had a partition wall separating them from other patients. The staff and patients we spoke with liked the layout of the emergency department, which meant that people could be cared for in privacy as well as being observed easily by staff.

Staff working in the emergency department did not undertake comfort rounds to ensure that patients had had their continence needs met, were comfortable and not in any pain, and had a drink if they needed one. We were told that this was because the patients were in the department for only a short time and were well cared for. We observed that call bells were positioned on the wall behind the patients' beds and were not within reach. The patients we spoke with were mostly satisfied with the care they had received; however, two of the patients told us that their continence needs had not been met. Some patients described incidents where care had been protracted and unsatisfactory.

Involvement in care

Most of the patients we spoke with were satisfied with the communication during their time in the emergency department. We observed positive interactions between staff and patients although we did observe one member of staff who was abrupt when speaking to a patient. The relative of one patient also told us that some of the doctors could be rude but that the nursing staff had been very caring.

Most patients told us that staff communicated well with them: for example, one patient told us that they had remained in the department for approximately eight hours but that staff had regularly updated them and provided an explanation. This was not always the case: another patient told us that they wanted pain relief but were not able to have any because the hospital did not have sufficient information about them. The patient told us that they did not know what this meant and did not understand why they could not have pain relief.

Most of the patients we spoke with were happy that they were listened to if they asked for something. The relative of one patient told us that their relative was going to be discharged but the relative did not think the patient was well enough to be discharged and so they requested that a specialist should review the patient. This request was granted, the patient was re-evaluated, and both the patient and their relative were satisfied with the outcome.

We spoke to another patient and their relative who were dissatisfied because the patient had been discharged in the early hours of the morning and had been brought back by ambulance two hours later.

Trust and respect

The NHS Friends and Family Test results show that patients attending the A&E were likely to recommend the department to their family and friends.The results are significantly above the England average. The nursing staff we spoke with told us that they had attended equality and diversity training. One member of staff told us that Peterborough was a multicultural area and that they had an understanding of the different cultures and religious needs.

We observed that patient records were stored securely and that patient notes were written in a clear and concise manner. Care and treatment required were well documented.

Discussions between staff and patients were undertaken at their bedside. Side rooms were available for some patients, while others had their privacy and dignity respected because there was a partition between beds and curtains could be pulled round as required.

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

(for example, to feedback?)

Requires improvement

Meeting people's needs

The hospital had not consistently met the national target of all patients attending the emergency department being admitted, transferred or discharged within four hours. Over the previous year the hospital had failed to meet the target on a significant number of occasions.

The breach rates were higher for admitted patients; typically, the highest number of breaches were for medical patients, the most likely cause of which was a lack of beds. The second and third most likely causes were long waits for a specialist or waiting for an assessment respectively. We were shown evidence that bed occupancy for medical beds frequently exceeded 90%.

Requires improvement

Accident and emergency

The emergency department did not meet the target for the number of patients who had left the department without being seen (September 2012 to August 2013), but met the target for patients having their initial assessment within 15 minutes of being brought in by ambulance.

The EMU, which was introduced in November 2013, had a proportion of beds on the ESSU. The purpose of the EMU was to assess patients referred by their GP who had a suspected emergency medical condition; once stable, patients could be discharged, admitted for a short stay or transferred to a specialist bed. However, we were told that the beds on the EMU had not been protected and were frequently filled with other medical patients. This impacted on the performance of the emergency department because the available beds had not been used for their intended purpose.

The trust had set up an internal urgent care board (UCB) with responsibility for overseeing key actions to improve patient flow through the hospital. Meetings were held weekly. We reviewed a sample of action notes and saw that there were different actions for specific work streams. These included actions to establish a surgical assessment unit; actions to improve the timeliness of patient assessments by the emergency department team as well as by different specialties; and plans to improve the protection of the number of EMU beds and to improve ward-based discharge arrangements, among other things.

The hospital did not have a separate paediatric emergency department. There had been a series of external visits to the hospital by the ECIST as well as by the NHS East of England Area team. The final outcome of these visits was the recommendation that a children's emergency department should be re-established because care of children had become fragmented due to the lack of a central unit. We were told that a proposal had been drafted and that it was planned that the paediatric emergency department would be re-established in July 2014.

We were told that patients attending the emergency department received a cold meal (usually cereal or a sandwich); this was because they were meant to be in the department for only a short period. We were told that patients did not receive hot meals even if they had been in the department for more than four hours. The patients we spoke to were satisfied that they had received sufficient nutrition and hydration during their visit to the emergency department.

Access to services

The emergency department was open 24 hours a day, seven days per week. We were told that the department never 'closed' its doors. If capacity was stretched, the trust would be placed on alert and the hospital's escalation policy would be followed.

When the hospital was close to capacity, the escalation policy was followed. Staff could observe current capacity using an online patient tracking system; this information was discussed at capacity meetings that were held twice a day routinely, and increased to three times per day as required. The level of concern regarding capacity was rated as green, amber, red or black, with black being the highest state of alert. Black alert was frequently reached.

We were told that patients could access an interpreter service if they were unable to communicate in English; we were also told that a number of staff were able to speak a second language. However, staff were not aware of an advocacy service if patients required an advocate. We were told by the lead for patients with learning disabilities that contact details of an advocacy service were available on the intranet.

Vulnerable patients and capacity

The emergency department did not have a specialist dementia nurse. We were told that the ESSU had one dementia champion who could be contacted when they were working a shift. One member of staff told us: "There is no dementia champion on the emergency department. We could call upstairs to the ward for support but we never have. I haven't completed any training on dementia; we ask the patient's next of kin for support."

Staff told us that if a patient with a learning disability attended the emergency department and they were unable to speak for themselves, the staff would talk to their carer or relative. Staff were unclear about how they would support or communicate with someone if they did not have a carer or relative with them. Staff were also unclear about how to arrange for an advocate for a

person. There was no mandatory training for staff on caring for people with a learning disability; however, the disability and equality lead adviser provided ad hoc training to wards or teams of staff if requested.

We spoke to the disability and equality lead adviser who told us that staff could access guidance on the intranet on caring for people with a disability and that this includes details of how to arrange an advocate. We were also told that a new strategy was being drafted to provide staff with guidance on how to care and support people with a disability; this was in the process of being finalised.

Staff told us that the crisis team would be contacted for adults with mental health needs and the CAMH team would be contacted for children with mental health needs who attended the emergency department. We were told that this did not always work well as the mental health teams did not always respond quickly, so patients frequently had to wait a long time for them to arrive.

The emergency department provided a service to a diverse population. We saw that there was signage in the department and patient information leaflets had been written in a number of different languages.

Leaving Hospital

The department failed to meet the target for unplanned re-attendance in the year to date being at least 1% above the national average in this category and year to date around 6.2% This meant that a higher than expected number of patients re-attended the emergency department within a given time frame, having previously been discharged.

The emergency department can access the GP notes through a clinical records viewer system. GP's are able to see patient results through an IT system known as ICE. We were told that a handwritten letter would be sent out to the GP if needed (if the patient required an urgent appointment, for example).

Learning from experiences, concerns and complaints

Patients attending the emergency department had a range of routes they could follow to provide feedback about the care and treatment they received.

All patients had the opportunity to complete the Friends and Family test; this asks questions about the level of satisfaction with the hospital experience. The results for the A&E department was significantly above the national average scoring 62 as opposed to the national average of 56. Patients could also make a formal complaint or contact the Patient Advice and Liaison Service (PALS) to provide feedback or for help in making a complaint.

We were told that complaints were responded to according to trust policy. The complaints-handling process was devolved to individual directorates for investigation of the complaint; this had caused a delay in response times. The matron for the emergency department maintained a log of all complaints and used this information to monitor trends and learn lessons. The department received between two and 10 complaints per month on average. The matron showed us an example of a complaint that had been responded to. We were also told that, depending on the severity of the complaint, the matron and/or lead nurse for the emergency department met with the complainant to discuss and address their concerns directly. One patient we spoke with told us that they had previously made a complaint and that they were satisfied with how this had been handled: a meeting with trust staff had been arranged, which they were pleased about.

Are accident and emergency services well-led?

Good

Vision, strategy and risks

Staff understood the trusts vision and values and were able to demonstrate these in their work. A risk register was maintained for the emergency department. High and significant risks fed into the directorate and trust-wide risk registers. Each risk had an owner as well as an executive lead. Risks were rated, monitored and reassessed each month, and each risk was linked to an action card. We saw that some of the high or significant risks for the emergency department had been reviewed in line with the date agreed; however, some of the medicine actions within the same document were overdue.

Quality, performance and problems

There was a clear structure for reporting lines at operational level within each of the units in the emergency department. We were told that the shift was always led by a band 7 nurse. Concerns could be reported

to the lead nurse for the emergency department and out of hours there was a site manager who could be contacted in the event of an emergency. In such cases, the duty manager would be called. A clear committee structure was in place, with each member having responsibilities relevant to their teams.

Staff were aware of the department's key targets, including the four-hour target, and told us about the importance of meeting this target, but that patient care must always come first. However audits were not being undertaken as planned, as guidance was awaited, and this meant that the department could not benchmark performance against others.

We saw that performance against target was monitored using a balanced scorecard. The scorecard specified targets and achievement against target each month or quarter. Achievement against target was colour-coded using red, amber and green.

Services for children had been reviewed and plans were in place to meet the national guidance available. However at the time of our inspection these were not in place and the services for children and young people were limited.

Leadership and culture

The department had a clearly defined structure and patient pathway. Staff told us that they felt well supported and were able to share concerns as they arose, through either whistleblowing or incident reporting.

We were told that there were fast-track pathways for some specialties. We reviewed a sample of patient notes and found that these had been followed. We were told by staff that inter-department working for obtaining a specialist opinion or a bed on a ward varied between the different wards and specialties. Data relating to reasons for breaching the four-hour target indicated that a significant percentage of breaches were due to lack of availability of beds as well as to waiting for specialist opinions.

The emergency department supported its staff following serious incidents and we were told that, where necessary, debrief sessions would be held with staff; we were told about a recent example of this. Lessons learned from incidents and complaints were discussed with the individuals concerned as well as being shared at the staff team briefing.

Team briefings took place and could be used to encourage and support staff and to boost morale when needed. We were told that patient accolades were also monitored and shared with staff.

Staff had access to formal counselling via occupational health if required.

Patient experiences and staff involvement and engagement

The staff we spoke with told us that they felt supported and listened to by management and that their line manager, the lead nurse and matron were all very approachable.

The trust had a policy called 'Raising concerns in a safe environment'; the staff we spoke with told us they were aware of the policy and felt confident in reporting concerns if they needed to. One member of staff told us how they had shared concerns in the past and that they were happy with how the information they had shared had been managed.

Patient feedback was sourced through a variety of mechanisms and the emergency department used the feedback to make changes. We were told that pain management on arrival into the department had featured as a concern for a small number of patients; as a result, the department had incorporated a medicines cabinet in the emergency department reception area. A qualified nurse worked on reception, which meant that patients treated for minor injuries could access pain relief promptly on arrival.

The noticeboard within the emergency department displayed details about recent performance against key indicators as well as details of recent action taken following patient feedback.

Learning, improvement, innovation and sustainability

Staff were given positive encouragement by management within the department, which promoted good team working. The number of accolades each month was recorded and also shared with staff individually. Staff briefings were also used as a forum to congratulate staff on achievements. We were shown an example of this: the December meeting recorded in the action notes a 'thank you' to everyone for achieving the four-hour target.

Requires improvement

Medical care (including older people's care)

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

Information about the service

Peterborough City Hospital's medical care service has 11 wards catering for the specialisms of cardiology, renal care, gastroenterology, general medicine, stroke care, respiratory care and care of the elderly and an isolation ward.. Linked to the hospital's accident and emergency service (A&E) is the emergency short-stay (ESS) ward, with 49 beds provided, and an ambulatory care unit (ACU), which has the capacity for up to 30 patients seen as day cases. The hospital had introduced an emergency medical unit (EMU) last autumn within the A&E department; this has the potential capacity of using up to 16 of the A&E or ESS beds when the EMU is operating effectively.

Overall, the hospital's medical care service has 307 beds. The bed occupancy for general and acute departments (including the medical care service) for the period from July to September 2013 was 90.7% across the 561 beds available. This is above the England average of 86.4%, indicating a higher than average demand on the beds available.

The cardiology care service saw 3,600 people as inpatients in the past year and also had 1,200 people seen as day cases in the same period. The cardiology service also provides diagnostic angiography, simple permanent pacing, transesophageal echo assessments and a full range of cardiac investigations. Rapid-access chest pain and heart failure clinics with one-stop diagnostics are held weekly.

The stroke care ward had 580 admissions in the past year. The stroke service provides a thrombolysis service using an in-house staff team during weekdays and a telemedicine service at night and weekends. High-risk transient ischaemic attack (TIA) patients are assessed within 24 hours. There is also a one-stop neurovascular clinic for low-risk TIA patients. Stroke follow-up clinics are provided with some nurse-led follow-up.

Care for older people is provided by two 29-bedded wards with one specialising in Parkinson's disease and the other in delirium/dementia. Outpatient clinics for falls, Parkinson's disease and general medicine are also provided.

The medical care service was last inspected in April 2013, as part of an overall hospital inspection, and the hospital was found to be non-compliant with regard to the care and welfare of people who use services and also for assessing and monitoring the quality of service provision.However at this inspection we found that documentation had improved and that the trust was now compliant in this area.

During our inspection, we visited 10 out of the 11 wards in the medical care service and spoke with 24 patients, 48 staff and four people visiting relatives. We also looked at the records of eight people.

Requires improvement

Medical care (including older people's care)

Summary of findings

We found that, while staff had effective handovers and access to the appropriate guidance available to care for people safely, a large proportion (40.7%) of safety incidents reported were from the medical care specialties. These incidents related to patient falls, pressure area care and infection control. Some staff and patients told us that they felt staffing levels were unsafe at night and at weekends and we saw that there were significant nursing vacancies in some ward areas.. However at our unannounced evening visit on 10 March 2014 we found there to be sufficient staffing on the three medical wards visited.

We found that targets set nationally and locally for patients were not always met. This included the transfer of patients to specific wards and effective discharge planning. The respiratory ward was not carrying out one national clinical audit (BTS emergency oxygen). National audits from the previous year were removed from the list for 2013/14. The stroke unit was under-resourced at consultant level. The cardiac unit did not have cardiologist cover during the weekend.

The interactions we observed between staff and patients were all positive and supportive and the staff responded to patients' needs, including for emotional support. Patients and visitors told us that staff were caring and kind at all times. However, we did see instances when staff were too busy to respond appropriately to calls for assistance and the call bell reports showed that over 20% of call bells were not responded to within five minutes. Ward managers monitored complaints and incidents and looked at themes; we saw evidence that actions had been put in place as required to address the areas of concern.

Governance arrangements were in place across the medical care service but not all clinical audits as recommend by the National Institute for Health and Care Excellence (NICE) were being carried out across all wards. Each ward followed trust wide processes for monitoring incidents and accidents and significant areas of risk were placed on the hospital's risk register.

Junior staff told us that there was a lack of effective change management and leadership and that key messages were not effectively cascaded down the organisation.

Requires improvement

Medical care (including older people's care)

Are medical care services safe?

Requires improvement

Safety and performance

For the period from December 2012 to November 2013, medical care specialties had the highest number of patient incidents: 123 incidents out of a total of 302 reported across the hospital (40.7%). These incidents related to patient falls, acquisition of pressure areas within 72 hours of admission and infection control issues. Pressure ulcers within 72 hours of admission are reported by the Trust but attributed to the community. We found a culture of reporting incidents across the medical wards.

Learning and improvement

We found that the hospital had protocols in place to monitor and assess risks to patients in the key areas of pressure ulcer care, catheter-acquired urinary tract infections, infectious diseases and falls with harm. We saw appropriate documentation on patients' files regarding the above and effective care plans in place.

The hospital recategorised the harm from falls to include all falls which resulted in injury in July 2013. This has led to a spike in reporting which shows the hospital as being above the national average. Whilst the trend is downwards it remains above the national average. We heard that there had been increase focus on fall prevention and saw that aids were in place to reduce the risk of harm from falls. A large proportion, over 50 % of rooms were single rooms which presented challenges for nursing staff to reduce the risk of falls. However the hospital raised the awareness of steps staff could undertake to reduce the risk of falls and this was clearly working on the medical wards.

We saw effective assessments of risks for venous thromboembolism on patients' files; 94.3% of these assessments had been completed against the target of 95%. Staff we spoke to were aware of the key risk areas for the hospital.

Systems, processes and practices

We saw effective handovers taking place to ensure that staff had appropriate guidance to manage the care of patients. We saw that incidents were recorded and reported effectively and that action plans to reduce risks were in place. There were effective infection control protocols in place. Staff told us that night staff cover was a concern at times and that sometimes they felt that staffing levels were unsafe. However at our unannounced visit on 10 March 2014 we found that there was appropriate staffing in the evening on the three wards we visited. Patients and visitors told us that the wards seemed short-staffed, especially at the weekends. Some wards had significant nurse vacancies and some staff reported that a high staff turnover affected staffing cover. Safeguarding training had been provided to staff and they were able to tell us of the procedures for reporting concerns. Medication systems were robust and secure, apart from one instance when there was no capacity assessment or care plan in place for self-administering of medication.

Monitoring safety and responding to risk

We found that staff were not using a low rise bed for one patient who had had a fall; such a bed had been used on previous wards as the patient had a history of falls. When we spoke to the relatives of the patient, they were concerned about why the low riser bed was not being used. The ward responded by providing a low rise bed but we found on the second day of the inspection that the falls risk assessment and care plan had not been updated to reflect the fall and the risks to the patient.

We found one person had not had their fluid and food intake charts and positional change charts updated for over four hours; the staff told us they had been very busy. This could have had an impact on the care and treatment of the patient as their records did not reflect their current status.

Staff showed appropriate understanding of the deprivation of liberty safeguards and in caring for people with reduced capacity to consent.

Anticipation and planning

Staff told us that each ward had an escalation procedure in place for staffing levels but that some wards were frequently on 'red' status as bank or agency staff were not always available. Staff could be brought in from other areas but staff told us that at times they were under pressure due to the lack of appropriate staffing levels.

Are medical care services effective?

(for example, treatment is effective)

Requires improvement

Medical care (including older people's care)

Requires improvement

Using evidence-based guidance

We found that the stroke ward's pathway for care and treatment were not in line with national guidance as occupational therapy and physiotherapy input did not meet national guidelines for the level of support patients required. Due to capacity and demand issues, patients were also frequently placed on other wards; however, they did receive medical reviews as required.

The trust participated in the Myocardial Ischaemia National Audit Project (MINAP) which showed that the trust was performing in line with other trusts apart from the number of referrals to angiography which was lower than expected. The trust are reviewing this issue with the cardiologists. The trust currently has no mortality outliers.

Performance, monitoring and improvement of outcomes

We found that only 65% of patients were transferred to the stroke ward within four hours. One patient and relative we spoke to said it had taken eight hours to be admitted to the stroke unit as there was a lack of available beds. Data to monitor the number of patients admitted to a stroke unit was seen to be achieving the targets set. In December the target was 80% and the trust achieved 89.4% of patients spending 90% of their time on a stroke unit.

We found that the respiratory unit was not carrying out clinical audits as per NICE guidelines for adult asthma, adult bronchiectasis, adult community-acquired pneumonia, emergency use of oxygen, and non-invasive ventilation. Staff were not able to tell us why these audits were not being carried out.The trust confirmed that national audits from the previous year were removed from the list for 2013/14. Other wards were carrying out effective clinical audits.

Staff, equipment and facilities

We found that the stroke ward was not meeting national guidance as there were only two consultants in post, as opposed to three. Also, for the cardiac wards, there was a lack of dedicated consultant cover at the weekends. There was an effective staff delegation of duties in place for each shift and wards used a RAG (red, amber, green) rating system for staffing cover emergencies. We found that access to CT scans for stroke patients was very efficient.

Staff on the medical wards told us that there was no consistent ownership of the four-hour transfer targets for patients from the emergency department, and that this had an impact on whether patients were appropriately cared for on the correct wards. We were told that one of the factors causing delays in transferring patients to appropriate wards was the cleaning of beds, which should take 30 minutes but frequently took an hour and a half due to the inclusion of an en suite bathroom.

Multidisciplinary working and support

We were told by staff that multidisciplinary working on the respiratory unit was not effective. The stroke ward had an effective system for multidisciplinary meetings and shared learning.

Are medical care services caring?

Requires improvement

Compassion, dignity and empathy

In the December 2013 NHS Family and Friends Test, ward A10 (gastroenterology) scored a 50 satisfaction rate compared with the trust average of 69. Ward B14 scored 39 and ward A9 scored 65. Both these wards were care of the elderly wards. On one ward, we observed one patient in distress calling out for over four minutes. Staff were within earshot but did not respond quickly to reassure the patient. From the records of call bell response times provided to us, we saw that for January 2014, five of the medical wards had significant delays in call bell response times, with all five having over 20% of calls not responded to within five minutes, which was the hospital's expected response time. Some patients we spoke to confirmed that they were kept waiting, especially at peak times in the day, for example during medication rounds.

Involvement in care and decision making

Patients we spoke to told us that they were involved in their care planning and were kept informed of what was happening. We saw from patient records that consent forms were signed and in place. We saw that there were effective procedures in place for assessing people's capacity and that patients' representatives were involved in decision making if the patient lacked capacity.

Requires improvement

Medical care (including older people's care)

Trust and communication

Most people told us that there was good communication with the staff and that they were kept informed of progress in treatment plans. However, two relatives said they found it difficult to speak to staff at times as staff members were very busy. Patients were complimentary about staff and appreciated the care and support they received.

Emotional support

The interactions we observed between staff and patients were all positive and supportive and that staff responded to patients' needs, including for emotional support. Patients and visitors told us that staff were caring and kind at all times. Patients on the stroke ward had appropriate access to a clinical psychologist.

Are medical care services responsive to people's needs?

(for example, to feedback?)

Requires improvement

Meeting people's needs

The capacity and demand issues in the emergency department impacted on the functioning of the ESS and ACU, which were used on a frequent basis for caring for the emergency department's patients. Staff told us there were pressures on the flow of patients from the emergency department and that frequently patients were not cared for on the correct wards.

We observed on one ward that a call bell was not responded to within 20 minutes. The patient we spoke to later said that they had experienced delays in call bell response times. However trust data shows that on average the call bells across the trust were responded to within five minutes. We found that some of the medical wards had response rates in excess of five minutes.

Vulnerable patients and capacity

The numbers of patients admitted with dementia were increasing and the trust highlighted patients with this condition on their electronic patient system so that all staff were aware that these patients required extra care. Two wards has special areas for patients who had dementia to sit in and this memory area was used to orientate people to their current environment. The hospital had a equalities and diversity lead who advised and supported staff caring for vulnerable patients. On our unannounced visit we saw care provided to one patient who had dementia. The care provided was seen to be sensitive and compassionate.

Access to services

Due to pressures in the emergency department, and to bed availability, not all patients were transferred to appropriate medical wards within the hospital's timescale of four hours.

Leaving hospital

Staff told us that effective discharge planning was not always in place and one patient told us that they were ready for discharge on a Friday but, as there was no senior medical cover on Saturday or Sunday, they remained in hospital over the weekend. We were told that 6.76% of bed days were lost due to delayed discharges of care against the hospital target of 5%. This was due to the challenges the hospital faced in discharging patients to a number of different counties and the lack of service provision. We were also told that cardiac rehabilitation in the community was fragmented, impacting on discharge planning.

Learning from experiences, concerns and complaints

We saw that complaints and incidents were regularly discussed within team meetings and that individual learning from complaints had taken place. Ward managers monitored complaints and incidents and looked at themes. We saw evidence that actions had been put in place as required to address the areas of concern raised within complaints. Most staff told us that complaints were responded to effectively, but not in all cases.

Are medical care services well-led?

Requires improvement

Vision, strategy and risks

The hospital had piloted an EMU in the autumn of 2013, but we found that this unit had not worked effectively for more than a few days at a time as there was an acute pressure for emergency department beds. The vision for the EMU was to provide effective care for patients to facilitate appropriate medical assessments, but staff told us of their frustration that there was not a coherent plan to ensure that this unit functioned effectively. Staff told us that physician support in the ACU was delayed at times.

Requires improvement

Medical care (including older people's care)

Staff told us that there appeared to be a lack of long-term planning and that issues were responded to reactively rather than proactively.

Governance arrangements

Governance arrangements were in place across the medical care service but not all clinical audits as recommend by NICE were being carried out across all wards. Each ward maintained its own system for monitoring incidents and accidents and significant areas of risk were placed on the hospital's risk register. These included five thoracic audits and one on Parkinson's disease

Leadership and culture

Junior staff told us that there was a lack of effective change management and leadership and that key messages were not effectively cascaded down the organisation. Some staff expressed concern about the pressure to constantly work extra shifts and that this was not always recognised by managers. Two staff told us they had no faith in the hospital's whistleblowing procedures as concerns would not be addressed.

We found that there was variable access to clinical supervision for nurses and that not all staff had had an annual appraisal. The departments appraisal rate was the lowest in the trust at 70%. Most staff did not receive regular supervision by their manager but they did say that there was effective informal support provided as required. We saw evidence that staff members' clinical competencies were assessed. We were told that regular team meetings took place on most wards.

Patient experiences, staff involvement and engagement

Some staff said that they did not feel confident in being able to voice concerns. We saw that appropriate systems were in place to record patient experiences and these were shared with staff. Senior staff considered that they were involved in the strategic direction of the hospital but not all junior staff felt that they could contribute meaningfully to this process.

Learning, improvement, innovation and sustainability

Management action plans were in place to highlight key areas for monitoring and review, and ward managers were able to inform us of the progress of these plans. However, not all junior staff were fully aware of the function of these plans.

Good

Surgery

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

Information about the service

The surgical division consists of three surgical wards, two trauma and orthopaedic wards, a 23-hour stay ward, a day treatment unit (DSU) and 18 operating theatres. There is a 12-bed post-operative recovery room and a separate two-bed recovery for children. The hospital provides a range of surgery including trauma, orthopaedic, ophthalmic, urology, gynaecology, vascular, colorectal, general surgery ENT and maxillary-facial surgery. The operating department uses one theatre for emergencies, one for trauma and two for obstetrics. The emergency and obstetric theatres provides a 24-hour service. There is a theatre team on site at all times and another that can be called into the hospital should it be required.

We visited eight surgical wards, including the trauma and orthopaedic (T&O) wards, the DSU and the operating theatres. We talked with 21 patients, two relatives and 32 staff, including nurses, healthcare assistants, operating department practitioners, doctors, consultants, support staff and senior managers. We observed care and treatment and looked at 11 care records. We received comments from people at our listening events, and from people who contacted us to tell us about their experiences. Before our inspection, we reviewed performance information from, and about, the trust.

Summary of findings

Services in the surgical department were generally safe for patients, although recruitment to vacant posts particularly in orthopaedics and theatre was proving to be challenging. Services were provided in a clean and hygienic environment in line with recognised guidance, which helped protect patients from the risk of infection, including hospital-acquired infections.

We saw staff who were caring; the patients we spoke with complimented staff on their caring approach and professionalism.

Shortages of beds resulted in some patients being admitted to an inappropriate environment, particularly in the planned surgery orthopaedic ward. Patients' operations were often cancelled or delayed due to lack of capacity. The operating theatre time available, due to cancelled elective surgery, was utilised by performing emergency surgery and thus minimising the need to attend to cases out of hours. Gaps in staffing were met using bank (overtime) and agency staff, but such staff were not always available. The trust has a recruitment programme; however, staff reported to us that there were delays recruiting and replacing staff.

Action plans were written as a result of reported incidents; however, there was no robust system in place to facilitate learning from incidents or complaints. We saw that appropriate equipment checks and maintenance were carried out. However, there was a lack of storage space throughout all the surgical wards.

Most of the staff we spoke with felt supported by their managers. A minority reported to us that they would be

Good

Surgery

afraid to raise concerns and they feared being victimised. However, most staff we spoke with said that they would challenge a senior member of staff for wrongdoing, either directly or via a senior colleague. Staff training and appraisals were carried out to ensure that staff were competent and had knowledge of best practice to effectively care for and treat patients. A clinical governance framework was also in place.

We found that staff were responsive to people's individual needs; however, staff told us that there were often delays in patients' discharge from the hospital.

Are surgery services safe?

Good

Safety and performance

Patient safety boards were displayed in the various surgical wards and in the operating department we visited. These showed the figures for the previous month relating to specific areas, such as the number of pressure ulcers and the number of falls. There was further quality information in the matron's scorecard, which showed equipment checks, staff training and compliance with recording and scoring of the Early Warning System (EWS). EWS is a method of identifying patients whose condition may be deteriorating. The National Early Warning System (NEWS) was being piloted in several areas in the hospital, including ward B5 (trauma). The ward staff had had adequate training on its introduction, and our inspection of the NEWS charts revealed that observation and escalation of care were documented appropriately. We saw that one patient had a deteriorating score and was referred appropriately to the medical team.

We observed good use of the paper-based system of surgical safety checklists in the operating theatres we visited. This included the use of the World Health Organization (WHO) surgical safety checklist, which is designed to prevent avoidable errors, for example the wrong site being operated on. We reviewed eight patient records specifically to review the completeness of the WHO checklist and noted that in all of the records the checklist was present in the files. We saw an audit that had been undertaken by the operating department team, which showed that compliance with completing the WHO checklist was more than 95%. This showed that adequate checks were undertaken to ensure that patients were safe within the operating department.

The hospital had reported one 'never event' (which is a nationally defined, largely preventable patient safety incident) in June 2013 since 2012.

Learning and improvement

Staff reported nearly a third of the trusts incidents on the NRLS system. of these 75% were in the "moderate harm" category. Staff we spoke with confirmed that they had access to the hospital's electronic incident-reporting system (Datix) and understood their responsibilities with

regard to reporting incidents. Senior staff were clear about any actions taken and learning outcomes implemented as a result of incidents. We spoke with three senior nursing staff who described meetings they attended, for example surgical governance meetings, where learning outcomes were discussed. However, this learning was not robustly cascaded down to the more junior members of staff. One member of staff told us: "I report something on Datix and it just goes into an abyss. I don't hear back." Staff we spoke with were unsure about any incidents that had taken place in their area or trust-wide or how any learning had arisen from them. We saw a log of incidents from the Datix incident-reporting system that showed actions had been taken. However, in only a small minority of them was it stated that staff should be informed to prevent future occurrences. None of the reports stated the way in which staff should be informed.

Systems, processes and practices

Equipment

We checked a range of equipment in the surgical wards and the operating theatre. All the equipment we saw had been checked and was signed as safe to use. We saw the checklists in the operating theatre that were undertaken prior to an operating list commencing, such as those relating to the anaesthetic equipment and specific equipment required to carry out the operation. We saw completed checklists for equipment that may have been required in an emergency, for example resuscitation and difficult intubation (inserting a tube into a patient's airway to assist breathing).

A review of the risk registers for general surgery, dated January 2014, identified that the plates securing the anaesthetic pendants were unstable. However, when we checked we found that this had been rectified in late 2013.

Environment

We found that all surgical wards had limited storage capacity, which meant that equipment was stored in corridors, making some of them appear cluttered. On some of the surgical wards, cupboards labelled 'equipment store' contained mostly stationery and some smaller equipment items, for example medical consumables. They also contained lockers, coats and bags, as staff used them to change in. Staff told us that there were changing facilities with showers and lockers; however, these were not situated on each floor. The operating department appeared to have enough storage space and had its own dedicated changing facilities, but these were insufficient for the numbers of staff that needed to use them. This meant that staff had inadequate changing facilities.

Most of the patients' accommodation comprised single rooms with en suite facilities. In addition, each ward had three, four bedded single-sex bays with their own toilet facilities. However, therapy staff reported to us that the large spaces in between the beds and toilets sometimes meant that patients were afraid to walk to the toilet alone in case they fell. They felt that this sometimes compromised patients' independence and mobility.

We heard patient call bells ringing on the surgical wards, but we observed that these were mostly answered promptly. Each ward had a receptionist who sat at the entrance to the ward. However, due to the ward geography, the receptionists were quite separate from the nurses' station at the centre of the ward. The phone on the nurses' station rang loudly and almost continually on all the surgical wards we visited. We observed non-nursing staff sitting or standing beside the phone, but not answering it.

Infection prevention and control

The hospital was clean. Infection rates (April–November 2013) were similar to those of other trusts for methicillin-resistant Staphylococcus aureus (MRSA) and Clostridium difficile. We observed that staff were using protective equipment and clothing, such as aprons and gloves. Hand hygiene gel dispensers were available at the entrances to surgical wards and units, and staff were observed using these. None of the gel dispensers we tested were empty. We noted that all the clinical staff we saw were adhering to the trust's 'bare below the elbow' policy and were wearing minimal jewellery. There were regular hand hygiene and infection control audits across the surgical areas. The results were discussed at staff meetings and displayed on the matron's scorecard and showed good practice. Staff were able to describe to us the 'five moments of hand hygiene'. This is a method of ensuring that hand hygiene is practised at key moments to minimise hospital-acquired infections.

All elective patients who attended the pre-operative assessment area before their operation, other than those undergoing an ophthalmic procedure or endoscopy, were screened for MRSA. This meant that a patient could be given appropriate treatment if their MRSA screening was

found to be positive. B7, the elective orthopaedic ward, did not accept any patients unless they were proven to be clear of MRSA. This was to protect patients who had undergone joint surgery from a preventable infection.

Patient records

We reviewed 11 patient records across six wards and in the operating theatre. We noted that appropriate assessments had been completed accurately, such as venous thromboembolism (VTE) risk assessments, pressure ulcer risk assessments, and nutrition and fluid assessments. The surgical wards had a system of auditing the notes to ensure that they were being completed accurately. A dietician told us that following an audit of the nutrition assessments in 2013, the dietetic department had amended the assessment tool to make it more user friendly for the nursing staff, who were mainly responsible for completing the assessments. This had resulted in greater compliance with completion. On most wards, patients' nursing records were kept at the bedside. Medical notes were stored securely in lockable trolleys.

Monitoring safety and responding to risk

Staffing

We reviewed the staffing establishment of the ward areas we visited and noted that for all the surgical wards the staffing establishment was the same. The hospital had a significant problem with capacity that meant the wards were almost always full. However, there was no flexing of staff to reflect patients' dependency other than to request a "special" for a particular patient. This meant that if the wards had a number of dependent patients, staffing was not adjusted to suit patients' needs. One ward sister told us that if they needed a 'special' – that is, a nurse to care for a patient on a one-to-one basis – this had to be approved by a senior manager. Most of the staff we spoke with were concerned about the lack of staff. They reported that often bank staff (those who worked flexibly) or staff from an approved agency were not available. We saw one ward sister still trying to find a member of staff for a night shift at 4 pm, after trying for several hours.

Several staff told us that the approval process to replace a member of staff who was leaving took too long. They said: "It often takes at least six months to replace a member of staff. I put in a request to replace a member of staff six weeks ago; it has only just been approved, which means no advertising of the role has been done. The old member of staff left a month ago and I have no idea when they will be replaced. It's so frustrating and impacts on our patients." A patient said: "Everyone is really sweet and kind, but the nurses are rushed off their feet, poor things." We spoke to the human resources department who told us that vacancies were discussed on a weekly basis and authorised. A rolling advert for staff was placed in current publications. The impact of this system was not currently being felt by the ward staff.

On B5, the trauma ward, the senior nurse on duty told us that there were three registered nurses and a healthcare assistant on duty during our inspection. However the off duty reflects that there were five registered nurses and four healthcare assistants on duty. We did not see this amount of staff on duty.The previous night there had been only two registered nurses and two healthcare assistants on duty. There were 29 patients and frequent admissions to the ward and transfers to others. It was clear that the staff were overstretched and that this impacted upon care. One nurse told us that they struggled to meet minimum staffing levels, particularly if there was staff sickness. Often, temporary nurses from the bank or agency nurses were not available. The same nurse told us that they were concerned about how gaps were going to be filled as there was a plan to withdraw nurses who were seconded from the armed forces. The planned withdrawal was due to take place during the summer of 2014.

There were a number of specialist nurses across the surgical division; these included a colorectal nurse consultant, two stoma nurses and breast care specialist nurses. However, although they supported the work of the ward nurses, it was not within their remit to fill any gaps in ward staffing.

The trust scored average in the national staff satisfaction survey for key finding one (% feeling satisfied with the quality of work and patient care they are able to deliver). We spoke to staff who told us that the shortages of staff meant that they could not give the care they wanted to.

Safeguarding

Nursing staff we spoke with were able to show us a good understanding and awareness of the trust's safeguarding systems and processes, and how they would report any concerns. This information was then shared with the rest of the staff on the particular ward. Patients and relatives told us that they felt safe in the trust. Staff on the surgical wards and in operating theatres told us they understood the requirements of the Mental Capacity Act 2005 to ensure

that treatment was provided in the patient's best interests. We were told that any decisions would be made with the input of people who could speak on behalf of the patient if the patient did not have capacity to make their own decision. We also found Mental Capacity Act checklists in patients' records that had been completed appropriately, and action taken to ensure decisions were made in the patients' best interests.

The hospital had a system in place to identify and escalate identified risks to the appropriate surgical risk register. Main risks identified within surgery included vacancies in the operating department and cancellation of surgery due to lack of beds, which led to breaches of waiting times. The year to date percentage of cancelled operations was 1.4% which was above the trusts target of 1%.

Anticipation and planning

At the time of our inspection, the operating theatre had 29 band 5 vacancies. This was above the trusts average vacancy rate of 10% at 15%. The hospital had a number of staff seconded from the armed forces which they had recently been told would be redeployed; further concerns were raised because these staff were all due to leave in the summer. The hospital had a plan in place to recruit to cover the shortages presented by the military staffs' departure.

One ward sister told us that her three experienced military nurses were being replaced by three newly qualified nurses who would need support. One patient told us: "The staff are so dedicated and wonderful, but there is not enough staff."

Are surgery services effective?

(for example, treatment is effective)

Good

Using evidence-based guidance

National clinical audits were completed, such as the fractured neck of femur audit (latest data was from October 2013) and national bowel cancer audit. Information on patient-reported outcome measures (PROMs) was gathered from patients who had had groin hernia surgery, vascular surgery, or a hip or knee replacement. All audits demonstrated that there was no evidence of increased risk, compared with national data, for patients treated within the hospital. The hospital performed better than expected for two questions in the audit of falls and bone health in older people relating to surgery.

We saw that the trust had implemented a clear pathway for all patients admitted with a fractured neck of femur. This service was led and delivered by consultants, which meant that an experienced surgeon was operating on all patients who had been admitted with this type of fracture.

There were care bundles in place for patients who required catheter or intravenous cannula insertion. This meant that patients received evidence-based care.

A staff member was able to describe the pathway for emergency surgical admissions from the A&E department, which allowed for continuity of care from the surgical team into the surgical wards. Due to the pressures in the emergency department, medical 'outliers' were often admitted to surgical wards. During our inspection, we noted that there were medical outliers in all the surgical wards; some had up to 11 medical patients. However, there was a physician allocated to the surgical wards from Monday to Friday to ensure that medical patients outlying on surgical wards were seen and reviewed so that their medical treatment could continue. At the weekends, there was a physician available to review medical patients if this was required. One member of staff told us: "It is frustrating because it means our surgical patients get cancelled and there is a continuous tide of patients moving around the hospital. On the upside, though, we have got really good at looking after people who are at risk of pressure ulcers."

Performance, monitoring and improvement of outcomes

Patient mortality

Surgical specialty groups met regularly to monitor mortality rates and actions taken to address any issues that arose. Written notes of meetings confirmed this. Mortality rates relating to fractured neck of femur in 2012/13 were lower (i.e.better) than expected. The specific hospital standardised mortality ratio (HSMR) is an indicator of the quality of care and compares deaths in hospital for specific conditions and procedures. The trust's overall HSMR was within the expected range, and was consistent with the previous year.

Pain management

Patient records showed that pain scores were calculated and pain relief provided appropriately to patients; this included the use of patient-controlled analgesia (PCA). Staff we spoke with confirmed that they had received training in PCA. Another told us about some recent training they had had with regards to caring for patients who had an epidural infusion to relieve pain after surgery. One patient told us that they were offered pain relief regularly on the trauma ward, B5, and were kept comfortable. There was a pain team that was available from Monday to Friday. This team routinely visited all patients who had been prescribed epidurals or PCA. Nursing staff we spoke with told us that the pain management team was available to review any patients with analgesia problems, when requested. This meant that patients who required pain relief or who had complex requirements to control their pain were seen and reviewed by a specialist team.

Consent to treatment

Clinical staff were able to give a detailed account of the consenting process and the people who were involved in it. This included doing a further check before an operation that valid consent had been obtained. This was finally checked on the WHO checklist prior to surgery commencing. One patient showed us an information leaflet they had been given prior to their operation which explained the consent process. They told us that they had signed their consent form in the outpatients department, which gave them time to consider what they had been told. During our review of 11 records, we noted that consent forms had been completed appropriately.

Staff, equipment and facilities

Ward sisters we spoke with explained to us that mandatory training was provided to ward staff and that this information was recorded centrally. This was confirmed by staff. However, most ward sisters kept their own records so that they could keep track of training for their own team; they found this to be more accurate. They told us about informal training that was carried out by the specialist nurses, for example the stoma nurse.

All the staff we spoke with confirmed that they had received an appraisal within the last year, which gave them the opportunity to discuss their work performance and career aspirations with their manager.

A new member of staff described their induction, which was both hospital-wide and locally in their department. They told us that the trust induction covered topics including health and safety and fire awareness. They went on to tell us that their local departmental induction had been very beneficial and also provided information about what the expectations were within their role. They described the good relationship they had with their mentor, who they said had been helpful and supportive.

Staff on wards and in theatres told us about their experiences of training and training availability. Most clinical nursing staff told us they had time to do mandatory training and had been given an e-learning account that they could access at work during less busy periods. Some told us that it was difficult to get the time to do their e-learning. Some told us that the e-learning system had not been working for several weeks and had been replaced with 'drop-in' sessions. Most staff told us that they had completed mandatory training. Ward managers told us they could access the e-learning account and analyse staff training records to ensure that the required training was being completed. We heard evidence from senior staff that monthly teaching for band 6 and 7 staff was being provided to improve management skills. One member of staff told us: "I found it really good, but I have noticed it has not changed the behaviour of some who have undergone the same training." There was some access to training from external sources, but some staff told us that this was funded by the staff member and not the hospital.

Staff who had worked in the day unit were competent to undertake minor operations only. However, in an effort to ensure that they increased their skills, we saw a training and competency package that was being undertaken by these staff.

Doctors were able to undertake regional training away from the hospital; however, some doctors' feedback, received prior to our inspection, indicated that supervision and training were poor. However, junior doctors on site rated their supervision as good.

Multidisciplinary working and support

During our observations on the ward, we noted that there was an effective system in place to discuss a patient's care and treatment, and that this included consultants, doctors and nurses and integrated multidisciplinary ward rounds. Each ward had a large wipeable board, which displayed admission date, expected discharge date, when risk assessments were due and if tests had been ordered. There were symbols displayed, for example if people had

dementia or were at risk of falling, thus highlighting patients at risk and ensuring that all staff were aware of the ward safety status. Although these boards were at a central point in each ward, the patients' names were covered to maintain confidentiality.

We also saw handovers, many of which involved the multidisciplinary team. Some involved discussion at the patient's bedside, which ensured that patients were involved when their care and treatment were being discussed and handed over to the next shift. On some wards, we saw that additional handovers were carried out at the ward board.

For those patients who were admitted to the trust for elective surgery, we saw documented evidence of pre-operative information to ensure that patient care and treatment were consistent.

We found evidence of multidisciplinary working in all areas we inspected. We saw records of patients admitted for surgery that demonstrated multidisciplinary team input.

Are surgery services caring?

Good

During our time spent on the surgical wards, we observed positive interactions and caring behaviours between staff members and patients. Patients were complimentary about the level of care they had received. Each ward had a system of 'intentional rounding', where patients' requirements were checked and care needs delivered. The records of these were audited by the ward sisters to ensure that patients were seen and assessed regularly by the nursing staff. However, patients observed that staff were always busy. One told us: "I don't want to trouble them." Another said: "They are really nice but often seem too busy to chat."

On ward B5, we saw one patient who had broken their arm and was unable to cut up their food. The uneaten food was taken away. The same patient had not had anything to eat for 20 hours as their surgery for a fractured arm had been delayed twice.

We heard patient call bells ringing on the surgical wards, but we observed that these were answered promptly. Each ward had a receptionist who sat at the entrance of the ward. The phone on the nurses' station rang loudly and almost continually on all the surgical wards we visited. We observed non-nursing staff sitting or standing beside the phone, but not answering it.

Involvement in care

Patients told us that they felt involved in decision making relating to their treatment. One patient, on B7, told us that their treatment was explained to them when they had to have emergency surgery. Another, on A4, told us that they had been in and out of the hospital since June 2013 and had experienced care in a number of wards and departments. They told us: "Everything is always explained. Even though I have had the same sort of procedure several times, they still go over it." They went on to explain that they trusted and had confidence in the doctors and nurses. However, another patient on B5 told us that, although the staff were excellent, nothing had been explained about their emergency procedure and they did not know when they were going to have their operation.

We saw in some wards that the name of the nurse who was allocated to care for a patient on that particular day was written on a board above the patient's bed, along with their consultant's name. This meant that everyone who interacted with the patient knew who was caring for them on that day.

Pre-operative assessments included a capacity assessment and took into account patients' and relatives' views. Where mental capacity was a risk, pre-assessment information included the contact details for the multidisciplinary team. We spoke with the disability adviser who told us that they provided advice for the staff on capacity and supported patients who required advice on entitlements, for example Disability Living Allowance.

Trust and respect

We found evidence that feedback from patients was actively sought. All staff we spoke with were fully aware of gaining feedback from patients. Forms were available and obvious at receptionists' desks, along with a box to collect them in. Part of the matron's scorecard involved positive feedback gained from patients' views. Patients we spoke with knew how to make a complaint and had been given information in pre-admission documentation. One told us: "If I wasn't happy, I would ask to speak to whoever was in charge." This was supported by the NHS Friends and Family test which showed that people would recommend these wards to their families and friends.

Good

Surgery

Emotional support

We spoke to 14 patients and one relative who all thought that staff were very caring and responsive to their needs. Patients told us that they were kept informed about their care and treatment and, in the main, they were involved in making decisions. The families of patients also felt well informed about their relatives' treatment and were updated when they visited the wards.

Are surgery services responsive to people's needs?

(for example, to feedback?)

Good

Meeting people's needs

The hospital was just below the national 18-week maximum referral to treatment (RTT) waiting standards at 88% instead of 90%; however, it did meet the 52-week RTT for patients to have planned surgery and the target for patients to receive an operation within 28 days following cancellation.

The Department of Health monitors the number of elective surgery cancellations; this is an indication of the management, efficiency and quality of care. The trust is performing in line with the statistical average for cancelled operations. Cancellations were mostly due to ward bed spaces being unavailable. We spoke with one patient who was waiting for orthopaedic surgery on one of the days of our inspection. They told us that their surgery had been cancelled three times since mid-December 2013.

We discussed cancellations with clinical, medical and surgical staff and were informed that elective surgery was often cancelled on the day due to pressure of beds and staffing. We were told that this was a regular occurrence and that, on occasion, whole lists were cancelled and then had to be rescheduled.

In the operating department, we saw data demonstrating that 40% of operating lists started late and 20% finished early. However, some of this time was utilised to provide operating time for emergencies. This meant that emergency operating lists were available during normal working hours. However the cancellation rate was marginally above the national average at 1.4% instead of 1%.

All patients who were to undergo planned surgery were seen by the nurse-led pre-operative assessment department. Patients undergoing breast surgery were seen in a separate pre-assessment clinic in the breast unit. We spoke with one patient on A3 who said they appreciated the opportunity to ask questions and have their fears allayed.

In addition to pre-assessment, the orthopaedic department held a 'joint school' where people who were to undergo knee and hip replacements had the opportunity to attend a class to learn about what was going to happen to them. They also met with a physiotherapist, occupational therapist, pain specialist nurse, ward nurse and other patients who were to undergo similar surgery.

Access to services

We tracked a patient's pathway when they were admitted as an emergency and noted that within the records the EWS demonstrated that the ward staff had acted in accordance with the policy to review the patient quickly. We saw on ward A2, in another patient's records, that it appeared that the correct procedure had not been followed when the EWS was triggered. There was no evidence that a review of the patient had taken place in either the nursing or the medical notes. Other patient records we looked at showed that the early warning charts had been completed accurately. NEWS was being rolled out gradually to the whole hospital, and some wards were already using NEWS to detect a deteriorating patient.

Nursing staff were able to show us information about advocacy services that were available to patients, and they explained that they would also direct patients and relatives to the Patient Advice and Liaison Service (PALS) if they needed any further information.

Staff reported to us that it was often difficult to get food from the outsourced food providers after 7 pm. There was no facility to make snacks on the wards. This meant that access to meals or snacks was difficult.

The trust had a multi-faith chaplaincy service that could be accessed by patients, relatives and staff members.

Vulnerable patients and capacity

Staff we spoke with were aware of their role in identifying vulnerable patients and how to raise a concern.

Good

Surgery

Nursing staff were able to show us information about advocacy services that were available to patients, and they explained that they would also direct patients and relatives to the PALS if they needed any further information.

Leaving hospital

Nursing and therapy staff reported to us that it was often difficult to arrange discharge back into the community when the patient needed support. Because of its location, the trust admitted patients from five local authorities, all of which had different arrangements in place for community support. Therapists reported to us that they often spent a disproportionate amount of time arranging complex discharges. One told us that they had estimated that they spent one day out of every 10 on the telephone arranging discharges. They reported that processes were disjointed, which caused further delays. This caused some frustration among the therapists as it limited the contact time they spent with patients delivering therapy.

We were informed by hospital staff that delays in discharge were often due to the unavailability of out-of-hospital care provision or social services support. A delay in out-of-hospital care provision had a particular impact on patients who needed rehabilitation support.

Learning from experiences, concerns and complaints

Staff we spoke with explained that patient and relative feedback, particularly around complaints and concerns, was encouraged; we saw documented evidence of this. There was evidence in the notes of some ward meetings that there was learning from complaints received. However, other wards did not have such a robust system in place. Every member of staff we spoke with told us that they would try to deal with the complaint themselves first but knew who to refer to should they need support. One told us: "It's always best to say sorry and try and nip it in the bud." However, we found that generally there was no robust system in place to learn from complaints.

Are surgery services well-led?

Good

Leadership and vision

Some nursing staff told us that they were confident in raising concerns with their direct line manager, or with a medical staff member if the issue concerned a patient. Generally, staff told us they felt supported by their senior staff. One told us they hadn't seen their matron on the ward for weeks before we arrived to carry out our inspection, but most informed us that matrons visited the wards on a daily basis. Furthermore, they told us that the consultants were mostly very approachable.

One ward sister told us they felt able to raise a concern directly with a member of the board. They had been invited to the board member's office to discuss their concerns. Several staff told us about the 'Ask Peter' initiative on the hospital intranet, which we were shown. This was a direct email address for the trust's chief executive. The site showed recent questions that had been categorised, so that they could be referred to easily.

Most staff members we spoke with told us that they did not receive feedback from complaints or incidents that they had reported or that related to the area in which they worked. This meant that learning from complaints and incidents was not always effectively communicated by the management teams at ward level and above.

Leadership and culture

Most staff reported to us that they respected their managers and told us that they felt supported by them. They said that both the chief executive and the director of nursing were visible and accessible.

The operating department had a management structure in place. Many of the band 6 and 7 staff had attended a leadership course. We were told by some staff that there were plans to extend this to include band 5s.

All theatres were involved in the daily theatre briefing session, which occurred at 8.15 every morning. Every theatre sent a representative. Any issues for that and the previous day were discussed and this information was disseminated to all the theatre staff.

There was a monthly learning half day that all staff attended. This covered any new developments, mandatory training and other learning topics. This was evidenced by agendas and minutes.

Staff involvement and engagement

We spoke with three junior doctors who told us they felt well supported and were satisfied with the experience they

were getting. Although we did not attend a ward round during our inspection, the junior doctors told us that they were supervised by consultants who used ward rounds as teaching opportunities.

Learning, improvement, innovation and sustainability

We saw good evidence of team and multidisciplinary team working in most areas we inspected. Staff told us they learned from their colleagues in other disciplines. For example, one nurse told us they had learned from a physiotherapist, who had made her consider and change her practice with regards to assisting patients to move.

Good

Intensive/critical care

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

Information about the service

The critical care service at Peterborough City Hospital has 16 beds in the combined critical care unit (CCU), delivering care to patients assessed with level 2 and level 3 care needs. Patients may be admitted as an emergency from the emergency department or wards, or from theatre post-operatively when they require enhanced observation or treatment following planned major surgery.

The critical care team consists of consultant intensivists, critical care nurses, a matron, a lead nurse and physiotherapists who are skilled and experienced in managing and delivering the care required by critically ill patients.

A critical care outreach team operated 24 hours a day, seven days a week, and assisted with the care of critically ill patients who were on other wards across the hospital. The outreach team consists of a highly skilled senior nurse and a consultant intensivist during weekend working hours. The team aims to prevent further deterioration of ward patients and facilitate appropriate and timely admissions to the CCU.

We talked to two patients, five relatives and eight staff, including nurses, two consultants and a foundation year doctor. We observed care and treatment and looked at care records and we reviewed performance information about the trust.

Summary of findings

Critical care patients received safe, responsive and effective care services. The service was provided in a spacious and clean environment. Admissions to the unit were organised so that they were appropriate and took place without delay. We saw that people received care and treatment according to national guidelines. Consultant-led one-to-one nursing, or two-to-one nursing, was provided according to each patient's assessed level of need. The staffing ratio was planned so that it was sufficient to meet the needs of critical care patients. Staff training and appraisals were carried out to ensure that staff were competent, were aware of best practice, and were effective in caring for and treating patients. Care delivered within the unit and to patients on other wards by the outreach team was observed to be person-centred and compassionate. Patients were supported to make decisions about their care where possible, and relatives were included in their family member's care planning. There was an unacceptable level of delayed discharges from the CCU. There was effective leadership at all levels within the critical care service.

Good

Intensive/critical care

Are intensive/critical services safe?

Good

Safety in the Past

The CCU has participated in the ICNARC (Intensive Care National Audit and Research Centre) Case Mix Programme reporting system. The ICNARC report for April to June 2013 showed that people were safely discharged and there were no reported early discharges. This means that patients were discharged appropriately. The report identified that the care provided to over two-thirds of people admitted to the unit was unplanned and that almost a quarter was planned, after local surgery had been performed. We saw that the number of visits by the outreach team prior to admission to the unit, was greater than the number of unplanned admissions. This indicated that people had been identified for admission to the unit and their care had been planned and anticipated prior to surgery taking place.

The ICNARC report identified that there was only a low risk of an early death within four hours of admission, or of a death after seven days following admission to the CCU. The number of deaths occurring in Peterborough hospital wards after discharge from the unit was lower than for similar units. Deaths occurring on the unit were not an outlier and were within the mortality ratio of other NHS adult CCUs.

Patient Records

We reviewed three patient records that contained comprehensive information about patients' assessment and monitoring. We saw that communication with relatives had been recorded in one set of records and that patients' comments had been recorded in two sets of records. Staff told us that 'do not attempt cardio-pulmonary resuscitation' was considered when a patient was in very poor health.

Learning and improvement

The National Reporting and Learning System (NRLS) for July 2012 to June 2013 showed that the CCU had a minimal number of patient incidents.

Staff we spoke with were familiar with reporting any incident via the trust's electronic reporting system. We saw records held on the unit of these incidents and the minutes of meetings where they had been discussed at multidisciplinary team meetings. We noted that 'current risks' that had been identified at unit level were visibly available on a noticeboard as reminders for staff in the staff meeting room.

It was felt by staff that there was an open culture to quality and improvement and a positive attitude to auditing and monitoring the progress and activity of the service that was provided by the unit.

The unit had reviewed the recently published guidelines produced by the Intensive Care Society (ICS) that promote the delivery of quality in critical care settings. The unit had followed the guidelines and ensured that it had an on-site lead consultant intensivist, plus a consultant who also worked in the outreach team. A consultant was available on a 24-hour basis and did not deliver other services, as specified in the ICS guidelines. In addition, there was a supernumerary sister in charge, a dietician, a pharmacist and an appropriate rehabilitation therapist as part of the multidisciplinary team. In line with these guidelines, patients were admitted to the unit within four hours of a decision being made to admit them and were continually assessed for rehabilitation and in case they needed escalation to level 3 care.

The service was focused on safety. Each member of staff we spoke with confirmed that they knew how to report incidents using the trust's electronic incident-reporting system. We were shown evidence collected on the hospital's internal electronic data system that incidents were analysed by senior clinical staff and appropriate specialists recommended improvements. Staff told us that they received feedback from the incidents they reported, both individually and in ward meetings.

We also saw evidence on the same data system that staff recorded the number of beds in use, delays in discharging from beds, the incidence of level 2 or level 3 needs, and other significant data that was used internally to inform clinical managers about staffing trends and patterns of care.

Systems, processes and practices

We saw that there was sufficient equipment available to meet people's needs. A member of staff responsible for managing the equipment explained how they managed the stock of this equipment.

We saw that life support equipment had been regularly serviced in line with the manufacturer's instructions. All

portable electrical equipment was tested and marked with the next test date. An emergency resuscitation trolley contained all the equipment necessary to deal with a medical emergency. The contents of the trolley matched the details of contents shown on the checklist, which was checked daily. We saw the recorded daily checks that had been made.

On arrival at the CCU, we observed that all staff and visitors had the opportunity to use the hand hygiene gel that was located in several different and appropriate places throughout the unit. We noted the environment to be visibly clean. Regular audits and checks of planned cleaning confirmed that the unit was meeting the required standards for cleaning the environment and for cleaning and decontaminating equipment.

In 2013, the critical care team at Peterborough City Hospital shared a national award relating to healthcare-acquired infections (HAIs) for its work on and intervention in ventilator-associated pneumonia; this had reduced infection rates and saved the trust money.

The ICNARC report for 2013 showed that the rate of CCU-acquired infections in blood in people who received elective surgery or who required assisted ventilation was lower than 1%, which was below the national average. When measuring rates of unit-acquired methicillin-resistant Staphylococcus aureus (MRSA) and Clostridium difficile infections in 100 admissions and 1,000 patient days, the former was nil and the latter 1%.

Monitoring safety and responding to risk

When any child is treated in the CCU, an accompanying paediatric nurse remains with them throughout their planned short stay on the unit. The unit has a policy to immediately transfer children to another hospital should they require critical care services. To accomplish this safely they refer to the Children's Acute Transport Service (CATS), a specialist intensive paediatric retrieval service transport team serving around 50 hospitals in the North Thames, Essex, Hertfordshire, Bedfordshire and East Anglia region.

There were enough appropriately trained and qualified nursing staff and consultants to meet patients' needs. The staffing rosters showed evidence that a consistent number of staff were employed to enable the unit to be flexible in staffing levels according to patient numbers and level of need. We saw that the Royal College of Nursing (RCN) guidance for nurse staffing numbers was being applied.

The unit had a specific number of hospital bank staff to use and sometimes employed agency nursing staff; these were selected individually and their competencies vetted by the unit prior to them working there. This had ensured that the multi-professional team had a suitable skill mix at all times.

Staff were aware of the application of the Mental Capacity Act when a patient did not have capacity and when a mental capacity assessment should be completed.

Anticipation and planning

The CCU had a comprehensive business continuity plan that gave details about how patients' care would continue to be provided in an emergency situation, or when the unit's bed capacity was in danger of being overtaken by demand. So that the unit could respond to patients' needs, it had an agreed capacity arrangement with the local critical care network it belonged to, so that patients would be cared for. We also found that emergency battery back-up supplies were an integral part of the equipment used; this ensured that vital medicines and life support systems would continue in the event of an electrical power cut or a disruption to the supply of medical gases. This indicated that suitable contingency arrangements were in place.

The unit is part of a critical care network that extends across most of the eastern region. The nurse matron is an active member of the nurse meetings hosted by the network.

Are intensive/critical services effective? (for example, treatment is effective)

Good

Evidence-based guidance

Patients admitted to the CCU were agreed on a consultant-to-consultant referral arrangement or by the outreach nurse to the critical care consultant / trainee when time-critical. Patients were admitted to the unit within a four-hour timescale after it had been decided that they should receive critical care.

The unit held regular clinical governance meetings and had contributed to the national database for critical care.

According to the ICNARC report for April to June 2013, more than half the patients admitted to the unit were in need of

level 2 care and just under half of the people staying on the unit required level 3 care (the highest level of care available). Only a minimum number of people required level 1 care. This showed that the unit was functioning effectively and was responding to patients' needs.

We saw that the RCN guidance for nurse staffing levels and the National Competency Framework for Adult Critical Care were used to guide staffing levels and decide the mix of staffing within the CCU. The guidance that was followed had ensured that sufficient staff were employed. There was effective leadership within the unit and staff told us they felt well supported by their managers.

We saw that risk assessments relating to basic needs such as falls, medication errors, skin integrity and nutritional needs were in place.

Clinical management guidelines were reviewed and acted upon to ensure that patients' needs were met. There was effective leadership at all levels within the critical care service. It was felt by staff that there was an open culture to quality and improvement and a positive attitude to auditing and monitoring the progress and activity of the service that was provided by the unit.

Monitoring and improvement of outcomes

The effective CCU ensured that patients were admitted to the unit within the four-hour national guidelines and these admissions had been monitored. There was clear criteria for admission to the unit; staff were familiar with these and saw them as an effective way of delivering of outcomes for people. We saw that this guidance was adhered to when we observed two patients being assessed by a consultant intensivist and outreach nurse for admission to the unit.

We saw the monitoring the unit had carried out to show that delayed discharges were a significant factor the unit had to manage. When a patient's health had improved and they no longer required a critical care bed, a number of patients experienced a delay in discharge because no suitable bed could be found in the hospital. Although the bed management team was tasked with finding a suitable bed, this took longer than the four-hour discharge core standards timeframe.

Sufficient capacity

The CCU is a 16-bed unit for combined level 2 and level 3 critical care patients. However, we were informed that two of the beds that were located in a four-bed ward were sometimes used for patients with non-critical care needs. We were told that this arrangement could affect patients by compromising the privacy and dignity of a patient receiving critical care and who might be in an adjacent bed when relatives were visiting non-critical patients.

We were told by staff that the capacity planning for critically ill patients could potentially be compromised when a surge in admissions occurred.

The CCU is part of a network of CCUs in other NHS trusts that make collaborative arrangements to ensure that demand for critical care beds can be met should an emergency arise.

Multidisciplinary working and support

We saw good communication by staff working within the unit and with other colleagues in Peterborough City Hospital. We observed the outreach team working closely with staff in other wards. We observed wards contacting the CCU outreach team whenever they identified a patient who was likely to have deteriorating and critical care needs. We accompanied a critical care consultant and outreach nurse assessing patients on wards that had requested the support of the CCU.

We saw that other healthcare professionals were involved in patients' critical care plans. Physiotherapists, speech and language therapists, dieticians and pharmacists were involved in the multidisciplinary approach to ensure that patients benefited from an intensive care approach.

The CCU is part of a network of CCUs in other NHS trusts that make collaborative arrangements for sharing knowledge and good practice and to ensure that the regional demand for critical care can be met.

Staffing

We saw that the RCN guidance for nurse staffing levels and the National Competency Framework for Adult Critical Care were used to guide staffing levels and decide the mix of staffing within the CCU. We saw evidence that staffing level calculations were based on patients' needs. We were informed that the whole-time equivalent staff mix accounted for sickness, annual leave, shift overlaps and training and education. This meant that sufficient staff were employed.

Good

Intensive/critical care

Staff Training and Support

Staff training and appraisals were carried out to ensure that staff were competent, were aware of best practice and were effective in caring and treating patients.

Are intensive/critical services caring?

Good

Compassion, dignity and empathy

Care delivered within the unit and to patients on other wards by the outreach team was observed to be person-centred and compassionate. We saw that patients were treated with the utmost respect and dignity throughout their treatment. We saw that nurses were attentive and were always in very close proximity to patients and spoke to them after introducing themselves. We noted that curtains were used to ensure privacy and that patient dignity was maintained.

One patient who was visited by the outreach team on another ward said: "The doctor and nurse are very kind and understanding. They listened to me and gave me all the information I wanted to know about my treatment. They made me feel safe in here." We observed this interaction and saw that the patient was shown respect and was treated with compassion.

Five relatives we spoke with all told us they had been treated with consideration and kindness by nurses and consultants. They told us they had spoken to the consultants and had also been telephoned by them and by nursing staff to keep them informed about their family members' progress. They all agreed that the CCU was providing individual care and that the staff had been emotionally supportive to them. One relative said: "The staff here are excellent. I have nothing but praise for them."

Involvement in care

Patients were supported to make decisions about their care where possible, and relatives were included in their family member's care planning. Staff we spoke with explained how they expected patients to be able to make decisions about their care whenever possible and they supported patients in this process.

We observed one patient who was proactive in making decisions about their recovery and rehabilitation. Nursing staff were seen to interact in a manner that was unhurried and at a suitable pace for the patient to understand. This patient told us they had decided when they wanted to drink independently, how they planned to achieve this and how they had been helped to do this. They also told us that they had been kept informed by consultants during the daily ward round.

Relatives we spoke with told us they had been kept fully informed about their family members' care and treatment.

We were told by staff how patients were supported to make decisions about their care. This was corroborated when we spoke to two patients and when we observed nurse and consultants talking to patients. One patient told us what they had chosen to drink and how they wanted to be supported to do this. Another patient who was visited by a consultant was observed to give their consent to the treatment they were given and to the proposed plan of care. The same person also consented to the presence of a foundation doctor and to a CQC inspector. We saw that the patient was treated with the utmost respect and dignity throughout their treatment. They said: "The doctor and nurse are very kind and understanding. They gave me all the information I wanted to know about my treatment. I feel safe in here."

Emotional support

There are quiet rooms for the sole use of relatives to discuss sensitive issues in privacy. There is a spacious and comfortable overnight facility for up to four relatives, should any relative wish to stay overnight and be near their family member.

A chaplaincy service is available and open to any denomination. Ethnic minority differences and language had been considered, with access available to an interpretation service, should this be required.

Trust and communication

Throughout our visit we observed that patient confidentiality was maintained. Discussion between staff that took place at the patient's bedside was quiet and could not be overheard. Other discussions took place in side rooms or in the nurses' offices behind the nurses' stations so that they were not overheard.

Patient records showed that treatment notes and assessments were written in a way that was easy to read and legible and provided a clear picture of the care being provided and the care that was needed. Records were kept at patients' beds at all times and there was clear and

regular communication about each patient's progress in these records. Patients' physical observations and intervention given were noted on these records, which had been designed specifically for critical care on the unit.

Relatives we spoke with told us they were able to make comments to staff about any aspect of care and also had the opportunity to complete a comment card that was available on the unit.

Are intensive/critical services responsive to people's needs?

(for example, to feedback?)

Good

Meeting people's needs

Patient welfare needs were responded to in the regular hourly close monitoring of each patient; this was recorded in their medical notes. To ensure that 24-hour cover was provided, a consultant was available at all times. The critical care outreach team provided a response 24 hours a day, seven days a week to patients who were identified in other wards as potentially in need of critical care. The team assisted with the management of these patients in other wards when their physical health was identified as deteriorating, or if they were considered to be in need of critical care on admission.

We also determined that the length of stay in hospital that most people experienced prior to admission to the unit was one day. This meant that the unit was able to offer and had planned and provided a safe service based on the measured numbers and assessed needs of people who were being cared for by Peterborough City Hospital.

The CCU provided an outreach follow-up visit to patients who had been discharged to other wards within the hospital. This helps to prevent patients from being at risk of not receiving appropriate care in other wards and that they receive continuity of care where it is necessary.

Relatives we spoke with during our visit to the CCU told us they were satisfied with the care their family members had received. One relative said: "The care is fantastic. It is 100% excellent care."

Patient needs were met by a full complement of staff able to manage level 2 and level 3 critically ill patients to a capacity of 16. Staff had been identified as permanent and bank or extra staff available to work within the CCU. All staff were qualified in specialties suitable for ensuring the appropriate provision of care to critically ill patients. Extra staff were planned in advance to meet demands upon the service. In addition, suitably qualified and pre-arranged agency nursing staff were employed.

There were plans in place to meet patients' critical care needs in the event of the unit reaching capacity through an arrangement with the local critical care network that Peterborough City Hospital is part of.

Access to services

Access to a CCU bed was an available resource for patients considered suitable for critical care. There were no reported instances of a critical care bed not being available, or of surgery being cancelled for elective surgery patients who had been identified as requiring a critical care bed.

Vulnerable patients and capacity

When patients did not fully understand, or were not involved in, decisions about their care and treatment, those decisions were made in their best interests. In these instances, relatives were involved.

Leaving hospital

The majority of patients were discharged from CCU to other wards in Peterborough City Hospital. The CCU had monitored these discharges and had data to illustrate the frequent delays, i.e. discharge arrangements that took longer than the core standard of four hours due to delays in finding beds in other wards within the hospital. This had not impacted upon patient safety, or on the capacity arrangements for the unit. However, it meant that there was a real and a potential unexpected staffing resource incumbent upon the CCU because of these delayed discharges.

The ICNARC revealed that, while trends show that the numbers of people admitted to the unit have increased over the past two years, discharges for just over half of the people discharged from the unit had been delayed for non-clinical reasons for more than four hours. During the inspection visit we saw that one person had a delayed discharge of 48 hours, although this was delayed for clinical reasons when a transfer to another hospital was being arranged. While the unit has recorded, reported and

tracked every patient discharge, there was a hospital-wide bed occupancy rate of 86% between April and September 2013 and discharge is dependent upon bed availability and the bed planning service to identify alternative beds.

Are intensive/critical services well-led?

Good

Leadership vision, learning and culture

We saw evidence that the matron was visibly leading the unit. A senior clinician we spoke with had a good understanding of the performance of their department and had a sound knowledge of the analyses of the electronic data that supported this understanding. The senior clinician told us how they had a vision for the CCU to be an exemplary service.

All staff had been involved in monitoring the quality of the unit and staff we spoke with were willing to implement changes in order to make continuous improvements. Team meetings and multidisciplinary meetings ensured that staff were kept well informed and involved in change and that they could openly discuss the service and clinical care matters. Learning from incidents and complaints was displayed on notice boards within the unit.

Nursing staff informed us that the matron and the CCU consultants were very approachable and supportive. We were informed that the matron and consultant were open to suggestions for improvements and that there was a culture within the unit that encouraged improvement and an understanding of risks. We saw that there was an emphasis on continuous development and training for all staff and that specialisms were encouraged.

We saw that changes and initiatives that were trust-wide were communicated to staff via emails, team and multidisciplinary meetings, and on the staff noticeboard in the staff room. We saw that current risks had been identified and a team briefing newsletter was used to communicate news across the trust.

Learning, improvement, innovation and sustainability

Latest research and good practice in critical care were shared and accessed via the CCU computer system and were available to all staff. The CCU employed a research nurse and had recently participated in a multi-centre trial for protocol management in sepsis (Promise) and the Intensive Care Foundation's 'Breathe' trial of ventilation techniques.

We saw that handovers between staff were carried out once in a team meeting situation in a staff room and then a second time on a one-to-one nurse basis at the bedside of each patient. This ensured an emphasis on understanding and learning from changes in patients' health and treatment as well as on the best practice to follow. We observed this taking place and noted that it constituted a learning session for staff that could be sustained as a way to improve care.

We also observed teaching and learning taking place when an outreach consultant accompanied a senior nurse and a foundation year doctor when they were visiting and assessing patients in other wards in the hospital to decide whether identified patients were suitable for admission to the CCU. The nurse and the foundation year doctor told us they valued the support from a consultant and the multidisciplinary approach, as well as the opportunity to learn in a way that required them to take the lead and to participate in the decision-making process.

Good

Maternity and family planning

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

Information about the service

The Peterborough City Hospital maternity service delivers around 5,000 babies annually. The maternity unit is located within the Women and Children's Health Department and includes a delivery suite, women's inpatient ward, antenatal outpatients clinic, a midwife-led birthing unit and a transitional care unit. There is a neonatal intensive care unit (NICU) where babies who require additional support following birth are cared for this is reported under Children's services.

The service also provides community midwives who cared for women and their babies both antenatally and postnatally. A specialist team of community midwives had recently been introduced to support women to have their babies at home where this was appropriate.

During the inspection we visited all areas of the maternity service. We talked to 15 women and 17 staff, including midwives, consultants, senior managers and the clinical director. We observed care and looked at records relating to both patients and the running of the service.

Summary of findings

Women we spoke with were generally positive about their experiences. Each person said that they had been very well informed throughout their pregnancy and that staff had been attentive to their needs and demonstrated a caring attitude. There was, however, a small number of negative comments about how quickly staff responded to queries or questions people may have had. Staff we spoke with were positive about the running of the service and there were clear lines of responsibility.

We saw how the service identified, responded to and acted upon things that had gone wrong to ensure that the service remained safe.

Effective practices were in place and these were continually monitored and reviewed to ensure that the service met the needs of the women it cared for. The service was staffed in line with recommended ratios; however, concerns were raised about the level of staffing within the antenatal clinic.

While overall the service was well led, we found that there was confusion within the senior team about how and where the staff should report quality issues. Also, there was no clear strategy or vision for the maternity service. We found that the service had not analysed information to determine how it could improve the running of the available maternity helpline.

Good

Maternity and family planning

Are maternity and family planning services safe?

Good

Safety in the past

As part of this inspection, we reviewed data for the past 12 months. We found that in general the maternity service at this hospital performed within expectations for a service of this type and size. However, in 2012 the hospital itself had recognised an increase in the number of incidents that had been reported and an external review was commissioned. One review was carried out by the Royal College of Obstetricians and Gynaecologists (RCOG). We saw that actions following this review had been implemented and changes to the service were being monitored. This demonstrated that there were processes in place that allowed the service to recognise where it had problems and take action where appropriate so that it remained safe.

Learning and improvement

We reviewed the maternity services dashboard. This document detailed the safety goals towards which the service was working. For example, we saw that the service had set a goal in relation to the number of women who suffered a post-partum haemorrhage (excessive bleeding following birth) of more than 1 litre. We were able to see from the dashboard that this service had not been meeting its goal of fewer than 5% of women having such a complication. When we asked how this was being managed, we were provided with details of a review that had been undertaken. The report following this review set clear recommendations that we saw actioned. The dashboard demonstrated that a marginal improvement had been made over the following months. We noted that the service was continuing work to ensure that this safety goal could be achieved.

Following a severe harm incident we saw that key people within the service carried out a full review into why such an incident happened. We noted that actions for improvement were identified and these were then monitored through an action plan. We saw that where changes in practice or policy were identified, these were shared with staff as 'lessons learned'. On the delivery suite we saw a staff noticeboard with a specific section dedicated to sharing learning following adverse incidents or complaints. All staff spoken with told us that there were clear methods in place for them to find out about how things needed to be changed.

Systems, processes and practices

The layout of the maternity unit enabled staff to provide consistent care to the women using the service. The delivery suite had designated areas for women requiring triage, undergoing high-risk inductions and in labour, and a recovery room for women having undergone surgery. There was access from the delivery suite to the women's inpatient ward. We saw that there were designated areas on that ward that allowed antenatal and postnatal women to rest and be cared for separately. Bathroom and en suite facilities were available. However, many of the areas seen were very clinical and did not present a homely atmosphere in which to give birth.

All of the areas we visited were clean and well maintained. Hand gels were readily available and we saw staff adhering to infection control practices such as wearing aprons and gloves as appropriate. Equipment was clean and easily located. We saw that the equipment stored on the maternity inpatient ward was in a cupboard clearly labelled and indexed so that items could be located promptly when needed. We saw that resuscitation equipment was checked regularly. There was a separate area where medicines were stored. We noted that the door to the medication store was secured with a key-coded lock.

Staff we spoke with referred to policies and procedures that they had to adhere to. We saw that various clinical guidelines were in place, such as for the induction of labour. The maternity service at this hospital had achieved level 2 compliance with the NHS Litigation Authority's Maternity Clinical Risk Management Standards (CNST). This meant that the unit had demonstrated that there were appropriate policies and procedures in place to reduce risk and the policies were carried out in practice.

Monitoring safety and responding to risk

The service had implemented a system based on the National Patient Safety Agency's (NPSA's) Intrapartum Scorecard (a tool for monitoring and improving patient safety in maternity units). We saw that throughout the day both staffing and the number of women using the service were reviewed continually. This ensured that safe care could be provided to the women coming into this service.

Good

Maternity and family planning

The NHS Safety Thermometer was also used to measure, monitor and analyse any harm that may have come to patients so that areas of risk could be identified and dealt with. Other safety goals were reported through the maternity services dashboard, for example injuries during birth and unexpected admissions to the NICU. This report was reviewed on a monthly basis by senior members of the maternity team and this ensured that any increase in the number of safety incidents would be identified so action could be taken.

There were generally sufficient numbers of staff to meet the needs of women using this service. The midwife-to-birth ratio was in line with the RCOG's recommended ratio of 1:28. However, there had been a high level of sickness absence within the department over the previous months. We were told that bank staff were always used to cover any shortfalls in staffing. We spoke to a number of staff who confirmed that they undertook bank shifts when required. The majority of staff spoken with told us that they felt there were enough staff to meet the needs of women during and following labour.

The service had a named midwife for safeguarding who was available to advise on any potential safeguarding issues. Staff also received training on safeguarding. We saw that the service remained involved in any referrals made that resulted in case reviews and that feedback was provided to staff involved in these situations.

Anticipation and planning

We reviewed the business continuity plans in place for the service. We saw that clear instructions were in place for events such as there being a lack of equipment, a lack of staff or a lack of a service such as electricity in the unit.

During our discussions with staff we were told that annual emergency 'drills' were undertaken. These drills were described as a role play of a potential emergency situation. This demonstrated that staff kept skills up to date in order to deal with rare but potentially adverse incidents.

Are maternity and family planning services effective?

(for example, treatment is effective)

Good

This service was effective, working in line with nationally recognised standards.

Evidence-based guidance

The clinical guideline 'Routine Postnatal Care of Women and Babies' (NICE 2006) and the UK National Screening Committee both advocate a complete physical examination of the newborn after birth. We saw a specialist screening team available during our inspection that was screening babies for hearing impairments. We noted that bloodspot screening also took place as routine. We were told that paediatricians and NIPE-trained midwives undertook the physical examinations of newborn babies before they went home; this conformed to the NHS Newborn and Infant Physical Examination (NIPE) programme.

Women received care according to professional best practice clinical guidelines. For example, we saw that venous thromboembolism assessments were carried out in line with guidance issued by the National Institute for Health and Care Excellence (NICE).

Clinical audits were undertaken to ensure that NICE and other professional guidelines were implemented. The service had a monthly newsletter and various staff noticeboards where it informed staff about outcomes, recommendations and improvements to services.

Monitoring and improvement of outcomes

We were told about various projects being implemented in order to improve outcomes for women accessing the maternity service at this hospital. One of these was a pilot of the national maternity safety thermometer in partnership with NHS QUEST. The purpose of this pilot was to work with other NHS Maternity units to promote harm-free care.

Another project being implemented was the Human Factors Programme. This course was designed to look at how human behaviour impacted on avoidable harms in order to reduce safety incidents and provide a safer service.

Good

Maternity and family planning

The head of midwifery told us that in order to benchmark the service against others in the area, an East of England strategic network group had been set up. This group was made up of heads of midwifery from local trusts and the purpose was to look at developing an East of England maternity dashboard. This would help the trusts taking part in the group to look at what they did well, or not so well, compared with others and to allow learning across the organisations to take place.

Sufficient capacity

At the time of our inspection, there were 92 hours of consultant presence, per week, within the labour ward as well as a lead obstetric anaesthetist and a duty anaesthetist. The consultant presence was just short of the national guidelines set out in 'Safer Childbirth – minimum standards for the organisations and delivery of care in labour (October 2007)'. However, additional obstetricians had recently been recruited to increase the number of hours' presence within the service.

Concerns were raised with us that the numbers of staff within the antenatal clinic were not appropriate for the number of women seen. We were told that sometimes some women could not be spoken with following their appointments. On these occasions women were told to call the maternity helpline that was in place. We spent time in this clinic and saw that the staff working here were more rushed than in other areas seen.

At the end of 2013, there had been an increase in the number of times that the service had had to close due to capacity issues. We saw that a detailed review had been undertaken and that an escalation procedure had been put in place. During 2014, the number of times the unit had had to close had been significantly reduced. However, from our review of the service's business plan and discussions with staff, we found that this hospital was expecting an increase its birth rate from around 5,000 births a year to 6,000 by April 2016. We were told that, at the present time, the service would not be able to support this increase due to an insufficient number of postnatal beds. Although no decisions had been made at the time of our inspection, the clinical director stated that various options had been looked at. These included using part of another ward for additional beds to support an increased demand within the service.

Multidisciplinary working and support

Staff received appropriate training and development to enable them to deliver safe and effective care. Midwives maintained their own training and development portfolios. Newly qualified midwives had access to the a preceptorship course. Training records provided demonstrated that almost 100% of staff within this service were up to date with their mandatory training. The women we spoke with told us that they felt the staff were competent and caring.

Midwifery staff were supported in their regular supervision and annual appraisal by several staff supervisors in a ratio of one supervisor to 15 midwives, which was within the accepted range. The supervision process was separate from the management of the unit and enabled the midwives to have honest debriefing and reflection sessions about their professional practice.

Are maternity and family planning services caring?

Good

The staff within the maternity service were caring and attentive to each woman's individual needs.

Compassion, dignity and empathy

Women were enabled to maintain their privacy and dignity. While on the labour ward we noted that all doors and curtains were closed. In the maternity inpatient ward and transitional care unit we saw that there was a mixture of single rooms and four-bedded rooms. In each of the four-bedded areas we saw that curtains could be drawn when people required privacy.

We spoke with eight women who had stayed as inpatients and they all told us that staff had respected their dignity. One person told us: "The staff have been really understanding and you can tell they care, which is nice."

We observed the interactions of staff with their patients on a number of occasions. We found staff to be kind and attentive to people's needs. Staff were knowledgeable about each woman's individual circumstances and were able to answer questions and provide reassurance where necessary.

Good

Maternity and family planning

Involvement in care

All of the women we spoke with told us that they had been involved in their care and treatment plans and those of their newborn babies where this was required. All of the women spoken with had a handheld patient record that documented key decisions and information about their care. We were told that women had time to consult with their midwives so that queries and concerns could be addressed. One of the women spoken with had unexpectedly had to stay in hospital following the birth of her baby. She told us that the staff had been "fantastic" in keeping both her and her partner up to date and involved in the care of their baby. They were clear on the expectations of treatment and the length of time their baby needed to stay in hospital.

The hospital's website had an area dedicated to services offered within the maternity unit. There was comprehensive information about all aspects of care and what women could expect when they received their support and treatment at this hospital.

The maternity survey undertaken in 2013 shows that the hospital scored the same as other trusts on all questions.

Trust and respect

Debrief sessions were offered to women following the birth of their babies. These sessions were generally carried out by a midwife or supervisor of midwives, but, depending on the complexity of the issues, more senior staff could be involved. The purpose of these sessions was to talk women through any issues and give them a chance to ask questions about the care provided to them. We were told by the majority of staff spoken with that if anything was identified as being wrong in retrospect, there was an open and honest culture within the department and women would be contacted and offered a debrief.

During this inspection we did not see any confidential patient information on display. We were told that, to ensure confidentially, when handover was taking place on the labour ward any confidential information would be shared within the resource room.

While we received positive feedback about the way in which people were communicated with, we received negative feedback on a number of occasions about the timeliness of communication. One person told us that they had asked a question about their baby and it took several hours for staff to respond.

Emotional support

We were told about how the staff were able to provide emotional support to women using this service. For example, one person spoke in great detail about how the staff had been available to support them when they had been emotional due to their situation. They commented that the support was "wonderful" and that staff really understood their situation and were able to provide reassurance. They told us that the best thing about the service was how "friendly and approachable all the staff have been".

The matron of the service spoke in detail about the emotional support available to women when things went wrong in their pregnancies. There were dedicated bereavement suites within the unit and women would be offered the use of a counselling service.

Are maternity and family planning services responsive to people's needs?

(for example, to feedback?)

Good

The service was responsive to meet the needs of the people using this service.

Meeting people's needs

We spoke to a woman who had developed complications late in her pregnancy. We were told how this has been identified by the community midwife and a change to the woman's birth plan took immediate effect. This involved being referred straight to the labour ward for an induction of labour. This demonstrated that the service was able to identify changes to women's health and meet their needs.

The clinics undertaken within the antenatal clinic at the hospital were for women who had complicated or high-risk pregnancies. For example, we saw that following an abnormal ultrasound, a consultant paediatrician was in attendance to see a woman and her partner in conjunction with the obstetrician. We saw that the woman was told about potential impacts on her baby once born and a plan of care was agreed and documented in the woman's handheld record.

There were two dedicated obstetric theatres available for use, for planned and emergency surgery. These were

staffed by separate theatre staff with the support of a midwife. We were told that the use of beds on the inpatient ward and in the transitional care unit could be flexible to meet the demands of the service. For example, there were single rooms available that could be used for women who had had a traumatic birthing experience. We were told that the use of antenatal and postnatal beds could be determined based on the needs of the service.

Access to services

There were good access routes into this service. Women could refer themselves through the trust's website or a referral could be made via their GP. Women also had the use of a dedicated maternity helpline that was staffed by a midwife from Monday to Friday, 8 am to 8 pm and in the mornings at the weekend. Outside these times, calls were directed to the triage service based on the labour ward.

Vulnerable patients and capacity

We noted that there were several specialist midwives and pathways for people to access in order to meet the needs of different patients. One of these was the 'Rainbow' pathway; this was dedicated for teenage pregnancies and more vulnerable patients, such as those with mental health needs. Other specialisms included caring for women with drug and alcohol problems and HIV. Those patients who had diabetes received specialist care from an obstetrician. We noted that patients undergoing planned caesarean sections were seen the morning of their treatment so that informed consent could be obtained by the consultant obstetrician.

Leaving hospital

Discharge plans were discussed with women before they left hospital. We spoke to one women who was being discharged on the day of our inspection. She told us that she was clear about the arrangements made for her and had been given everything she needed, such as medication and information prior to leaving the hospital. However, care did not cease when women left this hospital. They were discharged back to the community midwife who provided additional support to women and their babies in the days following delivery.

During this inspection we found that the service was experiencing readmissions of a higher than expected number. However, we noted that work was being undertaken to understand trends or recurring themes in why these readmissions were taking place so that action could be taken to try to reduce the number of readmitted patients.

Learning from experiences, concerns and complaints

Women's experiences of care were used to improve the service through patient surveys, complaints and comments. For example, we saw that the service was using the Friends and Family test to monitor the quality of the service that it provided. We saw that, where negative comments had been received, an action plan was developed so that changes in practice could be implemented. Comments from the Patient Liaison and Advice Service (PALS) were also considered and acted upon where appropriate.

Are maternity and family planning services well-led?

Good

Vision, strategy and risks

We asked to review a maternity strategy but we were told that there was no strategy in place. This was queried with the clinical director for the service; they agreed. We were told that work was ongoing in relation to this and a number of external factors had hindered the development of the strategy. Outcomes were awaited from various sources before a strategy could be drawn up.

When we spoke to senior midwives as part of a focus group, we were told that the vision of the service was to provide 'woman-centred care'. However, none of the more junior staff spoken with could tell us what the vision for the service was, nor could two of the more senior members of staff we spoke with. We also found no reference to a vision in any of the documentation we reviewed.

All levels of staff we spoke with were able to confidently tell us about the current risks within the service. We saw that all these risks had been documented and were being monitored via the service's risk register. We saw that there were clear escalation plans in place so that when a risk was identified as being unmanageable within the service, this was escalated through the trust-wide risk management process.

Good

Maternity and family planning

Quality, performance and problems

The governance structure within the maternity service was not well understood by all those who had responsibilities within it. We were given conflicting information about how the service reported on various quality and risk issues. However, we found that there was a good level of governance within the service to ensure that systems and process worked effectively. For example, we saw that a monthly maternity clinical governance meeting took place and that this considered information from a number of subgroups that had particular areas of focus, such as audit or risk.

There was a variety of reports that were completed on a regular basis and that collated and looked at performance over time. We reviewed the last two 'Complaints, litigation claims, adverse events and PALS concerns' (CLEAP) reports and saw that issues relating to the maternity service had been reported. We also noted that lessons learned were identified and shared within this report. The maternity service dashboard also looked back at performance over time so that trends in the care provided could be identified.

We found that the service did not always take into account available information that could improve service delivery. For example, we found that no auditing or review had been undertaken of the maternity helpline. We were told that approximately 90 women per day called this service. There was no information available when we asked about the most common reasons why people used this service.

Leadership and culture

The maternity unit had a clinical director but other leadership structures were still under development. A new assistant clinical director had been in post for three weeks and the Head of Midwifery was due to come back to this role on a full-time basis after being on secondment. Despite the recent changes in the structure, staff spoken with had a good understanding of escalation routes and the responsibilities of senior staff. Staff were clear about when and to whom they needed to report incidents and were confident that they would be informed of outcomes as appropriate.

All staff spoken with described an open and honest culture within the maternity service. We were told that the staff team worked well together and appropriate support was received from senior managers.

Patient experiences and staff involvement and engagement

There was a variety of mechanisms in place to gain patient feedback. We saw that the Friends and Family test was implemented within all areas of the maternity service and that posters advertising for feedback were clearly on display. We were told of a new initiative that was being considered in order to engage with the public. The deputy head of midwifery told us about plans to initiate a 'community roadshow', with the intention of increasing user involvement by taking staff out into the community and to the patient rather than expecting people to come to the hospital.

Each year the hospital takes into account staff feedback by participating in the NHS Staff Survey. Results are collated and analysed and areas for improvement are identified. Annual staff awards are given and we were told about a new award that was being sponsored by an external organisation. This award was for a 'midwife of the year' and the winner would be voted for by women who had used the service.

Learning, improvement, innovation and sustainability

We heard about how the community services had been redesigned in order to meet the needs of women in the community. Previously there had been three community teams, but, in order to provide consistent care to women and allow them to see the same midwife on a regular basis, we were told that the number of teams had been increased to five.

We saw that the service was updating its IT system in order to support service sustainability and improvement. Gaps had been identified in the current system that could have had an impact on patient safety and on the way in which the service reported on national requirements. For example, the service relied heavily on paper records and with the existing IT system there was a lot of duplication and retrospective entries. The new system aimed to reduce the amount of paperwork, making up-to-date records available to all disciplines of staff, including community midwives, and to the patient.

Good

Services for Children & Young People

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

Information about the service

Services for children and young people at Peterborough City Hospital consist of one ward that has 28 beds plus two high dependency beds (Amazon), a paediatric assessment unit that has eight beds (Jungle) and a neonatal intensive care unit (NICU) that has two intensive care cots, four high dependency cots and 14 special care cots. There is also a separate children's and young people's outpatient department (Rainforest).

We visited all departments within children's and young people's services. We talked with seven relatives, one patient and 26 staff, including nurses, healthcare assistants, consultants, doctors, support staff and senior managers. We observed care and treatment. Before our inspection, we reviewed performance information from, and about, the trust.

Summary of findings

Children's and young people's services were provided in a clean and hygienic environment in line with recognised guidance, which helped protect patients from the risk of infection, including hospital-acquired infections.

Children's care and treatment followed best practice guidance and monthly audits were carried out regarding patient safety, patient experience and the environment.

Parents we spoke with told us that they felt that their child received good-quality care and that they were informed about any treatment required.

We found that staff were responsive to people's individual needs; however, staff were unaware of the trusts guidance for staff on the ward areas when they needed to make a decision concerning same-sex accommodation. There was also limited support from the child and adolescent mental health services out of hours.

There was leadership at all levels within children's and young people's services and staff felt well supported by their managers. A clinical governance framework was also in place.

Good

Services for Children & Young People

Are children's care services safe?

Good

Nursing and medical staff we spoke with were knowledgeable about common incidents reported and the actions that had been taken as a result of them. Nursing staff confirmed that lessons learned were discussed at ward meetings and during clinical supervision. Records we reviewed confirmed this. Medical staff also confirmed that lessons learned were discussed at the doctors' half-day learning session every month.

We had reviewed all the incidents reported on Datix (the trust's incident-reporting system) between 1 July 2013 and 31 December 2013. We saw that appropriate actions had been taken as a result of the incidents; actions included information being displayed to ensure that, when a patient went to theatre, they had the correct name on their name band, and additional training and reflective practice with junior doctors following prescribing errors.

Safety in the past

Patient safety information was displayed in the ward areas we visited. This showed the figures for specific areas, such as whether a child's care had been escalated if needed, and, where appropriate, if the child protection register had been checked. This demonstrated to all patients the safety of the ward.

We noted that the trust had had no serious incidents in the last 12 months for in general paediatrics. The last serious incident (in June 2011) had been fully investigated and an action plan implemented, and we saw that the majority of the identified areas for improvement had been addressed. This included an observation policy and auditing the paediatric escalation warning scores (PEWS) to ensure that staff were taking appropriate action.

We also saw that the trust had contributed to the investigations of seven serious case reviews that also involved neighbouring counties. This meant that the trust was able to learn and develop its own practices where needed.

Learning and improvement

Nursing and medical staff we spoke with were knowledgeable about the common incidents reported and the actions that had been taken as a result of them.

Nursing staff confirmed that lessons learnt were discussed at ward meetings and during clinical supervision. Records we reviewed confirmed this. Medical staff also confirmed that lessons learnt were discussed at the doctors half day learning session every month.

We had reviewed all the incidents reported on Datix (the trusts incident reporting system) between 01 July 2013 and 31 December 2013. We saw that appropriate actions had been taken as a result of the incidents, this included information displayed to ensure when a patient went to theatre they had the correct name on their name band and additional training and reflective practice with junior doctors for prescribing errors.

Systems, processes and practices

Infection control

Infection rates (April to December 2013) for children's and young people's services demonstrated that there had been no incidents of methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia or Clostridium difficile.

The trust carried out various infection control audits; these demonstrated that, since April 2013, the departments within children's and young people's services had achieved 100% compliance in hand hygiene, dress code and hand sanitising gel being available at the point of care. Our observations during the inspection visit confirmed this and that staff adhered to 'bare below the elbow' guidance in line with national good hygiene practice. We saw that the premises were visibly clean and that toys were in a good state of repair, washable and visibly clean.

Equipment

We saw that all items of equipment available in the departments had 'I am clean' stickers on them which were easily visible and documented the last date and time when they had been cleaned. This meant that staff could be assured that equipment they used was available and fit for purpose.

We checked the emergency equipment, including for resuscitation and medication, in all the departments within children's and young people's services and noted that equipment and medication were checked on a regular basis and equipment was fit for purpose.

Safeguarding

Nursing and medical staff we spoke with were knowledgeable about what actions they would take if they

had any safeguarding concerns and they were aware of the trust's safeguarding systems and processes. Safeguarding children training data showed that, for staff working within the family and public health clinical directorate, 88% of staff had received level 1 training, 85% had received level 2 training, 73% had received level 3 specialist training, and 73% of applicable staff had received level 3 core training. However, the senior management team highlighted that there was an ongoing issue with recording safeguarding children training and that this was on their risk register. Records we reviewed confirmed this.

Monitoring safety and responding to risk

The ward areas within children's and young people's services used the PEWS system to identify sick patients before they became too sick and to prevent them from needing to be admitted to a high dependency unit (HDU) or intensive therapy unit (ITU). We saw that PEWS was in use as appropriate and monitored throughout a patient's stay. Following a review into the trust's processes, the relevant form had recently been reviewed to ensure that it was in line with national wording.

Medical staff informed us that a consultant handover occurred twice a day to ensure that patient care and treatment were consistent.

Staffing levels

We reviewed the staffing establishment of the different areas we visited and noted that the funded staffing levels met the needs of the service in line with best practice guidance. Nursing staff we spoke with told us that they felt there were enough staff to meet the patients' needs. One ward manager informed us that due to staff vacancies they used bank staff to fill any shifts; however, the bank staff members used were those who were already employed by the ward. The vacancy rate int his department was lower than the trusts average at 8.6% rather than 10%.

We saw a red, amber and green (RAG) rating system in use for every shift and actions to take to ensure that staffing levels were not below the minimum standards. This meant that patients could be assured that there would be appropriate levels of staffing to meet their needs.

Anticipation and planning

The children's and young people's services had various business continuity plans in place. These included plans that related specifically to the service: for example, if the trust had low capacity for beds, what action would be taken if adults were admitted temporarily to Jungle? Staff were also aware of trust-wide business continuity plans, for example if there was no water supply or if the IT systems did not work. Staff we spoke with told us that they had received training for emergencies and knew how to access the plans if they needed to be put into action.

We were informed that cost improvement plans were also agreed for each financial year; however, the clinical director informed us that the cost improvement plans would not compromise patient safety or the care provided.

Are children's care services effective?
(for example, treatment is effective)

Good

Evidence-based guidance

Medical staff we spoke with told us that children's and young people's services participated in national and local audits and NICE guidance. National audit results demonstrated that the trust's performance was similar to that of other trusts, for example on the healthcare of children and young people with suspected epileptic seizures. Staff informed us that audit results were discussed at a specific audit meeting and also at junior doctors' learning events. We were told that a business plan was being written to develop the epilepsy service, specifically to provide an epilepsy nurse-specialist and psychologist support for the patients.

Data results for mortality rates demonstrated that the trust was not an outlier for children's and young people's services and we saw evidence that information published by Dr Foster was reviewed on a regular basis.

We found that there was no formal local guidance for paediatric surgery or anaesthetics in relation to the age of the child or young person. We were informed that the trust had a strong anaesthetic team that allowed for safe anaesthesia in small children. We were also told that it had been acknowledged that local guidance was not in place and that local policies were being written for anaesthetics for children and surgery for children; these would be approved by the children's board.

Monitoring and improvement of outcomes

We saw that a monthly audit was carried out by the matron of the clinical directorate for all areas within children's and

young people's services. The audits covered the areas of patient safety, the environment and patient experience. The audit results demonstrated that, from April 2013 to December 2013, all quality metrics for patient safety were achieved each month; these included compliance with fluid balance recording, hand hygiene and patient identification. The main area for improvement was the number of drug errors and/or prescribing errors. Staff informed us that junior doctors were asked to complete reflective learning as a result of the incidents.

Sufficient capacity

Medical and nursing staff we spoke with told us that they had received mandatory training and were able to take time from the ward to complete training. We were informed that the central database that recorded mandatory training was inaccurate and that accurate data was held locally at departmental level. Training data for Amazon ward demonstrated that there were various levels of compliance. The lowest attendance rates for training that had to be renewed were in health and safety (6%), awareness of the Mental Capacity Act and deprivation of liberty safeguards (30%) and diversity and human rights (43%). The highest attendance rates were for level 2 safeguarding children (91%), patient slips, trips and falls (93%), paediatric basic life support (95%) and level 1 safeguarding children (97%).

Multidisciplinary working and support

Medical staff informed us that a consultant-led handover occurred in the morning and in the evening. Any new patients who had been admitted to the ward area would be reviewed at the next available handover. This ensured that patient care and treatment were consistent.

One patient and their relative informed us that due to their condition they were required to go to Addenbrooke's Hospital for a scan; they confirmed that, whenever this was required, the transfer to Addenbrooke's Hospital and back to Peterborough City Hospital was always well organised. Staff also told us that a member of the play team would accompany a child to ease anxiety when they needed to go to another department, for example to have blood tests taken. This meant that the child was always supported effectively by appropriate staff members.

Two parents we spoke with informed us that their child had been admitted to the ward area after going to the accident and emergency department (A&E). They told us that they were happy with the transfer of care from A&E to the ward area.

Are children's care services caring?

Good

Compassion, dignity and empathy

We spoke with seven parents and one patient during our inspection. The majority of parents told us that they were very happy with the service they received from the children's and young people's services. One person told us that they were "very happy with the care and compassion of the staff".

We spoke with two administrative staff members who appeared to have a lack of understanding of different cultures. This meant that people's equality and diversity rights were not always understood.

Involvement in care

People we spoke with told us that they were involved in their relative's care as appropriate. One person told us that a doctor had explained the specific reasons why their child needed to take certain medication following their admission to the ward. Another person told us that they felt that they were not always told what the plan was; however, they felt that this was because the doctors were not sure (this specifically related to their child receiving a scan and when this would be).

Trust and respect

A patient we spoke with said that they felt staff "address me appropriately and keep me informed of my ongoing care".

All parents we spoke with told us that they felt the staff were caring. The majority of parents told us that staff showed them around the ward areas so they were familiar with the facilities available for parents. This included a separate kitchen, lounge area and access to a computer with internet facilities.

Emotional support

One person told us that visiting hours were between 8 am and 8 pm, which allowed their child's friends to visit in the evening.However parents could visit at any time and remain with their child should they wish to do so.

Staff members informed us that information was available on the ward areas for the chaplaincy services. The posters we saw on display confirmed this. Staff members told us

that the chaplain was available for support to the patient, the family and staff, if needed. We spoke with one of the chaplains who confirmed that they had a good working relationship with children's and young people's services.

Are children's care services responsive to people's needs?

(for example, to feedback?)

Requires improvement

Meeting people's needs

The environment of children's and young people's services was visibly clean, bright and child-friendly. We noted that ward areas were designed to respect the patient's privacy and dignity.

We were informed that there was no specific adolescent ward area. Staff members informed us that patients between the ages of 16 and 18 would be admitted to an adult ward unless there was capacity on Amazon ward. Patients with a long-term medical condition, for example diabetes, would be accommodated on Amazon ward if necessary.

We were unable to see any guidance to support staff when they needed to make decisions concerning same-sex accommodation in the children's and young people's services. However we were later advised that a policy did exist although staff could not provide this for us during the inspection. Staff we spoke with told us that decisions to move patients in the bays were made on an individual basis as and when required. However we could not be assured that decisions were made using a consistent approach or that the child's or young person's preference was sought in line with national guidance.

Access to services

Children could be referred to Jungle directly by their GP or by A&E. Once admitted to Jungle, the child would be reviewed by a paediatrician or registered children's nurse before being admitted to Amazon ward or being discharged home.

Interpretation services

Staff members in the Rainforest outpatients department explained to us how they accessed and used the translation service. They told us that this would be initially flagged at the referral stage and a translator would be booked for the appointment; this would be either with an interpreter who attended the appointment or by phone.

Vulnerable patients and capacity

Staff members confirmed that the child and adolescent mental health services (CAMHS) were not available out of hours.This service was provided by the local mental health trust. However, staff at Peterborough City Hospital had access to the crisis team if needed, although we were informed that the crisis team was at times hesitant about seeing a child or adolescent or about making a decision until the patient had been seen by CAMHS. We saw evidence that the CAMHS team supported and trained staff members in the ward areas and noted that a letter had been sent to the ward manager thanking them for a staff member's involvement in a young person's admission.

Leaving hospital

We were shown information that was provided to parents when their child was discharged from hospital. This included a business card with a direct telephone number for Amazon ward. The clinical director informed us that lengths of stay had been reduced and early discharges improved by implementing consultant cover for each week, with a consultant handover twice a day, seven days a week.

Learning from experiences, concerns and complaints

Parents we spoke with were aware of the process to raise a concern or make a formal complaint. We saw that information was clearly displayed for people who used the service and who wished to raise a concern or complaint.

Staff we spoke with told us that concerns and complaints were discussed at ward or department level and actions were taken as a result of them. We saw evidence of this displayed in the ward areas. Staff members were able to give us examples of learning from feedback from patients and their relatives. One comment had been that there was a lack of age-related toys in the Rainforest outpatients department; the department was working with the play team at the time of our inspection to rectify this.

Good

Services for Children & Young People

Are children's care services well-led?

Good

Vision, strategy and risks

The nursing and medical staff we spoke with were able to explain what the trust's vision was, which included providing quality and safe care and a positive patient experience. Staff informed us that the vision for the trust was available to read on the trust's intranet pages.

Staff also told us that they received regular updates about the trust's performance and any risks; these were communicated through team briefings and regular emails.

Quality, performance and problems

Children's and young people's services were within the family and public health clinical directorate and we were shown the reporting structure for quality and performance issues within the directorate. This included monthly meetings between the associate clinical director and the lead nurse for children's and young people's services and an overview of all incidents and complaints. A local governance meeting was also held; this then escalated to the family and public health governance committee.

Any risks identified at a local level would be escalated as appropriate through the reporting structure and to trust board level. We saw evidence of this and that action cards were in place to mitigate any potential risks.

Leadership and culture

The nursing and medical staff we spoke with told us that they felt well supported. We were also told that, since the clinical leadership model had been introduced roughly 18 month before our inspection, clinical staff felt more engaged.

Staff also informed us that members of the trust board would often visit the ward areas; these included the chairman, chief executive officer and director of nursing.

Patient experiences and staff involvement and engagement

We saw patient feedback boxes in all areas within children's and young people's services. Staff members informed us that this information was analysed on a monthly basis and then discussed at ward or department meetings to see what action staff could take to improve their service. Records we reviewed confirmed this.

Learning, improvement, innovation and sustainability

Nursing and medical staff told us that they received clinical supervision and appraisals. The trust's appraisal rate for children's and young people's services was 98.6%. This meant that staff were receiving appropriate support and development through the use of the appraisal system.

Good

End of life care

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

Information about the service

Peterborough City Hospital does not have any dedicated wards for end of life care.

End of life care is provided across the hospital wards and in the haematology/oncology day wards. The specialist palliative care team (SPCT) is a multi-professional group serving the catchment area of Peterborough, Cambridgeshire, Leicestershire, Lincolnshire, Rutland and Northampton.

The SPCT is a consultant-led multidisciplinary team that consists of two consultants in palliative medicine, and it is shared between Sue Ryder Thorpe Hall Hospice and the trust. Within the hospital are 2.2 whole-time equivalent (WTE) clinical nurse specialists (CNSs) and 0.6 WTE associate CNSs. There are also 0.6 WTE clinical psychologists, funded by the mental health trust. In addition there are chaplains, dieticians, occupational therapists and physiotherapists. The community team includes four CNSs and 1.8 associate CNSs supported by an administrator and managed by a 0.6 WTE CNS. The trust has close links including shared medical appointments with the local hospice.

During the inspection we identified 37 patients in receipt of some form of end of life care. Of these patients, 26 were being cared for at the trust and 11 were in receipt of care at home from CNSs. We visited 12 wards where people were receiving end of life care. We spoke to four doctors, eight nurses and support staff. We also spoke with patients and relatives. During the course of the inspection, we discussed end of life care with small groups of staff. In addition, we visited the mortuary and hospital faith centre to talk to the chaplain about the service and the support available for those grieving.

We observed care and treatment being provided and looked at care and medical records to ensure that patients received safe and effective care that was responsive to their needs.

Good

End of life care

Summary of findings

The trust had a strong focus on end of life care. The trust had used CQUINs (Commissioning for Quality and Innovation targets agreed with the local commissioning groups) to develop and improve the service provided to patients at the end of their life. The trust was clear with regard to the actions required to review and replace the Liverpool Care Pathway. The Amber Care Bundle was being piloted on two wards. The action plan demonstrated that it would then be rolled out across the trust to meet the Department of Health's guideline timeframe of July 2014.

The palliative care team was very committed and provided a service seven days a week. The team was alerted immediately to any admission of a terminally ill patient. There was very good multi-agency working and close working with both the community team and the local hospice.

Staff were clear about 'do not resuscitate' policies and documents viewed were appropriately signed. Equipment was available and clean, appropriate checks had been made and staff understood how to use the equipment.

The care provided to those who had died was excellent and led by a very passionate bereavement centre manager. In addition, the chaplaincy service and the faith centre provided support to both patients, their families and friends and staff of all faiths and cultural backgrounds.

Are end of life care services safe?

Good

Safety in the past

The trust had reported 11 incidents via the Datix system that directly related to departments where end of life care was given. Three were linked to the Macmillan unit, one to the haematology/oncology department, one to diagnostics and six to the mortuary. All of these incidents had been rated according to their impact on a person's safety and well-being. There had been no serious incidents reported.

We looked at records for patients and found that they were clear, had risk assessments in place and 'do not attempt cardio-pulmonary resuscitation' (DNACPR) forms. We reviewed 20 DNACPR forms and found that all but 2 were completed correctly and appropriately signed. One patient on the palliative care register who had chosen not to be resuscitated did not have a DNACPR form. Before we completed the inspection, we checked to see whether the form had been completed and it had been. However, we noted that the form was in triplicate and one copy should be given to the patient, but all three copies remained in the medical records.

Learning and improvement

All incidents reported had been investigated locally and staff spoken to during the inspection could clearly articulate that actions had been taken. For example, a patient had arrived in the mortuary without an identification wrist band, so staff had taken action to ensure that patient identification was secure and a wrist band applied. The local investigation report and recommendations were reported to the clinical area and added to the 'lessons learned' agenda of meetings for feedback to staff.

E Track, the system that records patient details on admission and through the care pathway to discharge, flags areas of risk to patients. For example, a patient who is known to be at risk of falls will be flagged on the system, a large red triangle will be placed on their bedroom door, and a note will be added on the white board that is used for handover and care planning. Those patients in need of end of life care are also highlighted by the E track system.

Good

End of life care

Recent improvements in the team had included the recruitment of two Marie Curie Nurses. This was managed via CQUINs, which enabled the team to provide a service seven days a week. A clinical psychologist provided psychological support to patients and staff and also shared their skills and experience with the staff to improve patient care.

Systems, processes and practices

Equipment

Staff said that they had appropriate and sufficient equipment to care for patients in the wards and in the mortuary. Equipment checked during the inspection was found to be clean and well maintained. There was a problem with storage on some wards and hoists were being stored in bathrooms. This was a potential issue as it limited safe access for patients and staff to baths, which could lead to harm for staff or patients. Staff explained that the defibrillator on the resuscitation trolley was always temporarily replaced at the time of service to ensure that wards were never without the equipment they needed in an emergency. Regular checking of equipment took place and records seen clearly demonstrated that this was happening.

Infection control

Staff were seen to be using appropriate methods to prevent and control infections. They could also explain the processes that they would take should a patient have methicillin-resistant Staphylococcus aureus (MRSA) or Clostridium difficile. On one ward, staff said that they had had two cases of C. difficile in a year and in both cases the infection had been acquired in the community. The ward areas were seen to be very clean and odourless. Hand gels were in place and used by staff on the wards but it was noted that one specialist nurse entered the ward area without disinfecting their hands.

Monitoring safety and responding to risk

The trust's SPCT audits identified that it was sometimes difficult to identify patients who were deteriorating in a timely fashion. This could lead to late referrals to those who were needed to support a rapid discharge for end of life care at home. To address this concern and improve end of life care services, the trust board had signed up to a review of the Amber Care Bundle. The Amber Care Bundle has been developed to improve the quality of care of patients at risk of dying in the next one to two months and who may still be in receipt of active treatment within the hospital.

When we inspected one of the wards where this review was taking place, the staff were clear about its use and how patients went onto (and, if needed, came off) the Amber Care Bundle.

Audits of the Amber Care Bundle had identified an increase in patient involvement in their care at the end of their life, an increase in patients achieving their preferred place of death, and a reduction in patients dying within 100 days of discharge. The Amber Care Bundle was currently in use on only two wards but it was being rolled out to all appropriate wards following the pilot.

Doctors and patients and/or their family made the decision as to when the patient was at the end of life and at what point they did not want to be resuscitated if they suffered a respiratory or cardiac arrest. A DNACPR order on a patient's file meant that a doctor was not required to resuscitate a patient if their heart stopped; this was designed to prevent unnecessary suffering. All but 2 DNACPR forms were completed and signed and the staff we spoke to understood the consequences for them and the patient of ensuring that the form was correct and accessible. However, the consent process to DNACPR was not always followed in terms of either the patient's capacity to sign for themselves or a decision made in the patient's best interests if they lacked capacity.

To support this aspect of end of life care, training on the Mental Capacity Act 2005 was recorded as being provided to staff. Training on safeguarding children and adults was provided at a variety of levels and to a variety of trust staff, who understood how to make a referral if they had a concern.

Anticipation and planning

The trust was keen to develop the end of life care service and had recently introduced a sitting service to directly support patients with a terminal illness and their families. This service provides someone to sit with the patient whilst carers go out and ensures that the patients' needs are met during this time.

Systems were in place to ensure that terminally ill patients or those approaching the end of their life were supported. This meant that there were referrals to the SPCT, or alerts by Vocera (a pendant through which staff can speak with each other) and referral to the chaplain.

Good

End of life care

Are end of life care services effective?
(for example, treatment is effective)

Requires improvement

Evidence-based guidance
In line with the National End of Life Strategy (2008), the trust had begun to implement the five patient-centred tools to improve quality in end of life care.

Following recent guidance from the Department of Health, the trust had stopped using the full Liverpool Care Pathway and had moved to piloting the Amber Care Bundle. When visiting the wards, it was clear that staff were aware of this and knew how to use the Amber Care Bundle even if it was not being used on their ward. The trust had listened to the experience of other trusts and noted that a maximum of two wards should be supported at any one time. Hospitals had failed when they had tried to implement the Amber Care Bundle too quickly. Staff on the two wards using the Amber Care Bundle felt that it was very helpful and understood that it would be rolled out across the trust following the four-month pilot. It should be noted that the Amber Care Bundle action plan had been implemented in April 2013 and was being met, but the roll-out to other wards had not yet happened.

Monitoring and improvement of outcomes
Nurses and doctors across the trust praised the SPCT for its commitment and efficiency. There were clear systems in place that supported rapid identification of patients, which enabled the team to act swiftly and effectively. Patients on the wards felt that the staff were very helpful and provided them and their families with support through their end of life care. However, communication on preferred place of death was poor in the trust and had been made part of the CQUIN for the the preferred place of death. Subsequent auditing of the CQUIN has now led to a change in the discharge sheet, and this has resulted in improved communication.

The trust participated in two National Care of the Dying audits. These were two-yearly audits in which trusts could participate to evaluate how compassionate and appropriate their care was for end of life care. It also provided evidence of high-quality care. The trust scored in line with the national average for those trusts that participated in 2011. In addition, there had been a number of clinical audits carried out by the trust in relation to patients in receipt of end of life care. The trust had action plans in place to address any deficits in care.

One staff member felt that not enough emphasis was placed on pain control for patients receiving end of life care by the medical staff and that they could be quicker in responding to requests for pain control out of hours. The staff member said that the SPCT staff always responded quickly and patients were not left without pain control. A patient who had pain control via 'patches' said that: "I have to ask them to change the patches."

Sufficient capacity
Staff were supported with sufficient and up-to-date equipment to ensure that terminally ill patients experience good end of life care. The trust recently reviewed all the syringe drivers and purchased more up-to-date ones. A syringe driver is a piece of equipment that delivers medication over a set period of time. It is used in end of life care to continuously administer analgesics (painkillers), anti-emetics (medication to suppress nausea and vomiting) and other drugs where appropriate. This prevents periods during which medication levels in the blood are too high or too low, and avoids the use of multiple tablets (especially in people who have difficulty swallowing).

All staff had access to supervision and support and training was provided to all staff in the SPCT. Psychological and spiritual support were provided by the clinical psychologist and the chaplaincy team.

The trust mortuary provided a very good service, not only for people who died in the hospital but also for those who died in the community. The facilities were very spacious and provided excellent areas for relatives. There were three large, well-furnished and decorated, private viewing rooms. Local and regional undertakers used the service and those spoken to during the inspection had a very high regard for the staff and service provided. They said that "it is brilliant here": access was easy, the relatives were more than pleased with the service and patients were treated with dignity and respect after death.

Good

End of life care

Multidisciplinary working and support

It was clear from speaking to members of the team and other staff that the team was well respected throughout the trust. Patients spoken to during the inspections praised their commitment and support.

The clinicians confirmed that the SPCT was a multidisciplinary team that consisted of a consultant two days per week, two and a half CNSs with the support of Marie Curie and a clinical psychologist, and provided a seven-day service. The team was based with the community team on the trust site. The team worked with the transfer of care team to ensure that all patients' needs were facilitated in a timely manner. They also worked very closely with the mortuary and chaplaincy teams. There were regular reflective sessions for staff that took place in the faith centre. These sessions helped staff review practice and learn from each other's experiences in a safe environment.

The team was supported by the Somerset database, System One for GPs and out-of-hours services, and E track. These three systems held registers and patient details of those people who were in need of end of life care. There were also joint education groups for sharing and learning. Out of hours, the team was supported by a regional on-call consultant for palliative care.

Are end of life care services caring?

Good

Compassion, dignity and empathy

Throughout the inspection, staff were seen to treat people with compassion, dignity and empathy. The services offered by the bereavement centre and mortuary were considered to be very good, as was their extended use to patients families in the longer term. The service was working with Peterborough Cruse to run counselling sessions in the evening to help support those who were coming to terms with their loss. In addition, people who had had a variety of 'loss' experiences came for counselling (for example, people who had suffered a stroke or lost a limb). All sudden deaths came into the mortuary, which provided a counselling service to support people and families.

The bereavement centre had produced a practical guide to bereavement and had considered the relevant recommendations of the Francis Report that applied to its area of work, such as having a separate bereavement room for those who had lost children or babies. Staff provided support to those who needed to visit the bereavement centre.

A relative and patient said that staff turn off call bells and then go away to do jobs before coming back to help them: "It takes a long time." Another patient said: "I have pain relief via a cannula. The cannula had moved and needed putting back in. The nurse replaced the cannula but the bed was wet and the nurse put a towel over the wet bit. She said that she would get dry sheets but this took five hours. I eventually got pain relief from an agency nurse. She was very good and the majority of staff are sensitive and passionate."

All 26 patients we spoke to were complimentary about the care they had been provided with and felt that people understood how they were feeling and how to support them through end of life care and their families after their death.

Involvement in care

The patients we spoke to felt that they were involved in their care planning and had been provided with sufficient information to allow them to make decisions. Some patients had decided that they did not want DNACPR and this was documented and signed on most occasions. One set of medical records reviewed contained a DNACPR form that had not been signed. On discussion with patients, they said that they had made choices and had been listened to by staff. One patient said that they felt very safe and that staff cared for them very well.

Peterborough has a 17.47% non-white minority and as such the hospital staff needed to communicate with those whose first language was not English as well as with people with disabilities. For those whose first language was not English, the hospital had done this by providing leaflets in a number of different languages. These leaflets could be seen around the trust in a variety of departments, for example the mortuary, outpatients, on wards and in the faith centre. The faith centre also catered for those with hearing problems by having a loop system. Translators were provided to support people during consultations and treatment sessions.

Good

End of life care

Trust and respect

We were told that staff spoke to the elders of communities at an early stage to ensure that both the patient and their family were kept informed and that staff were clear about what arrangements needed to be made for death and burial. The hospital staff, and in particular the mortuary staff, were aware of the needs of individual faiths and cultures and responded well to these.

One patient was concerned that staff appeared to be "walking on egg shells" as they did not know how to talk to the patient about their end of life care: "I want straight answers and no one will give me them."

Emotional support

The faith centre provided 24-hour access to a place of peace and quiet. This was located in the centre of the trust building and was very light and airy, providing a tranquil place to pray or reflect. The chaplaincy team was available throughout the day and evening and was on call for emergencies.

To maintain patients' independence and their 'normal life', the SPCT could refer patients for physiotherapy, occupational therapy and to other specialists if needed. All therapists and specialists had access to the E track system and could see when patients requiring end of life care had been admitted.

Are end of life care services responsive to people's needs?

(for example, to feedback?)

Good

Meeting people's needs

The SPCT was available seven days a week and, in conjunction with the patient and relatives, ensured that patients' end of life wishes and preferred place of death were recorded in their care plans. Transport staff clearly understood the need to expedite a patient's transport to ensure that they died in their preferred place.

Access to services

The SPCT tried to see all patients within 24 hours of admission but the team was not yet meeting this target. Visiting times were clear and meal times were protected. However, for end of life care patients, these times were flexible to meet the patient's and relatives' needs. Referrals were usually made by healthcare professionals but anyone may contact the service directly. Telephone numbers for all the team were readily available. Referrals could be made at the point of diagnosis or at any time during a patient's illness. The team would meet families and/or individuals at all stages of treatment.

Vulnerable patients and capacity

The SPCT was aware of patients with reduced capacity and took appropriate steps to ensure that they were involved in their care and had the support of their family members and key personnel.

Leaving hospital

For those patients with end of life care, there was a home transfer team. This team facilitated rapid transfer for patients who would prefer to die at home. Staff we spoke to said that the service provided by all agencies involved was very good. We also spoke to the patient transport services, which said that they "pull out all of the stops" to ensure that patients with end of life care packages got to where they needed to be. Records showed details of discharge plans. Discharge letters were now electronic and white board meetings (meetings of multi-disciplinary staff around the information board on the ward) were held on a daily basis to discuss and arrange discharge.

Learning from experiences, concerns and complaints

There had been four complaints recorded for the end of life care service over the last year. The key concerns were wrong medication nearly given to the patient, poor communication relating to planning hospital care at home, a patient not being able to see a relative before they passed away, and nurses who should have shown more compassion. All four complaints were investigated, responses provided and apologies given. There were clear actions that had been taken by the trust to ensure that these issues did not arise again, with examples of such action documented in the annual complaints report. However, the number of days taken to close one of the complaints was 124; this was over the maximum trust target of 30 days to close a complaint.

All complaints, including those relating to end of life care, were investigated by ward managers. Complaint responses were shared with staff and staff were also asked what they felt should go into the letters. There were monthly action plans for complaints and compliments; these were shared

Good

End of life care

on best practice days and in 'lessons learned' forums. Each ward had a complaints folder and a manager reviewed the trends to see what learning from experience could be gained and shared at staff meetings.

Are end of life care services well-led?

Good

Vision, strategy and risks

The trust had a dynamic SPCT with a shared vision and a strong working relationship with the community and the local hospice. The team was very aware of the trust's strategy and the trust had agreed with Lincolnshire and Cambridgeshire Clinical Commissioning Groups a CQUIN to improve the care of patients at the end of their life. The CQUIN stated that the trust would review the possibility of implementing the Amber Care Bundle and provided a detailed action plan for implementation. The trust had implemented the Amber Care Bundle on two wards and intended to roll it out to the rest of the trust as soon as possible. Evidence was seen on the wards we visited of the Amber Care Bundle in use and staff felt that it was a good tool to use.

Quality, performance and problems

The SPCT was well led by specialists who understood their role and were passionate about ensuring good care outcomes for patients at the end of their life.

Leadership and culture

There was strong leadership for the end of life care team. The SPCT was well thought of and had set a culture that engaged all staff across the trust. The team worked across the trust and was located with the community team, which staff said helped to make for a better care pathway for patients from community to hospital and back again.

Patient experiences and staff involvement and engagement

Patients knew the members of the SPCT by name and praised their care and support. The patient experience went beyond death, as relatives were supported by the bereavement centre and chaplaincy service. Some patients we spoke to felt more settled knowing that plans were in place for them and that these included plans for after their death.

Learning, improvement, innovation and sustainability

The trust had several CQUINs in place to help develop and improve care and performance for those receiving end of life care. One had led to the recruitment of more palliative care nurses, which allowed the trust to provide a seven-day palliative care team.

Good

Outpatients

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

Information about the service

Peterborough and Stamford Hospitals NHS Foundation Trust provides a wide range of outpatient services across two hospital sites. This part of the report details the findings of the inspection of Peterborough City Hospital. The trust outpatient attendance for 2013 was 103,152 for new patients and 284,874 for follow-up attendances. We visited the outpatient clinics for haematology, orthopaedics, neurology, surgery, orthodontics, gynaecology, paediatrics and obstetrics.

We spoke with 15 patients and 10 staff, including medical staff, nursing staff, healthcare assistants, managers and administrators. We received comments from staff focus groups and from people who had contacted us about their experiences. We also reviewed the trust's data.

Summary of findings

Outpatients services were safe, and staff were well trained and knowledgeable. All staff understood the principles of safeguarding for children and adults and knew how to refer concerns.

The trust had responded positively to concerns about the booking office and call centre. A review of these departments had resulted in more staff being employed and systems refined; this has led to a more effective service. The trust has had 12 patients wait longer than the 13 week target, however this is in proportion to 103,152 new attendances in the year to date.. Some outpatient clinics run over but 'did not attend' rates have dramatically decreased as a result of the appointment 'chase and alert' system.

Good

Outpatients

Are outpatients services safe?

Good

Outpatient services were safe.

Safety in the past

There had been no serious incidents reported in the last six months. Of the incidents recorded, the most prevalent issue (19 calls) was staffing levels in the call centre. Staff we spoke to told us that the trust had responded to this and actions had been taken to improve staffing levels. Staff we spoke to were aware of how to respond to safeguarding concerns for both children and adults.

Outpatients' areas were clean and staff were seen to be using the appropriate equipment for infection control purposes. However, there was no hand gel seen in the reception area.

Staffing levels were good. Administration staffing levels were very good, having been increased following a recent review.

Learning and improvement

Matrons used monthly scorecards to monitor patient safety, the environment and patient satisfaction.

Systems, processes and practices

There were good systems in place to ensure that patients attended clinics, with reminders for attendance being left on answerphones and text messages sent. The patients we spoke to said that they were impressed with the communication that they had received concerning their appointments. Letters were clear and people felt that they had been provided with sufficient information about their appointment. However, patients also said that there were some delays and one person said: "I had to wait for up to an hour before I was seen."

Monitoring safety and responding to risk

Datix was used by all staff to record incidents as well as a variety of issues ranging from staffing level problems to staff safety concerns. All the incidents and issues recorded had been reviewed and actions taken to mitigate risk. Some of these issues, such as staffing, related to the trust as a whole and were recorded on the trust risk register. The need to increase the number of administration staff had been raised through this system and had been addressed.

A check of appointment attendance showed a decrease in those people who missed appointments: for example, from quarter 4 in 2012 to December 2013, the percentage had dropped from 12.3% to 8.6%.

There was a business continuity plan for outpatients that was reviewed regularly to ensure that service provision could be maintained should an emergency situation occur, for example a fire or the loss of electrical supply.

Staff understood the need for Mental Capacity Act 2005 training and could explain how it would be used when considering treatment plans and general consent to care and decision making.

Anticipation and planning

The recent review of the booking system and call centre and the resulting increase in staffing had greatly improved the planning of day-to-day activity in the outpatients department. Patients were booked in for a 15-minute slot but occasionally this could not be maintained and some patients said that they had been waiting for 90 minutes. Although patients had to wait, they felt that all the staff were trying to be as helpful as possible.

Are outpatients services effective?
(for example, treatment is effective)
Not sufficient evidence to rate

Evidence-based guidance

The consultants and doctors using the department were actively engaged in research and implementing national guidance in treatments.

Monitoring and improvement of outcomes

The trust monitored its performance through the 'performance scorecard'. This scorecard clearly identified each quarter's percentage targets and the trust's progress for the year to date. One of the key indicators for the trust's outpatients service was breaches of the 13-week target on the outpatients waiting list. The trust had 12 breaches so far in the year to date. There were three breaches in quarter 1, one in quarter 2, none in quarter 3 and eight so far in quarter 4.

Sufficient capacity

The staff and patients we spoke to did not have any concerns that there were not enough staff on duty. There had been staff increases for administrators in the booking

and call centres. Staff felt that they had all the equipment they needed. A new scanner had been purchased for the central referral team, and this had improved processes for staff and patients alike.

The general environment was pleasant and staff advised us that they had tried to introduce a new system to get patients through the department as the seating area was quite small. Water was available for people should they need it.

Multidisciplinary working and support

Staff throughout the outpatients department were complimented by the patients we spoke to. Three patients said that they thought that the staff were very knowledgeable and able to explain things to them. They also commented that there was good communication between the trust and their GP. For example, should a nurse suspect that a patient was suffering from dementia, they could make a direct referral to the GP to ensure that the patient would receive the right care and necessary treatment.

Are outpatients services caring?

Good

Staff in the outpatients department were seen to be caring.

Compassion, dignity and empathy

Patients told us that the care they received was very good. Even though staff were busy, they had time to talk with patients. They were also seen to be ensuring that patients were well informed about what was happening with their appointments and treatment. Staff were seen to act with compassion and dignity.

Involvement in care

The patients we spoke to felt that they had sufficient information to help them make decisions and also felt that staff gave them time and involved them in their care.

Trust and respect

Patients could see waiting times on a screen, which also displayed the average waiting time for people to be seen in the clinics. Interpreters were available and could be booked via the booking system in the department. Some 99% of interpreter appointments were face to face, with the interpreter attending the appointment and staying with the patient through the process.

Emotional support

Psychological support was available for those patients attending pain clinics. The pain clinic was sited at the Stamford and Rutland Hospital. Other types of emotional support could be provided through referrals to other departments and external agencies. The chaplain was always available and could be contacted during the clinic times.

Are outpatients services responsive to people's needs?

(for example, to feedback?)

Good

Meeting people's needs

The hospital met the referral to treatment times with patients waiting above 18 weeks to be treated. One patient said that the service ran smoothly from one process to the next in outpatients. Depending upon the type of clinic, some can run an hour over time. Another patient said that they had waited for three months for a consultant's appointment. The patient had developed atrial fibrillation and felt that it had been too long to wait for an appointment.

Access to services

Patients said that they could access the service well and usually had to wait only between five and 15 minutes before being seen. Patients also liked the noticeboard, which regularly informed them of the potential length of waiting times. Clinics were open between 8.30 am and 7 pm.

Information leaflets were sent to patients prior to their appointment to inform them of the process and any pre-visit preparation that may be needed.

The trust had taken steps to improve the number of patients who did not attend for appointments (DNA). Patients acknowledged that these steps had been very helpful and the impact had been seen in the vast reduction in DNA.

Good

Outpatients

Vulnerable patients and capacity
All staff had been on equality and diversity training and were aware of patients who may be vulnerable.

Learning from experiences, concerns and complaints
The patients we spoke to said that they were quite happy with the service. They also told us that the trust sent letters to patients asking what it could improve.

Managers carried out an audit every month with afternoon feedback sessions. The findings of these were also used in learning sessions with staff. The month of our inspection, the audit was due to look at the referral process. The review of the booking system had shown areas where lessons could be learned and improvements made to the process.

The trust had not performed well in turning around complaints in 30 days. Although the data was not specific to the outpatients department, the trust continued to breach the 30-day target and was currently taking 45 days to turn a complaint around for the year to date.

Are outpatients services well-led?

Good

The outpatients team was well led by the local management.

Vision, strategy and risks
There was a trust-wide vision but not a specific one for outpatients, which had not been classed as one of the trust priorities for 2013/14. The trust had a board assurance framework (BAF) that was reviewed on a regular basis at board meetings. This was a statutory document that the trust was required to produce. The trust board used this document to monitor action plans and manage risk throughout the trust.

There were trust-wide and specialty risk registers but no specific risk register for outpatients.

Quality, performance and problems
The trust had a quality governance framework that comprised a quality assurance committee. This included non-executive directors, executive directors, GPs, Healthwatch and governors. It also had a quality governance operations committee and used a matron's balanced scorecard.

Consultants and nursing staff we spoke to told us that they felt that the clinical governance meetings were positive and well led. Staff knew how to report incidents and also received feedback from investigations. There were also meetings every Thursday morning to discuss current issues that were having an impact on the performance of the department.

Leadership and culture
All staff we spoke to understood the management structure. The trust had introduced clinical directorates in September 2012 but the impact of this was yet to be fully seen.

Patient experiences and staff involvement and engagement
Although there were clear signs to show patients where to go, patients were still getting lost and arriving late for appointments. The trust had volunteers to assist those patients who appeared lost and direct them to the right department. We spoke to one of the volunteers who said she felt that it was a good idea and that she enjoyed helping people find their way around the hospital.

Learning, improvement, innovation and sustainability
Team briefing sessions now included action taken in response to concerns raised. The trust held a quarterly 'lessons learned' event. There were scrutiny panels for key quality concerns such as falls and Clostridium difficile. The 15 steps challenge was a success; this is a toolkit that the trust can use to check the quality of care in a variety of settings. The trust had used this tool and had placed a member of staff in a wheelchair to test accessibility throughout the hospital for those people who could not walk independently.

Good practice and areas for improvement

Introduction

Care at the hospital was generally safe,effective, caring and well led however the hospital struggled to be as responsive as it could be to meeting the needs of the patient.This was due to a number of factors including the number of beds available within the hospital and the demand placed upon these beds. The population of Peterborough was expanding due to increased building in the area and improved road links also added to demands for services. The hospital also discharged to five local counties each with a different referral system which could cause delays in discharge.

The hospital monitored services well and took action to improve outcomes for people. However due to the staffing pressures training and appraisal was not always completed which can impact upon the outcomes for patients.

We found two areas of good practice which included women being offered debriefing sessions post birth to enable them and the staff to understand the experience. A joint school was also run by the hospital in order that patients attending for hip or knee replacement surgery fully understood the implications of the surgery they were about to have and to adequately plan for discharge.

Areas of good practice

Our inspection team highlighted the following areas of good practice:

Joint School

The hospital has a joint school for patients who are having knee or hip replacement surgery. This is run jointly with medical, nursing, physiotherapists and occupational therapy staff. This promotes pre planning for discharge by patients and increases their awareness of the surgery.

Debrief session

The maternity unit offers debrief sessions for women following the delivery of their baby. This allows women to voice any concerns or queries following a difficult birth. It provides reassurance for women and advice on future pregnancies.

Mortuary and bereavement services

The mortuary team provided excellent sensitive services. The services offered by the bereavement centre and mortuary were considered to be very good, as was their extended use to patients families in the longer term. The service was working with Peterborough Cruse to run counselling sessions in the evening.

Ventilator-associated pneumonia infection control

In 2013, the critical care team of intensive care consultants at Peterborough City Hospital shared a national award relating to healthcare-acquired infections (HAIs) for its work on and intervention in ventilator-associated pneumonia; this had reduced infection rates and saved the trust money.

Areas in need of improvement

Action the hospital MUST take to improve

Action the hospital SHOULD take to improve

- The trust should ensure that A&E staff are clear on the checking procedure in respect of whether a child is on the child protection register.
- The hospital should roll out intentional rounding to all areas including A&E.
- The hospital should continue to support all staff in raising concerns.
- The hospital should enhance joint working with the Mental Health Trust to ensure a better service for patients.
- The hospital should review admissions to inappropriate wards.
- Equipment should be stored in designated spaces to reduce the risk of trip hazards.
- The trust should review the accommodation and services available for adolescents to improve their patient experience.
- The trust should review pain relief for those patients at the end of their life.
- The trust should ensure that services for children within the A&E department meet national guidance.