The Princess Alexandra Hospital NHS Trust

The Princess Alexandra 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**
Urgent and emergency services	**Requires improvement**
Medical care	**Requires improvement**
Surgery	**Requires improvement**
Critical care	**Requires improvement**
Maternity and gynaecology	**Good**
Services for children and young people	**Requires improvement**
End of life care	**Requires improvement**
Outpatients and diagnostic imaging	**Inadequate**

Summary of findings

Letter from the Chief Inspector of Hospitals

We carried out a comprehensive inspection between 21 and 23 July 2015 as part of our regular inspection programme. In May 2015 the intelligence monitoring system showed that there were two elevated risks and ten risks. The elevated risks were around mortality and the risks included risks from survey questions and audit data such as the four hour target in the A&E department.

The Princess Alexandra Hospital NHS Trust is located in Harlow, Essex and is a 419 bedded hospital excluding maternity and children's services and escalation areas. The hospital provides a comprehensive range of safe and reliable acute and specialist services to a local population of 258,000 people. The trust has 5 sites; Princess Alexandra Hospital, St Margaret's Hospital, Herts and Essex Hospital, Cheshunt Community Hospital and Rectory Lane. At our inspection on 21-23 July we inspected The Princess Alexandra Hospital. On our unannounced inspection on 30 July 2015 we inspected The Princess Alexandra Hospital, St Margaret's Hospital and the Herts and Essex Hospital.

During this inspection we found that the trust had significant capacity issues and was having to reassess bed capacity at least three times a day. This pressure on beds meant that patients were allocated the next available bed rather than being treated on a ward specifically for their condition. We found that staff shortages meant that wards were struggling to cope with the number of patients and that staff were moved from one ward to cover staff shortages on others. The trust sees on average around 300 patients a day in its emergency services.

We have rated this location as requires improvement overall due to concerns in safety, responsiveness and the apparent disconnect between ward staff and the middle managers. We found that the staff were exceptionally caring and that they went the extra mile for their patients.

Our key findings were as follows:

- Shortages of staff across disciplines coupled with increased capacity meant that services did not always protect patients form avoidable harm, impacted upon seven day provision of services and meant that patients were not always treated in wards that specialised in the care of health issues.
- The security of women, babies and children was not always maintained within the hospital.
- There was a disconnect between ward staff and the duty matron level as capacity pressures were managed.
- Agency staff did not always receive appropriate orientation or training to assist them in the care of patients on individual wards.
- The storage, administration and safety of medication was not always monitored and effective.
- Information flows were not always robust.
- The staff provided good care despite nursing shortages and often went the extra mile to ensure that patients had a good experience within the hospital.
- Staff were compassionate and ensured that patients dignity and privacy was respected.

We saw several areas of outstanding practice including:

- The acting ward manager for the Dolphin Children's ward had made a significant improvement in a short time to the ward and showed outstanding leadership and determination.
- The play specialist providing dedicated time to fundraise to purchase toys and set up playgroups for the children was outstanding.
- The teenage zone within the children's ward was outstanding and was very responsive to the needs of teenagers.
- The gynaecology outpatient and emergency service as a function, including the termination of pregnancy service was outstanding and provided a very responsive service which met the needs of women.
- The outcomes for women in the maternity service were outstanding and comparable with units in the top quartile of all England trusts.

Summary of findings

- The permanent staff who worked within women's services were passionate dedicated and determined to deliver the best care possible for women and were outstanding individuals.

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

Importantly, the trust must:

- Ensure that there is a system in place to protect patients from avoidable harm whilst awaiting an outpatient appointment.
- Ensure that an end of life care pathway is in place so that patients receive appropriate care and treatment.
- Ensure that disposable items of equipment are not reused on patients.
- Ensure that the maternity unit is secure and that there is an effective system in place to ensure the safety of babies from abduction from the unit.
- Ensure that the child abduction policy is updated, reflective of current practice and tested.
- Ensure that the escalation policy is reviewed to prevent medical outliers being placed on the birthing unit at times of high capacity.
- Ensure that medicines administered to patients take into account the patient's allergy status and that the policy for the administration of medicines is adhered to. That medicines are stored appropriately and that appropriate checks are maintained to ensure the safety of medicines.
- Ensure that all staff are appropriately trained, appraised and inducted for their roles, including agency and temporary staff.
- Ensure that equipment is checked in accordance with trusts policies including resuscitation equipment.
- Ensure that all guidelines and policies within the children's accident and emergency high dependency room are up to date with current practice.

Action the hospital SHOULD take to improve

- The trust should continue to work towards improving the levels of all disciplines of staff in order to provide appropriate staffing levels and in order to provide a seven day a week service.
- Review the provision of maternity services at the trust to ensure that the service provision can be sustained beyond the next twelve months.
- The trust should review the level of understanding of the major incident policy amongst all staff.
- The trust should review the level of understanding of safeguarding processes in the children's and young people's services.
- Review the information flows within the directorates to ensure that all staff are aware of audit information and learning from incidents and complaints to improve services.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	Requires improvement 	Overall we found the accident and emergency department at the Princess Alexandra Hospital requires improvement in the domains of safety, responsive and well led. We found that effective and caring domains were good. The accident and emergency department required improvement within safety because the deployment of staff did not always meet the needs of patients. For example, on the first day of our inspection there was one registered nurse responsible for six cubicles in the minor's treatment area and one nurse allocated to look after three patients in the resuscitation area. The clinical decisions unit had no call bell facility at the patient's bedside. The department required improvement to provide a safe service for patients living with a mental health condition or in crisis as there were no risk assessments and poor completion of paperwork. The findings within the responsive and well led domains also required improvement because we found that the clinical decisions unit was being used for inappropriate patients that required enhanced observation. We also noted that the breaches within the department were taken from the decision time to admit instead of the admission time. This is incorrect practice. There was a lack of senior nurse leadership which created a co-ordination presence and we were told by nursing staff that a half hour break was an often occurrence within a thirteen hour shift. We found that the emergency nurse practitioners would not engage with inspectors to discuss areas of good practice and some health care assistants did not feel listened to. However, we have rated the effective and caring domains as good as we found national and local audits were completed and on a regular basis. Care pathways were clear, effective and had associated algorhythm's for each pathway. There was an essence of care notice board which had a rolling focus each month. We saw good interactions between nurses and patients with nurses explaining

Summary of findings

the care they were providing for patients. We observed a doctor who assessed a patient that arrived as an emergency via ambulance and the doctor took the time to look after the patient's relatives as well.
There was particular good feedback from both patients and relatives with regards to the care provided within the emergency assessment unit.

Medical care **Requires improvement**

Medical services required improvement.
The high levels of nursing vacancies coupled with low levels of consultant oversight of patients and the use of inappropriate escalation areas, gave us concern that the safety of care could be compromised. Significant capacity issues within medical services meant that patients were not always placed in the specialty most appropriate to their diagnosis. We found that daily ward rounds by the consultants to these patients did not always occur. Nursing staff were moved to other wards to cover shortages. This meant that they may not have the skills, experience of knowledge to care for the specific needs of patients in these areas. A significant proportion of patient moves and discharges occurred after 20.00hours. There was a good approach to the investigation of incidents and staff were engaged in the investigation process. Processes were in place to safeguard patients from abuse.
National audits to assess the effectiveness of services were completed but the results indicated the need for improvements in several of these. We did not have confidence the issues were being addressed in a robust way. There was a lack of robust action planning to address the issues raised in national audits. We had particular concerns in relation to stroke services.
Patients without exception praised the attitude and approach of staff and the care they received. Ward managers demonstrated excellent leadership skills and a commitment to the patients they cared for. However, issues of consultant oversight and movement of nursing staff were not being addressed in a robust way. There was good engagement of patients and staff throughout

Summary of findings

medical services. There were some examples of the development of services to meet local needs, such as the ambulatory care unit and the ortho-geriatric unit and clear protocols and pathways in these.

Surgery **Requires improvement**

Surgery services required improvement overall. There were concerns relating to safety with nursing staffing identified as a significant risk. Staff had escalated these concerns however reaction to respond and put adequate measures in place had been slow. Incidents and risk assessments were not always managed consistently. There were variations in the management, identification of outcomes and shared learning across the surgical wards. Incidents were not updated to ensure risks were monitored and managed appropriately and there was no robust system in place to ensure policies were updated, in line with best practice and with ease of accessibility for staff.

Melvin unit (SSU) is a nine bedded unit designed to be a 24 hour short stay unit but at times of peak pressure admission criteria are not always maintained and patients with higher acuity are admitted and stay longer that the 24 hours period. Local audits could be improved by ensuring benchmark measures were set and feedback and outcomes communicated effectively. There was no provision of ear nose and throat (ENT) or ophthalmology out of hours or at weekends. One ophthalmology patient stated that they would have preferred to have been made aware of out of hours arrangements prior to attending the Princess Alexandra Hospital only to be sent elsewhere for treatment and support.

There were good initiatives such as the enhanced recovery programme and multidisciplinary communication between the surgical teams and ortho-geriatrician. There was a good system of discharge planning involving a multi-disciplinary team that extended to ensuring care and support in the community. Two patients on different surgical wards told us that they felt they were treated with compassion, dignity and respect, and that they were well informed regarding their care plans.

At a local level staff felt supported by the immediate senior nursing team on the wards and in theatre and by the matrons however pressure to maintain

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immediate clinical care meant that wider clinical oversight was not possible. There was limited sharing across the various areas when good initiatives and practice was happening.

Critical care

Requires improvement

The critical care services required improvements to ensure the responsiveness and leadership of the service.

Patients were cared for in a clean environment in which staff showed good awareness of reducing the risk of infection. The units did not meet the minimum requirements of the Department of Health's infection control in the built environment guidance in respect of the space around each bed.

On the day of our inspection staff were very busy, with one senior nurse having been deployed elsewhere in the hospital on bed management duties and a matron on a non-clinical shift but helping in clinical areas. We observed a well-coordinated team of permanent and agency staff delivering a good standard of patient care and safety.

There was evidence that staff used learning from incidents and complaints to improve practice and deliver safer, more effective care. Consultant input was good and junior doctors were adequately supported to provide safe treatment and assessment. Physiotherapists, microbiologists and pharmacists were spoken of highly by staff and were available at short notice when needed.

Relatives and a patient spoke very positively about their experience of care and treatment. We found some evidence of efficient and responsive multidisciplinary involvement from a range of medical specialties although medical staff said that this was variable and they could not always depend on it. Staffing overall was cited as a risk by staff, including the high turnover of nurses and the lack of development and progression opportunities available.

The critical care service was not responsive to patients needs as access and egress from the unit was delayed due to capacity issues within the hospital. There was a lack of a dedicated bed manager who could liaise across the hospital to ensure that beds were available for patients requiring complex care. The theatre recovery area

used to support patients who following surgery required admission to critical care areas. Whilst the trust had taken action to mitigate the risks to the patient they remained under the care of the anaesthetist and admitting team and did not have direct access to critical care specialists.
Staff spoke of leadership and culture on the unit variably and some staff were afraid to speak out due to the pressures from the senior leaders. Whilst staff took action to mitigate risks to the department these were not owned by the senior leaders and longer term planning and strategic oversight was not in place.

Maternity and gynaecology

Good

We rated maternity and gynaecology services as services as Good overall. We rated the services as Requires Improvement for being safe, as Good for being responsive, well led and effective and Outstanding for being caring.
The midwife-to-birth ratio was higher than the recommended average. The environment in the unit was not secure and meant that there was a risk of child abduction. The gynaecology service had very clear processes for the delivery of a safe service across all recognised gynaecology pathways. Records management and completion within gynaecology was excellent.
The number of medical staff and consultant hours are in accordance with Royal college of Obstetricians Good Practice No 8 recommendation (March 2009) to be provided to deliver the maternity and gynaecology services which was positive. This meant that women were safer because medical staff were available to offer advice and treatment.
The outcomes for women who used The Princess Alexandra Hospital were outstanding, being consistently better than expected when compared with other similar services. The Termination of pregnancy process followed all elements of national guidelines and legislation and was an outstanding function within gynaecology.
The service had a robust process for auditing, learning from national reports and recommendations as well as keeping up to date with current guidelines.
The maternity and gynaecology service provided outstanding care to women. Feedback from people

Summary of findings

who use the service, those who are close to them and stakeholders was all positive about the way staff treat women. Women thought that staff went the extra mile and the care they receive exceeded their expectations. The CQC maternity survey results were in line with the England average on all areas and the Friends and Family Test was consistently above the England average for scores in all aspects of antenatal, birth and postnatal care. The service consistently received more compliments than complaints.

The maternity and gynaecology service was responsive to the needs of women because it had planned how to manage the fluctuating and increasing demand on service capacity. The service had developed the gynaecology provision into a standalone service within women's services, which had a significant benefit to the quality of cares.

The service was stretched for capacity and demand and as a result the trust had changed a postnatal bay in the midwife-led birth unit into a medical bay for female medical outliers, which was not acceptable. The trust took immediate action to address this and changed their escalation policy so that it would not admit medical outliers to this area again. The future delivery of the service to meet the needs of the local population had not been planned out and left some uncertainty regarding the future because the facilities to provide the services were small and in need of expansion.

The maternity and gynaecology service leadership locally was good. The medical midwifery and operational leadership team were respected. Staff spoke highly of the clinical leads for the service and how involved and approachable they were, which created an open culture. It was evident that staff worked well together. Governance and risk management systems within maternity and gynaecology services were robust and well established which provided a level of assurance to the trust on the provision of maternity and gynaecology. Work was required to assure the future of the service because there was no clear strategy for service delivery.

Summary of findings

Services for children and young people

Requires improvement

Services for children and younger people required improvement overall in all domains except caring which we rated as good.

The Dolphin ward safeguarding children's procedures were not as robust or as embedded as they could be. Items of out of date breast milk were stored in the fridge and single-use items were not being immediately disposed of and could have been reused on patients. There were notable staffing shortages for registered staff in the Neonatal Intensive Care Unit (NICU) and on the Dolphin children's ward. There was a child abduction policy but it was out of date, there had been no tests on child abduction and the door to the NICU was not secure.

There was a lack of transitional arrangements for moving a child from children's care into young adult then into adult care, which meant the pathways for care, specifically on conditions such as epilepsy and asthma, were not clear. There were gaps in management and support arrangements for staff, such as appraisal, supervision and professional development in the Dolphin children's ward.

Outcomes for children who use services were in line with expected ranges nationally, with the exception of diabetes care, which required improvement.

Care within the children's service and NICU was good. Feedback from all family members and children we spoke with was positive about how the care was provided and the parents believed that staff could not do enough for their children.

Children and their families were active partners in their care. We observed how families were actively engaged and encouraged to participate in the planning of care for the child.

The children and young people's service was not always responsive to the needs of children. The service was not meeting the needs of children's through outpatient services because there were delays in receiving an appointment in a timely way. The service was achieving 38.4% of patients being seen within 18 weeks of referral for treatment and there were notable backlogs and delays in ophthalmology services for children. Services were planned and delivered in a way that met the needs of the local population and plans to improve the service to meet the growing demand were being

developed. In the children's ward they had indoor and outdoor play areas and for teenagers the 'teenage zone' was an excellent idea to support the needs of younger adults.
The vision for the future of the service had not been developed. The staff within the service were not all aware of the trust's vision or strategy. The arrangements for governance and performance management did not always operate effectively because the risk registers used to monitor performance did not clearly identify what the key risks for the service were. The local leadership teams within the services, which had undergone some changes, were good and demonstrated good leadership to their teams.

End of life care

Requires improvement

Services for end of life care required improvement, with some improvements required in safety and leadership and significant improvement required in effectiveness.
There were environmental concerns that could potentially interrupt services and prevent a safe service from being delivered. Lessons were not consistently learnt or shared from incidents that occurred within end of life care, which meant that opportunities to improve the service were sometimes missed. We found that patient records were not always appropriately updated, which could result in inappropriate care being given.
The trust did not have a specific pathway for patients at the end of their life since the withdrawal of the Liverpool Care Pathway. There was a draft plan still in its infancy. This meant that we could not be assured that patients received the appropriate care at the end of their lives. We saw that Do Not Attempt Cardio Pulmonary Resuscitation forms did not always comply with The Mental Capacity Act 2005.
The results of the National Care of the Dying Audit showed some positive results in organisational key performance indicators, but improvements could be made in the clinical results when compared nationally.
Staff at The Princess Alexandra hospital were passionate about end of life care and displayed

kindness and compassion when delivering care to patients at the end of their lives. Consideration was given to the needs of patients' relatives and loved ones, such as open visiting hours.
Local leadership in end of life care required improvement to implement the actions taken to address the concerns in safety and effectiveness. Staff spoke highly of the support they were offered by the specialist palliative care team. Relatives and friends were invited to share their experience, so that end of life care could be improved.

Outpatients and diagnostic imaging

Inadequate

Overall we rated the outpatient and diagnostic services as inadequate. The outpatients department had issues with medical records not always being available for the clinic which had resulted in a number of serious incidents. Whilst the trust had taken action to address these issues, this area requires further improvement as monitoring of clinic records availability was not undertaken. We also noted a safety issue within the clinical procedure room at St Margaret's hospital which, once highlighted to the trust was investigated and remedial action was taken. The significant patient back log of patients waiting for appointments was being addressed by the hospital but this work had only commenced in January 2015 and was only reviewing those patients waiting more than a year for an appointment. The lack of clinical prioritisation of the waiting list has led to the safety domain as being rated as inadequate. The departments had sufficient staff and implemented good systems to ensure that incidents were not repeated.
The diagnostic services, by contrast, did not have a waiting list and took part in local and national audits and took steps to address any areas highlighted through audit. Auditing processes were less well developed in the outpatients department. Staff were competent and sufficiently skilled for their own area of work. There were good examples of staff working collaboratively to meet patients' needs, for example in cancer multidisciplinary teams.
Patients were treated with kindness, dignity, respect and compassion when receiving care and

Summary of findings

treatment. Patients spoke positively about how they were treated by staff. Consultants gave patients helpful information so that they could make their own decisions about care.

The responsiveness of the outpatients' service was inadequate. Patients were not consistently offered timely access to services. The trust was not currently reporting referral to treatment times due to information technology issues. However, there was a significant backlog of patients waiting for appointments. Shortages of administration staff and lengthy waiting times made clinics crowded and often delays occurred. Short notice cancellations and problems with letters for appointments meant that patients either did not turn up to appointments or were waiting a long time to see consultants as appointments were double or triple booked.

The managers of this area were aware of the issues and had plans in place to address them. However, at the time of our inspection these had not been addressed. Staff were well supported and there was a culture of learning and driving improvement. Staff were well supported and trained to undertake their roles within the departments.

The Princess Alexandra Hospital

Detailed findings

Services we looked at

Urgent and emergency services; Medical care (including older people's care); Surgery; Critical care; Maternity and gynaecology; Services for children and young people; End of life care; Outpatients and diagnostic imaging

Detailed findings

Contents

Background to The Princess Alexandra Hospital

Sites and Locations:

The trust has five sites; Princess Alexandra Hospital, St Margaret's Hospital, Herts and Essex Hospital, Cheshunt Community Hospital and Rectory Lane

Population served:

The Princess Alexandra Hospital NHS Trust is located in Harlow, Essex and is a 419 bedded hospital excluding maternity and children's services and escalation areas. The hospital provides a comprehensive range of safe and reliable acute and specialist services to a local population of 258,000 people.

Deprivation:

The Indices of Multiple Deprivation indicates that Harlow is the 95th least deprived borough out of the 326 boroughs in the UK. (1st being the most deprived). The health of people in Harlow is varied compared with the England average, about 21% children live in poverty. Life expectancy for men is lower than the England average. The rate of alcohol-specific hospital stays both adults and under 18 are worse than the England average. 18.2% of children (year 6) and 27% of adults are classified as obese and the levels of teenage pregnancy are worse than the England average. The rate of smoking related deaths was worse than the average for England and rates of sexually transmitted infections and TB are worse than average.

Our inspection team

Our inspection team was led by:

Chair: Professor Juliet Beal, National Nursing Advisor, Care Quality Commission

Head of Hospital Inspections: Fiona Allinson. Head of Hospital inspections, Care Quality Commission

The team included nine CQC inspectors and a variety of specialists including, a director, a director of nursing, head of clinical services and quality, a pharmacist, two medical consultants, a consultant in emergency medicine, a consultant obstetrician, an intensive care consultant, a consultant midwife, a consultant critical care nurse, a junior doctor and seven nurses at a variety of levels across the core service specialities.

Detailed findings

How we carried out this inspection

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

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

The inspection took place between 21 and 23 July 2015.

Before visiting, we reviewed a range of information we held, and asked other organisations to share what they knew about the hospital. These included the clinical commissioning group (CCG); the Trust Development Agency; NHS England; Health Education England (HEE); General Medical Council (GMC); Nursing and Midwifery Council (NMC); Royal College of Nursing; College of Emergency Medicine; Royal College of Anaesthetists; NHS Litigation Authority; Parliamentary and Health Service Ombudsman; Royal College of Radiologists and the local Healthwatch.

We held a listening event on 21July 2015, when people shared their views and experiences of

The Princess Alexandra Hospital NHS Trust. Some people who were unable to attend the listening event shared their experiences with us via email or by telephone.

We carried out an announced inspection visit between 21 and 23 July 2015. We spoke with a range of staff in the hospital, including nurses, junior doctors, consultants, administrative and clerical staff, radiologists, radiographers, pharmacy assistants, pharmacy technicians and pharmacists. We also spoke with staff individually as requested and held 'drop in' sessions.

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

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

Facts and data about The Princess Alexandra Hospital

Size and throughput

This organisation has five locations, providing the following services:

There are 511 beds at this trust.

The main clinical commissioning group at this trust is West Essex CCG.

The trust serves a population of 350,000 from West Essex and East and North Hertfordshire.

The trust employs 2711 (WTE) of which 17% are bank or agency.

The trust has an annual turnover of £190 m, and in 2014/15 the deficit was £22,274 m.

There were 101,987 emergency attendances in 2014/15 and 284,493 outpatient appointments in 2014/15. There were 42,100 inpatient admissions and 21,706 day case procedures undertaken in 2014/15.

Safety

There were 151 serious incidents, including 3 never events reported on StEIS between 1 April 2014 and 31 May 2015.

There were 3070 events reported to NRLS from 1 April to 30 September 2014, of which 0.4% (less than 1%) caused severe harm to the patient. There was no death within this period.

Detailed findings

There were 34 cases of C Diff in this trust between April 2013 to March 2015, and 1 cases of MRSA. Data from the Patient Safety Thermometer showed that there were 15 falls, 205 pressure ulcers, and 77 cases of catheter urinary tract infections between March 2014 to March 2015.

Effective

As at 2013/14 the HSMR in this trust was 100.9, with a rate of 99.6 during the week and 100.1 at the weekend.

As at 2013/14 the SHMI in this trust was 102.3.

There were 2 mortality outliers in this trust in Skin and subcutaneous tissue infections and Therapeutic endoscopic procedures on upper GI tract.

Caring

From the CQC inpatient survey in 2014, this trust performed in the bottom 20% of trusts for 10 questions. For the remaining 50 questions analysed, the trust performed at a similar level to other trusts.

Responsive

Between 2013/14, this trust received 379 complaints.

The following Trusts did not submit any (admitted, non-admitted and incomplete) RTT pathway data for 2014/15.

For quarter 1 of 2015-16, 97.5% of cancer patients were seen by a specialist within two weeks of an urgent GP referral, which is above the operational standard of 93%. The proportion of patients waiting less than 31 days from diagnosis to first definitive treatment was 97.5%. 86.6% of cancer patients waited less than 62 days from urgent GP referral to first definitive treatment, which is above the standard of 85%.

Well led

As at March 2015 there were 2711 whole-time equivalent staff working in this trust including 783 nurses, 391 doctors and 1537 staff in various other clinical, professional and supporting roles.

Staff sickness levels in this trust were 3.47% for the year to 31 March 2015 . Staff turnover was 18.9% gross, with voluntary turnover of 13.9% in the year to 31 March 2015.

Results from the staff survey in 2014 showed that this trust performed in the top 20% of trusts for 2 questions, and in the bottom 20% of trusts for 5 questions. For the remaining 22 questions analysed, the trust had a similar performance to other trusts. The response rate in this trust was 54%.

CQC intelligent monitoring

In the latest Intelligent Monitoring report (May 2015), this trust had 10 risks and 2 elevated risks.

The priority banding for inspection for this trust was 1, and their percentage risk score was 7.4%.

The risks identified were as follows:

- Proportion of ambulance journeys where the ambulance vehicle remained at hospital for more than 60 minutes.
- Composite indicator: A&E waiting times more than 4 hours
- A&E Survey Q41: Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left the A&E Department?
- Composite indicator: In-hospital mortality - Genito-urinary conditions
- Composite indicator: Referral to treatment
- Inpatient Survey Q25 (2014) "Did you have confidence and trust in the doctors treating you?" (Score out of 10)
- SSNAP Domain 2: overall team-centred rating score for key stroke unit indicator
- TDA - Escalation score
- Proportion of patients who received all the secondary prevention medications for which they were eligible.
- Ratio of the total number of days delay in transfer from hospital to the total number of occupied beds.

The elevated risks were as follows:

- Composite indicator: In-hospital mortality - Dermatological conditions.
- Composite indicator: In-hospital mortality - Gastroenterological and hepatological conditions and procedures

Detailed findings

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Medical care	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Surgery	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Critical care	Good	Good	Good	Requires improvement	Requires improvement	Requires improvement
Maternity and gynaecology	Requires improvement	Good	☆ Outstanding	Good	Good	Good
Services for children and young people	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
End of life care	Requires improvement	Inadequate	Good	Good	Requires improvement	Requires improvement
Outpatients and diagnostic imaging	Inadequate	Not rated	Good	Inadequate	Requires improvement	Inadequate
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Notes

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

Urgent and emergency services

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

Information about the service

Our inspection of the accident and emergency department included the emergency assessment unit and was carried out over two days as part of an announced inspection.

The accident and emergency department at The Princess Alexandra Hospital provides a 24-hour, seven day a week service to the area population of approximately 258,000. The department see's around 120,280 attendances a year (April 2014 to April 2015), of which around 20% are children.

Patients present to the department either by walking in via the reception or arriving by ambulance. The department had facilities for assessment and treatment of minor and major injuries, a resuscitation area and a separate children's emergency department. The department also had a clinical decisions unit.

The department has undergone construction work to increase space and enhance services that were provided. This included a separate new children's accident and emergency department which opened in September 2014, reception and ambulance handover area.

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 could not be reached, patients may be transferred to the emergency assessment unit. There was a separate clinical decisions unit within the department and during our inspection this was occupied by patients for admission from the emergency department.

Summary of findings

Overall we found the accident and emergency department at the Princess Alexandra Hospital requires improvement in the domains of safety, responsive and well led. We found that effective and caring domains were good.

The accident and emergency department required improvement within safety because the deployment of staff did not always meet the needs of patients. For example, on the first day of our inspection there was one registered nurse responsible for six cubicles in the minor's treatment area and one nurse allocated to look after three patients in the resuscitation area. The clinical decisions unit had no call bell facility at the patient's bedside. The department required improvement to provide a safe service for patients living with a mental health condition or in crisis as there were no risk assessments and poor completion of paperwork.

The findings within the responsive and well led domains also required improvement because we found that the clinical decisions unit was being used for inappropriate patients that required enhanced observation. We also noted that the breaches within the department were taken from the decision time to admit instead of the admission time. This is incorrect practice.

There was a lack of senior nurse leadership which created a co-ordination presence and we were told by nursing staff that a half hour break was an often

Urgent and emergency services

occurrence within a thirteen hour shift. We found that the emergency nurse practitioners would not engage with inspectors to discuss areas of good practice and some health care assistants did not feel listened to.

However, we have rated the effective and caring domains as good as we found national and local audits were completed and on a regular basis. Care pathways were clear, effective and had associated algorhythm's for each pathway. There was an essence of care notice board which had a rolling focus each month. We saw good interactions between nurses and patients with nurses explaining the care they were providing for patients. We observed a doctor who assessed a patient that arrived as an emergency via ambulance and the doctor took the time to look after the patient's relatives as well.

There was particular good feedback from both patients and relatives with regards to the care provided within the emergency assessment unit.

Are urgent and emergency services safe?

Requires improvement

We rated safe as requires improvement. The accident and emergency department at The Princess Alexandra Hospital required improvement to protect people from avoidable harm. Staffing levels were sufficient during our inspection. However, the deployment of staff within the unit required improvement to provide care to patients. For example, during the first day of our inspection we noted that there was one nurse within the resuscitation area who was looking after three patients and another nurse working within the minor's treatment area responsible for six cubicles. There were no call bells for patients within the clinical decisions unit to summon assistance. We also found that there was no standardisation for the checking of resuscitation equipment which could mean that essential equipment was not available.

Staff within the emergency unit were aware of the challenges within the departments and in particular the service provision against demand. This was pro-actively managed with re-design and enhanced areas to increase pathway and flow through the departments. The accident and emergency department and in particular the clinical decisions unit had limited space to increase the footprint of the departments but care was provided in a safe environment.

Staff had received mandatory training which included safeguarding children and adults. However, mental health risk assessments were not fully completed for the patients we reviewed, one of whom had been in the department for 15 hours.

Staff were able to demonstrate knowledge about the policies and procedures for the department. However, some staff that included registered nurses and doctors had limited knowledge with regards to wider trust policy and procedures. We spoke with patients within the departments who provided mixed views of the service they received.

Incidents

- The trust reported one serious incident relating specifically to the accident and emergency department to the National Reporting and Learning System and the

Strategic Executive Information System between April 2014 and March 2015. The serious incident reported was a delayed diagnosis. The department had not reported any never events.

- We asked nine staff members if they reported incidents and had knowledge of the reporting system. Staff told us that they knew how to report incidents via the hospital system. However, feedback was quite sporadic whereby sometimes they would receive a conclusion but most of the time it was so busy that feedback often did not happen.
- We spoke with senior nurses and doctors with regards to evidence of learning from incidents. No evidence was available or provided which demonstrated learning from incidents.
- Monthly governance meetings occurred through which the department, as a whole, met to discuss their respective areas and incidents are a regular agenda item. We looked at three previous meeting minutes which confirmed that the accident and emergency and clinical decision unit worked cohesively to deter incidents from happening through awareness.
- We reviewed the mortality and morbidity meeting minutes for the previous three months. We saw that an executive team member attended and meetings had also been attended by junior doctors. Individual cases were discussed at each meeting and actions were drawn up and followed up to improve care and patient outcomes.
- Staff within the department understood the requirement to be open with patients. During our inspection we pathway tracked a complaint following incident involving a patient who used the emergency department. We saw that a thorough and robust investigation took place. The patient affected was given an explanation and apology and actions taken as a result of their complaint.
- We were told that band seven nurses investigate minor rated Datix incidents and the band eight nurse manager investigates all moderate and major incidents. Clinicians also regularly lead upon the investigation of moderate and serious incidents including the completion of root cause analysis and action plans.

Cleanliness, infection control and hygiene

- Mandatory training showed that 98% of staff within the accident and emergency department and clinical decisions unit had received infection control and prevention training. However during our inspection we observed poor Infection control practices. On three occasions, nurses and doctors wore the same gloves whilst walking between patients in cubicles. On one occasions we observed a doctor not wear gloves whilst carrying out a cannulation which is an exposure prone procedure. We brought this to the doctors' and their consultants' attention who immediately addressed the situation.
- There were hand sanitizing stations throughout all departments and along the corridors between departments including at all door entrances. However, we found four of the dispensers empty when we went to use them.
- The accident and emergency department environment was visibly clean. Housekeeping staff thoroughly cleaned the area and equipment when patients left cubicles. In the children's accident and emergency department cleanliness was of a high standard.
- Once a piece of equipment was cleaned a green sticker was attached which stated 'I am clean' with the date recorded.
- Clinical areas were segregated from cleaning storage areas. The storage of chemicals for the use of cleaning were stored which conformed with the control of substances hazardous to health.
- There were no reported cases of Methicillin Resistant Staphylococcus Aureus or Clostridium difficile within the departments.

Environment and equipment

- The emergency department had a designated children's accident and emergency department which had secure monitored access with closed circuit television through the department. The children's emergency department had a dedicated waiting area which was equipped and decorated appropriately for children waiting to be seen.
- The resuscitation area had sufficient space around each bed space for teams to provide care for patients. Resuscitation equipment was available. However, there was no standardisation with regards to what equipment should be in the resuscitation equipment trolleys within each bay. There was no checklist against what equipment there should be available. We were told by a nurse that it was a matter of 'just knowing'. This meant

that there was an associated risk when agency or staff that were not familiar with the equipment worked in the resuscitation area and not knowing if appropriate or sufficient equipment was available in an emergency.

- There was a specific area within the children's accident and emergency department for children and neo-natal resuscitation with appropriate equipment. The senior nurse told us that they transfer children across to the main department resuscitation area if required.
- We looked at the daily and weekly safety checks carried out on emergency resuscitation equipment. For example, defibrillators and emergency drug packs. We found them to be consistently checked within the adult accident and emergency department. However, within the children's accident and emergency department we found a number of days where the emergency trolley had not been checked. Between May and July 2015 the checks had not been performed on; 24 May, 13, 27 and 28 June, 4 and 19 July 2015.
- We looked at various pieces of equipment across all areas within the accident and emergency departments and found consistent scheduled servicing on all equipment with stickers attached stating when the piece of equipment was last serviced and when the next service is due.
- The clinical decision unit was positioned along a corridor in between the accident and emergency department and the emergency assessment unit. The clinical decision unit required improvement for patients that needed to call for help. None of the bed spaces had a call bell available, which the department managers were aware of. We spoke with a senior nurse who told us that there was a hand bell that they placed on each bedside to alert the nurse. We asked to see the hand bells we had been told of and none could be found. We asked the department to address this immediately.
- We noted that the bed space around each bed within the clinical decision unit was limited and when equipment was required for patient care this created a cramped environment which made the area difficult to work within and a risk in an emergency situation.

Medicines

- During our inspection we checked the records and stock of medication including controlled drugs and found correct and concise records with appropriate daily checks carried out by qualified staff permitted to perform this task.
- Within the resuscitation area a drug cupboard that was open with drugs stored within it. The cupboard was not organised and appeared confusing with no drug kept in specific order. We brought this to the attention of a senior nurse who ensured that the cupboard was locked.
- We looked at seven patient prescription charts within the accident and emergency department. All of the charts we looked at were completed and signed by the prescriber and by the nurse administering the medication.

Records

- We looked at sixteen patient records between the accident and emergency department.
- Every patient had risk assessments completed apart from one patient with a mental health need who had been in the department for fifteen hours and no mental health risk assessment had been completed. All patients had a Waterlow body map completed. The Waterlow score or Waterlow scale gives an estimated risk for the development of a pressure sore in a given patient. (It is recommended by the Royal College of nursing that if patients are in an area for longer than six hours a risk assessment for falls and pressure ulcers should be completed).
- All of the records had regular observations and re-assessments completed which were recorded appropriately and signed by the nurse, doctor or allied healthcare professional making the entry.
- Medical and nursing notes were easily defined between clinical observations and nursing / medical notes with sections segregated for ease and clarity.
- All of the records we looked at were stored in a safe manner.

Safeguarding

- The trust has adult and children safeguarding leads. The department had access to these leads.
- We spoke with staff including six nurses, four doctors and three reception staff who all understood their responsibilities in respect of safeguarding. They were aware of the trusts safeguarding policies and procedures and who to contact for advice. Staff within the children's accident and emergency department could explain the procedure to be followed if there was a concern about a child.

- We looked at mandatory training records which confirmed that all staff had undergone the appropriate safeguarding training at the correct level.
- Weekly safeguarding meetings were held within the department. Standing agenda items included review of issues concerning Children and Adolescents Mental Health crisis team, child death rapid response service and domestic abuse service affecting children. Child protection services updated the trust staff and assisted in the department developing the Children and Young People's policy. There was good contact with external agencies trough this meeting.

Mandatory training

- We were provided with the records of mandatory training and supplementary training for all staff with compliance across the teams.
- Training was provided in different learning formats which included face to face training in the classroom and E-learning (E-learning is electronic learning via a computer system). Staff told us that there was limited time allowed to complete extra training and it was difficult to get funding for courses.
- There was a dedicated nurse within the accident and emergency department that supported the education. They led on ensuring the department staff received training such as basic and advanced life support, induction training for new nurses joining the department and in particular induction for nurses working within the resuscitation area.
- Trust data showed that within both the adult and children's accident and emergency department's compliance with mandatory training was 98% and compliance with mandatory training within the emergency assessment unit was 100%.
- Compliance with induction and mandatory training for medical staff was 100%. During our inspection we saw five junior doctors were taken off of the department in the afternoon for two hours. This was to allow training for those doctor's. Support was provided in the department by consultants to ensure medical cover remained in place. This meant that junior doctors were supported in their education whilst working within the department.

Assessing and responding to patient risk

- The trust is performing about the same as other trusts within England in the Care Quality Commission accident and emergency survey 2014 for four of the five safety indicators. Themes included how clean the department was, if you ever felt threatened and how long you waited for medical professionals.
- The department operates a streaming system of patients presenting to the department either by themselves or via ambulance and are seen in priority dependent on their condition.
- There was a system of rapid assessment for patients within the waiting room by a senior nurse who was trained in advanced assessment skills. This meant that patients were directed to the most appropriate clinical pathway. Over 90% of these patients were seen within 15 minutes of arrival.
- Due to the recent design layout of the department which included a specific area for ambulance crews to hand over the care of their patients, this facilitated a process whereby patients were being managed or assessed for risk of deterioration whilst waiting.
- Patients arriving as a priority (blue light) call were transferred through to the resuscitation area. These calls were phoned through in advance (pre-alert) so that an appropriate team were alerted and prepared for the patient's arrival. We observed two pre alert calls during the first day of our inspection and found a systematic approach was adopted for each call. The nurse or doctor taking the pre-alert call referred to a decision log which was divided into trauma and medical with each having a clear action algorithm.
- We raised concerns with the senior nurse around the acuity of patients within the clinical decision unit. We noted a patient within the unit who had a significant national early warning score and presented as an acute unwell patient who did not fit the clinical decision unit generic pro-forma on a number of the exclusion criteria. The senior nurse informed us that they were unaware of this and took appropriate immediate action.
- The senior nurse within the children's accident and emergency department told us that the majority of children's nurses held paediatric advanced life support qualifications. However, the percentage could not be confirmed. We reviewed staffing rota's with senior staff and confirmed that at least one nurse on duty at any one time had advance paediatric life saving skills.

Nursing staffing

- The accident and emergency department's staffing levels were flexed to ensure there were sufficient

numbers of staff at times of peak demand. However, when we spoke with nurses they did not corroborate this and told us that at times of high demand they were 'rushed of their feet'.

- During our inspection the resuscitation area was under staffed in accordance with the department's acuity of one nurse for every two patients and dependent on clinical need, one nurse for each patient (1:1). We noted there was one qualified nurse for three patients. When the department became busy the management reacted and increased the number of nursing staff in this area.
- The children's accident and emergency department is open between the hours of 7.30am through to 1.00am seven days a week and then the main accident and emergency department accept children. The children's accident and emergency had one vacancy for a qualified nurse and the senior nurse manager told us that they will be fully staffed by September 2015. During our inspection there were three paediatric trained nurses working in the department who were also qualified in paediatric advanced life support.
- We observed two nurse handovers which were comprehensive and included all patients at risk. For example, patients with a high national early warning score or pressure area risk.
- We looked at rosters for a sample of days over the previous three months (March to May 2015). We noted that the accident and emergency department including the children's department and emergency assessment unit had occasions whereby staffing levels fell short and these had to be back filled with agency staff. Agency staff were suitably inducted into the area.
- The children's accident and emergency department has permanent staff recruited within the department. We saw that at 8pm in the evening a nurse from the major's area in the main accident and emergency department went across to work in this area. This was to ensure a consistency of care with children that are transferred across at 1am when the children's department closed.

Medical staffing

- The department currently has slightly less that the England average whole time equivalent of consultants employed within a rota (21% v 23%). However, it has a higher number of middle and junior grade doctors to provide adequate cover.
- There was a GP based in the hospital to ensure effective streaming and assessment of patients alongside the departments nurse. The GP operated between the hours of 10.00am to 10.00pm, seven days a week. We were told that this supported a quicker assessment which enhanced patient safety and care. We were unable to obtain a percentage of patients that the GP referred to care pathways other than the accident and emergency department.
- The department regularly employed locum middle grade doctors. We spoke with two locum doctors who told us that they were consistently used. The locum doctors had received the trust and department specific induction and were familiar with the department's protocols.
- The consultants provided sufficient hours to cover the accident and emergency department. However, this was due to an individual's own commitment to provide the extra hours.
- Weekly teaching sessions were facilitated for junior doctors. We spoke with a junior doctor who told us they were of high quality and beneficial.
- The children's emergency department was staffed with registered children's nurses and paediatrician's. Some of the nursing staff rotated between the children's ward and the emergency department. A paediatric registrar was available in the department between 9am and 10pm to review children. Outside of these hours an arrangement was in place whereby a paediatrician was available from the ward to review children. The children's emergency department was led by a consultant paediatrician.

Major incident awareness and training

- The department manager told us that the trust had an emergency planning and resilience manager that was responsible for major incident planning, training and exercises.
- We looked at the major incident plan for the department which contained relevant sections relating to the roles of accident and emergency staff including reception and security staff. The plan also included how the department should be prepared and the immediate actions that should happen for a major incident standby and major incident declared.
- The department had a chemical, biological, radiological and nuclear (CBRN) incident lead. Equipment was checked regularly and the department was prepared for any such incident.

Urgent and emergency services

Are urgent and emergency services effective?

(for example, treatment is effective)

Good

We rated effective as good. The department completed local audits within the emergency departments and emergency assessment unit with individual nurses leading audit themes. The accident and emergency department was performing in the upper quartiles for the Royal College of Emergency Medicine audits for renal colic, fractured neck of femur and severe sepsis including septic shock.

Like many trusts the unplanned re-attendance rate to accident and emergency within seven days has been consistently above the standard of 5%. However, this was in line with the England average of other trust accident and emergency departments. Staff were qualified and had the skills to carry out their roles effectively working within multi-disciplinary teams and as autonomous practitioners.

Adult patients' care and treatment was planned and delivered in line with current evidence- based guidance, standards, best practice and legislation. For example, there were a number of care pathways in the department for patients with specific conditions to follow. However, within the children's emergency department these were not always in line with national guidance and had not been reviewed for some time.

Evidence-based care and treatment

- The department took part in the national Royal College of Emergency medicine audits which included standards relating to pain relief: renal colic, fractured neck of femur and pain in children.
- Local clinical policies and procedures were available within the department, staff reported to us that they were aware of the procedures and used them when needed.
- We noted that clinical care pathways were clear and effective with algorithms for staff to follow. For example, these included and were not limited to conditions such as stroke, trauma and myocardial infarction (heart attack).
- The department displayed an essence of care notice board. The board had a monthly focus on different subjects such as pressure ulcers, nutrition and record keeping.
- We spoke with a consultant within the department who explained to us that there were issues with regards to sending trauma images across to Cambridge trauma centre. This was not a problem within the department but within the information technology systems between the two sites and doctors found this frustrating.
- Within the main accident and emergency department, patients were receiving the appropriate care or early intervention as recommended by national guidelines such as the National Institute of Clinical Excellence and the Royal College of Emergency Medicine. However, within the children's accident and emergency department we found in the children's high dependency unit a number of clinical guidelines out of date. The trust informed us that they were part of the Partnership in Paediatrics network and that these policies were from this partnership. Whilst the trust has access to updated policies it has yet to receive hardcopy updated policies.There were twenty two clinical guidelines that we looked at and we found twenty one of them out of date. For example, Infusion drug rates showed it was last checked on 13/07/2012 with a review date of 01/08/2013. Croup initial management had a review date of January 2013. This meant that we were not assured that current guidelines were in place for treatment as no reviews had taken place. We brought this to the attention of the nurse in charge of the department.

Pain relief

- We looked at eight sets of patient notes and specifically at pain relief offered to patients. Pain relief was offered to all patients that required it and nursing notes were recorded to that effect.
- We spoke with three patients who had recently returned from the X-ray department and in particular the management of their pain. One person told us, "I was offered pain relief by the nurse in the waiting room which was very quick." Another person told us, "I had some pain killers and the nurses checked on me again to see if they had helped."

- We reviewed the Royal College of Emergency Medicine audit data which asked the question, 'Was analgesia provided in accordance with local or national guidelines'. The department scored 94% against the required standard of 100%.

Nutrition and hydration

- The trust stated that regular food and fluid rounds were undertaken. However , despite spending two days in the department, we did not observe these occurring. During our inspection we saw that should patients require something to eat or drink then they would have to find a nurse to ask and request this. For example, we spoke to a patient who had not been offered anything to eat or drink for a considerable amount of hours and their relative had to bring this to the attention of nursing staff.

Patient outcomes

- We asked all departments within urgent and emergency care what audits they undertook to ensure compliance with procedures and nursing standards were assessed and any actions required took place. We were informed that local audits and learning had been undertaken. We saw a sample of audits which consisted of hand hygiene, pain relief and communication.
- The unplanned re-attendance rate in the accident and emergency department within seven days was consistently higher than the required standard of 5%. The department had an average re-attendance rate of 8%. However, the England average was above the 5% standard with an average of 7%.
- The Royal College of Emergency Medicine standard for consultant sign off states that three types of patient groups should be reviewed by a consultant prior to discharge. These are: adults with non-traumatic chest pain, febrile children less than one year old and patients making an unscheduled return to the department with the same condition within seventy two hours of discharge. Audit data told us that 68% of patients were discussed with a specialist trainee (ST4) or more senior doctor which was in the upper England quartile.
- The trust is performing in the upper quartiles for the following 2013 CEM audits: Renal Colic, Fractured Neck of Femur and the Severe Sepsis and Septic Shock. Within the Renal colic Audit in 2013 the trust performed in the upper quartile of NHS trusts in England for 10 of the 17 questions we reviewed. These were around the promptness of analgesia being given and the review of effectiveness.
- In the Fractured Neck of Femur audit the trust again performed in the upper quartile for seven out of 15 questions. The trust was in this quartile for the promptness of providing analgesia but the scores for evaluation for this were around the national average.
- The trust performed in the upper quartiles for ensuring the blood glucose monitoring, provision of oxygen and fluids within the emergency department were given to patients in severs sepsis and septic shock but performed less well in ensuring that antibiotics were given and blood cultures were taken before patients left the emergency department. However in the Severe Sepsis and Septic Shock audit 2013 the trust performed in the upper quartile for eight of the 11 measures we reviewed.

Competent staff

- We observed shift handovers and noted that they were comprehensive, constructive and efficient. Should anything need clarifying then this was asked in a professional manner.
- Nursing staff appraisal rates for the department were at 97% with the remainder planned within the next month. We spoke with five staff in the accident and emergency and emergency assessment unit who spoke positively about the appraisal process and that it was of benefit to them. Staff said that it did not just feel like a tick box exercise and they were listened to.
- We spoke with non-clinical staff who told us that they received the mandatory training as part of the whole department team. This included patients living with dementia and learning disabilities.
- We spoke with various grades of clinical staff about their education and progress within the department. The staff demonstrated a desire for further education and courses but many informed us that they were told funding was not available.

Multidisciplinary working

- We witnessed multidisciplinary team working within the accident and emergency department. During our inspection we observed a pre-alert telephone call made

to the department from the ambulance service. Once the call had finished, we saw the nurse brief all clinicians that would be involved in the care of the patient and that everything was in place to receive the patient.
- We observed a good working relationship between department staff and ambulance crews. We spoke with three ambulance crews who spoke highly of the department. One of the ambulance crews was from out of area and complemented the smooth transition of care of their patient.
- We were told that when a request for a specialist doctor input from within the hospital, for example an orthopaedic doctor assessment, this could take a considerable amount of time. This would often cause a care pathway problem and subsequent delays within the department.

Seven-day services

- There was a seven day consultant out of hour's service provided via an on call system.
- The emergency department offered all services where required, seven days a week.
- We were told by nursing staff that external support services are limited out of hours and it often proves quite difficult at weekends which have an impact on patient discharges and care packages.

Access to information

- We noted that all staff had access to information they needed to treat and care for patients and to be able to carry out their respective role.
- Particular mention needs to be made with regards to the reception staff that assisted all staff including staff from other departments in the trust with information that was required.
- Patient information was protected and only available to those staff that required a need for access. Staff were aware of the Data Protection Act and senior staff were aware of the principles of Caldecott.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff we spoke to were knowledgeable about how to support patients who lacked capacity. Not all junior staff including doctors were aware of the need to assess whether a patient had a temporary or permanent loss of capacity.
- We observed that nursing and medical staff did ask patients explicitly if they understood the care and treatment they were receiving. This included their consent for treatment and tests.
- We examined the training records which demonstrated to us that all staff had received Mental Capacity Act training.

Are urgent and emergency services caring?

Good

We rated caring as good. The accident and emergency department including children's services and the emergency assessment unit staff were caring. We observed an instance where a patient was very unwell and dying. The patient and their relatives were treated with the upmost respect and dignity.

All services were busy on the days of our inspection. Patients who were in the departments were always spoken to appropriately and tasks were undertaken in a caring way with patient and relatives consideration at the forefront.

We spoke with a number of patients across all departments and the majority we spoke with were happy with their care and we saw occasions were appropriate that patients and relatives were involved in their care.

We did not see that any patient was cared for in any corridor. There was a pro-active approach to the available bed space in the departments to ensure that privacy and dignity were respected. The reception area did not allow for people to be able to pass confidential information over. There was a barrier to create some privacy but this had little effect.

We heard nurses and doctors take the time to explain the care to patients in a manner that was understood without being confusing.

Compassionate care

- We noted that all of the staff at various different levels across clinical and non-clinical roles that had patient contact was friendly, kind and interested in the patient's best interest.

Urgent and emergency services

- The trust has seen consistently higher scores than the national England average for the accident and emergency friends and family test with the exception of December 2014 where it dipped slightly under the average.
- The England average friends and family score was 85 between the periods of March 2014 to February 2015. The Princess Alexandra Hospital urgent and emergency services score was an average of 96, reaching 97 in November 2014 which was above the national average.
- We spoke with patients in the emergency assessment unit and the feedback we received was that the department was excellent. We observed staff in the department speak with patients and relatives with empathy and an understanding of their individual needs.

Understanding and involvement of patients and those close to them

- We spoke with parents of children who told us that the nurses spoke to their child so that they felt involved and everything was explained to the parent to minimise any worry.
- Whilst we were speaking with reception staff we witnessed reception staff accompany relatives around to see their relatives or friend so that they had support to find them.
- We found that patients were clear on what to expect with regards to their treatment and were clear when treatment required had been provided. We heard from speaking with patients that they had received regular observations. The patients were aware of this and were also involved in the need of taking the observations as part of their treatment plan.

Emotional support

- We witnessed staff providing patients and relatives with emotional support whereby staff demonstrated an understanding of the impact of treatment had on patients and relatives wellbeing.
- Patients who had a mental health illness were afforded privacy and dignity through the use of a designated room.
- There was a chaplaincy service available on request to support patients, relatives and staff if required.

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

(for example, to feedback?)

Requires improvement

We rated responsive as requires improvement. The trust has consistently been below the national England average, and standard, of the percentage of patients seen within four hours. Total time spent in the accident and emergency department has steadily increased month on month since April 2013 and currently stands at nearly forty five minutes longer than the national England average.

From data we have reviewed, the percentage of emergency admissions waiting between four to twelve hours from the decision to admit to being admitted has fluctuated. However, it has remained in line with the national England average.

The trust escalation protocol was sufficient. However, this was not used in a best practice approach. For example, there was an inconsistent regular approach to the nurse that worked within the ambulance handover area. This meant that there was not an overview of the department from the same nurse all the time when taking a handover and choosing the best pathway.

Service planning and delivery to meet the needs of local people

- During periods of demand we witnessed that the department struggled to cope. There was a lack of clear co-ordination within the teams which caused the flow through the department to become confused. For example, patients placed within the clinical decisions unit that should have been cared for within the majors or resuscitation area.
- Despite the improvements over the past year, the department had limited space which restricted growth in line with the growing population and due to the hospitals current footprint. For example, the clinical decisions unit did not meet the needs of the rest of the department.

- We spoke with various staff in a clinical and non-clinical staff who demonstrated an understanding of the need to recognise cultural, social and religious needs of individual patients attending all of the urgent and emergency services available.

Meeting people's individual needs

- There was a good range of leaflets available and posters displayed in the waiting areas and along corridors providing health information and advice on available services within the community for people to use. These were available in other languages.
- All staff had received training with regards to communicating and delivering care to patients with complex needs. For example, patients living with dementia and patient with a learning disability. This included reception and security staff. There was access to support from the trust wide specialist nurses but not an identified lead within the department.
- The department had a hearing loop based in reception to assist patients with hearing loss.
- The trust had access to a telephone translation service for which staff could use.
- The department had improved the environment with regards to an ambulance handover area. Rather than ambulance crews waiting down a corridor and handing over within an area where confidentiality could not be assured. The trust had completed design changes within the department and there was a specific ambulance handover area whereby confidential information could be handed over and the patient was included within the clinical handover of care if appropriate. There were specific nurses that were designated to work in this area who were trained in triage.
- Access to support from mental health teams was poor and particularly the children and adolescent mental health team with regards to a slow response to any request.

Access and flow

- The accident and emergency department operated a streaming system of assessing patients presenting to the department either by themselves or arriving by ambulance and patients are seen in priority dependent on their presenting condition.
- The trust has been consistently below the national England average, and standard, of the percentage of patients seen within four hours. 95% of patients should be seen within four hours of arrival. Between April 2014 and April 2015 the trust has only exceeded the standard twice, in May 2014 they achieved 97% and July 2014 they achieved 96%. They met the standard in August 2014 with 95%. Between December 2014 and March 2015 the average achievement was 78% with January 2015 being the lowest with 69% of patients seen within four hours.
- The trust measured and reported the target times by measuring the number of hours that the patient waited for a bed from the time that a decision had been made to admit them to the hospital. Usually emergency departments measure the time frame in terms of the time of arrival to admission. This meant that the performance of the trust may be different to that that was reported and that patients may in fact be waiting excessive amounts of time to be admitted.
- The initial median time from ambulances arriving at the accident and emergency department and initial assessment was below the England average. There were 1,010 patient care hand-overs from ambulance crews which were delayed over thirty minutes during the winter period (November 2014 to March 2014) compared to all trusts.
- We looked at the data of the percentage of patients that left the department before being seen and between the periods of January 2014 to January 2015 the trust was below the England average with 1.3% patients leaving before being seen compared to the England average of 2.6%.
- The department was above the England average for the total time that patients spent in the accident and emergency department. The average total time spent in the department was 150 minutes with a peak in December 2014 of 180 minutes. The England average was 130 minutes.

Learning from complaints and concerns

- The urgent and emergency services at The Princess Alexandra hospital advocates the patient advice and liaison service available throughout the hospital.
- We found whilst walking around the departments that there was limited information available for patients and relatives on how to make a complaint or compliment and how to contact the patient advice and liaison services.

Urgent and emergency services

- We asked four members of staff whether they received information on complaints and concerns that the department received. We had a mixed reply with one member of staff stating that it was fed back through staff meetings and others stating they were not regularly informed and it was kept in-between the management.
- We reviewed one complaint which had been investigated appropriately and action taken to ensure that action had been taken and new processes implemented to ensure that patient care improved.

Are urgent and emergency services well-led?

Requires improvement

We rated well led as requires improvement. We found that the trusts strategy and vision was not embedded into the accident and emergency departments with exception of the emergency assessment unit whereby we spoke with the lead consultant who ensured that their department was aware and the consultant was very engaged and had the passion to drive their department. We found that the trust had responded to the paediatric demand but had not fully taken into account the needs of a growing population which included an elderly population. We spoke with managers and there was no effective strategic vision going forward.

Within the accident and emergency department there was a lack of engagement from the nurse practitioners within the minor's treatment area when we attempted to speak with them. We could see that there role was imperative. However, they unfortunately could not find time to tell us about their role.

We were told that there was no local risk register however on review of the documentation we saw that a risk register for the emergency services existed. On review of the register we saw that issues raised in this report were highlighted on the register. However the review of these risks appeared ad-hoc and whilst it was unclear when these risks had been added to the register review dates suggested that some of these risks had been held for more than 18 months.

The department managers were aware of the challenges to identify and provide good quality care but struggled to deliver the actions the trust required at times against the demand placed on the department.

The senior nurse who was designated as the shift co-ordinator was often at times involved in clinical care and not able to stand back with an overview to lead the department and had to often 'juggle' many tasks which caused stress.

During our inspection of the emergency assessment unit we witnessed the general manager arrive and requested that inspectors did not take more than one member of staff away from the ward and keep our interviews to a minimum. We respected this request but staff found their presence intimidating and awkward when speaking with us.

Vision and strategy for this service

- Not all of the staff we spoke with was aware of the trust's vision, strategy or journey. Some staff mentioned that they were unsure of where the hospital was going and where it would be in a number of years' time. However the trust had set up a number opportunities for staff to talk about the options and have provided regular updates to staff. The department did not currently have its own strategy.
- The level and communication of departments was not cohesive and the children's accident and emergency department particularly felt insular with regards to the whole urgent and emergency services. This was felt due to them being in a separate building.
- Staff in the accident and emergency department were proud and defended their skill retention but were worried that the trust vision did not support this because the executive managers just accepted that accident and emergency would always be there and they just get on with it with no recognition.
- Nursing and medical leaders in the department were passionate about the vison and direction of the department but we heard through conversation, of concerns how the trust would translate their vison to accident and emergency staff.

Governance, risk management and quality measurement

Urgent and emergency services

- Monthly departmental meetings were held where teams reviewed the quality improvement and patient safety. We were provided with minutes of previous meetings held. We were assured that risks are managed within the department.
- Local risks that could not be managed would be escalated to the corporate risk register. There were three red rated risks associated with the Emergency department which included patient flow through the department, ambulance handover times and shortages of staffing. These risks had been reviewed in April 2015 and were due for further review in May 2015. However previously the risks had been reviewed at less frequent intervals, some of which had not been reviewed for over six months. It was unclear when these risks had been added to the register review dates suggested that some of these risks had been held for more than 18 months.
- Managers were aware of some of the issues we identified and they were keen to resolve key issues to address each risk they had.
- Senior leaders and the executive team seemed to be reactive rather than pro-active and they did react to warnings about demand and flow in the departments. However, they took less action if the waiting times were below twelve hours.

Leadership of service

- The nursing leadership of the teams was led by the senior band eight manager who was respected by the staff and appeared available to staff with an open door.
- The children's department was led by a manager that was passionate about their department and very proud of the services it offers to patients.
- There was good staff morale and staff appeared happy within their role. Junior doctors were happy with the education and leadership from consultants they received.

Culture within the service

- The departments operated an open, friendly and inclusive culture. There appeared to be a no blame approach within the department and feedback from conversations with staff corroborated this.
- We noted positive interactions between senior, junior and student nurses within the children's accident and emergency department.
- A senior nurse told us of the stress in the department due to the demand placed on them to achieve against statistics and this at times placed pressure and the culture would change.

Public and staff engagement

- The trust encouraged public engagement through the friends and family test. Whereby feedback cards could be completed and left for the trust.
- The department held a User Experience Group with representatives from the Healthcare Forum. A wide range of issues were discussed at this meeting. There was appropriate challenge from the Healthcare Forum but we could not see that action had been taken as a result of the meeting from the minutes we reviewed.
- Some staff and in particular health care assistants felt they were not listened to. For, example, should a member of staff put an idea forward they receive little or no feedback.

Innovation, improvement and sustainability

- We saw limited evidence of staff innovation on an individual or team basis that was put into practice and owned by the department. We saw that one complaint had had action taken to implement a system to ensure that patients were safe.

Medical care (including older people's care)

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

Information about the service

Medical services at the Princess Alexandra NHS Trust included cardiology, stroke, and other medical and care of the elderly services. 27,640 patients were admitted to medical services during 2014.

There were principally nine medical wards however we visited the following wards: Winter Ward, Henry Moore Ward, Harvey Ward, Ray Ward, Fleming Ward, Locke Ward, Lister Ward, Harold Ward, the Stroke Unit and the Ambulatory Care Centre.

We talked with 39 staff in addition to meeting with the senior managers for medical services. We talked with 26 patients and 6 relatives. We observed the care provided and interactions between patients and staff. We reviewed the environment and observed infection prevention and control practices. We reviewed care records and attended handovers. We reviewed other documentation from stakeholders and performance information from the trust.

Summary of findings

Medical services required improvement. The high levels of nursing vacancies coupled with low levels of consultant oversight of patients and the use of inappropriate escalation areas, gave us concern that the safety of care could be compromised. Significant capacity issues within medical services meant that patients were not always placed in the specialty most appropriate to their diagnosis. We found that daily ward rounds by the consultants to these patients did not always occur. Nursing staff were moved to other wards to cover shortages. This meant that they may not have the skills, experience of knowledge to care for the specific needs of patients in these areas. A significant proportion of patient moves and discharges occurred after 20.00hours. There was a good approach to the investigation of incidents and staff were engaged in the investigation process. Processes were in place to safeguard patients from abuse.

National audits to assess the effectiveness of services were completed but the results indicated the need for improvements in several of these. We did not have confidence the issues were being addressed in a robust way. There was a lack of robust action planning to address the issues raised in national audits. We had particular concerns in relation to stroke services.

Patients without exception praised the attitude and approach of staff and the care they received. Ward managers demonstrated excellent leadership skills and a commitment to the patients they cared for. However,

Medical care (including older people's care)

issues of consultant oversight and movement of nursing staff were not being addressed in a robust way. There was good engagement of patients and staff throughout medical services. There were some examples of the development of services to meet local needs, such as the ambulatory care unit and the ortho-geriatric unit and clear protocols and pathways in these.

Are medical care services safe?

Requires improvement

Medical services require improvement to ensure that all patients are protected from potentially avoidable harm. There was a high nursing vacancy rate in medical services and whilst this did not directly impact on the safety of care on most wards, we were concerned the low availability of permanent registered nurses on Winter Ward increased the risk of unsafe care. In addition, high vacancy rates on other wards limited the flexibility to manage unexpected shortfalls in staffing on medical wards generally.

Consultant ward rounds did not take place on all wards daily and there was a high use of both senior and junior locum medical staff which gave us concerns about the continuity of care for patients and the safety of decision making when there was reduced Consultant overview.

Bed capacity issues resulted in the use of inappropriate facilities such as the Midwifery Birthing Unit, the redeployment of nurses at short notice and increased dependence on temporary staffing. Support systems such as cleaning were not sufficiently robust. These factors combined to compromise the safety of care.

Processes were in place for the review of serious incidents and the learning from these was communicated to staff to bring about improvements to practice. Safe processes were in place for the management of medicines. There was a consistent approach to the identification of deteriorating patients but we found inconsistencies in escalation when the tool indicated the need for escalation.

Incidents

- There were no never events (serious largely preventable patient safety incidents that should not occur if proper preventative measures are taken) in medical services between May 2014 and April 2015.
- 84 serious incidents were reported in medical services between May 2014 and April 2015. Of these, 59 were grade 3 pressure ulcers and 8 were slips, trips or falls. We

found systems were in place to investigate these incidents through root cause analysis and a scrutiny panel chaired by the director of nursing or assistant director of nursing.

- "Safety huddles" were used to discuss incidents and complaints on all medical wards.
- Ward managers were aware of the numbers of pressure ulcers reported for their ward and the Quality Notice Boards on the wards contained information on the number of pressure ulcers which had developed after admission to hospital. All pressure injuries are scrutinised at the weekly Essential Care Scrutiny panel with any learning identified completed by ward managers. Actions taken to reduce pressure ulcers included training for staff and the introduction of clinical champions. There was also a trust wide action plan in place with ward action plans for specific ward based issues.
- We received mixed feedback from staff as to whether incident reporting was encouraged. A junior doctor told us errors were occurring at weekends due to pressure and staffing levels but there was no time to complete incident forms. Nursing staff we talked with said they completed incident forms when staffing levels compromised patient care.
- Staff were aware of the "Duty of Candour" which ensures patients and/or their relatives are informed of incidents which have affected their care and treatment and are given an apology. They told us of incidents which had occurred and had been discussed with patients.
- We were told each speciality within medicine reviewed all deaths and a monthly mortality and morbidity improvement group reviewed audit data from each specialty. Additional medical staff had been put into place at weekends to address the issues identified.
- In-hospital mortality for dermatological conditions and gastroenterological conditions was identified as an elevated risk in the autumn of 2014. The trust had responded to these concerns but we were awaiting further information from the trust. We saw notes of a gastroenterological morbidity and mortality meeting attended by consultants from March 2014 but were not provided with any evidence of any meetings since.

Safety thermometer

- The NHS safety thermometer is an improvement tool to measure any harm and harm free care to patients. It provides a monthly snapshot audit of the prevalence of avoidable harms in relation to new pressure ulcers, patient falls, venous thrombo-embolism and catheter associated urinary tract infections
- Safety thermometer data was collected by the trust on a monthly basis. A high number of pressure ulcers were reported consistently across the year (March 2014-March 2015) with low numbers of falls and catheter associated urinary tract infections.
- Safety thermometer results were electronically available to ward managers. However, we did not see these displayed on the wards. We were told by a ward manager the results were not felt to be meaningful as the numbers were inclusive of community acquired pressure ulcers and the majority of the ulcers were community acquired. The ward quality boards provided information about the number of pressure ulcers and falls which had occurred on the ward.
- Within the emergency assessment unit, the quality and safety dashboard displayed information which informed us that there had been four incidents resulting in harm and sixteen resulting in no harm. With regards to patient falls within the unit there had been two falls resulting in harm and two with no harm recorded.

Cleanliness, infection control and hygiene

- There were no cases of MRSA in medical services between August 2014 and July 2015. We saw weekly MRSA screening was undertaken in all the wards we visited.
- Ward and department cleanliness audits had been carried out monthly.
- Most of the wards we visited appeared visibly clean. However, we found there had been no cleaning by lunchtime on the Midwifery Birthing Unit where medical patients were placed on the first day of our inspection visit and patients told us cleaning in this area was "patchy." We found a refrigerator in a relative's room on Harvey ward was not clean and was being used to store nutritional supplements brought in by the patients relative.
- On the second day of the inspection there was a sewage leak from the sluice room into the ward on Fleming ward. This was cleaned up promptly by staff, the estates department were informed and a full deep clean was carried out.

- We observed staff cleaning clinical equipment after use and equipment was labelled as clean with the date of cleaning.
- Patients told us they felt the wards were clean. One patient said, "I have been in a few hospitals and this is good." Another patient said, "They (the staff) are always in here mopping and polishing."
- We saw staff using the appropriate personal protective clothing and equipment and following "bare below the elbows" guidance in the clinical areas. Clear signs were in place at the entrance to side rooms which were being used for patients with infections.
- Hand gel was available at each bedside and we saw staff cleaning their hands appropriately. Hand hygiene audits were carried out on all the medical wards and reported monthly. Compliance was over 95% on all wards between April 2014 and March 2015. The results were displayed along with other quality indicators on display boards on each ward.
- There were two endoscopy rooms situated within the Alexandra day surgery unit. These rooms were spacious and appropriately equipped. There was a clear pathway for clean and contaminated flexible endoscopes, used scopes were passed via a hatch from the endoscopy room to the decontamination area, which meant that there was no cross contamination. Equipment was decontaminated in line with national guidance. Documentation records were in place that provided a full audit and traceability process.

Environment and equipment

- We observed wards had moving and handling equipment available to care for patients safely and equipment was maintained and checked to ensure it was safe for use. We were told pressure relieving mattresses could be obtained within 24 hours and when patients were admitted through the Assessment Unit the pressure relieving mattresses were normally obtained prior to transfer to the ward when it was required.
- We examined the resuscitation trolleys on each ward and found they were locked and we saw records of daily checks.
- We found scalpels being inappropriately stored in unlocked store rooms on Locke Ward. This was a safety concern. Following our inspection action was taken to address this and they are now stored in a locked room.
- Endoscopy was situated within the Alexandra day surgical unit. The unit was undergoing major refurbishment with the aim to gain joint advisory group accreditation. The current environment was not compliant with single sex accommodation with three mixed patient's bays in a cramped area. Temporary buzzers had been put in place for patients to call nurses whilst the refurbishment was ongoing. The risk assessment for the building works had been completed on the 31 March 2015 and had stipulated that the contract phase was for four weeks. This had not been updated throughout the works and therefore current risks were not clearly identified.

Medicines

- The hospital used a comprehensive prescription and medication administration record chart for patients which facilitated the safe administration of medicines. Medicines interventions by a pharmacist were recorded on the prescription charts to help guide staff in the safe administration of medicines.
- We looked at the prescription and medicine administration records for ten patients on two wards. We saw appropriate arrangements were in place for recording the administration of medicines. These records were clear and fully completed .The records showed people were getting their medicines when they needed them, any reasons for not giving people their medicines were recorded. This meant people were receiving their medicines as prescribed.
- Medicines, including those requiring cool storage, were stored appropriately. We saw controlled drugs were stored appropriately, but staff had not always followed the hospital policy in recording stock checks. Controlled drugs are medicines which are stored in a special cupboard and their use recorded appropriately within the controlled drug book.
- There was a pharmacy top-up service for ward stock and other medicines were ordered on an individual basis. This meant that patients had access to medicines when they needed them while in hospital. Staff told us that there was often a delay in obtaining medicines for patients to take home, and that some patients chose to go home and return to collect their medicines at a later date.

- The pharmacy team visited the wards daily. We saw that pharmacy staff checked that the medicines patients were taking when they were admitted were correct, that records were up to date and the medicines were prescribed safely and effectively.
- We observed medicines rounds in progress and saw staff checked the identity of patients prior to administering their medicines. We observed them talking to patients and explaining their medicines to them during administration. We saw nurses undertaking drug rounds were interrupted by staff during the round, distracting them from the task in hand and increasing the risk of errors.
- Medicines audits had been carried out and the results fed back to the individual wards.

Records

- Records were kept in both paper and electronic format and all professionals documented in the same record. The main record was a paper record and a new electronic patient administration system had been introduced which was used for discharge documentation. The nursing assessment and care plans were kept at the bedside with the observations charts and the ongoing evaluation of nursing care was documented in the multi-disciplinary record.
- Records were generally stored on the ward in notes trolleys which were by the nurse's station.
- The care records we examined contained an initial nursing admission assessment and a standard range of risk assessments including assessments of the risk associated with moving and handling, pressure ulcers, falls, nutrition and bed rails. These had been updated weekly. The risk of blood clotting was assessed on medication charts.
- The initial nursing assessment was structured using a framework developed by the trust using the acronym "compassion" to identify the patient's nursing needs and the ongoing evaluation of care used the same acronym. Care plans were in place for additional care interventions such as catheter care however, there were some inconsistencies in the use of care plans. For example on the stroke unit one person had a mobility care plan but no other care plans and on Ray ward we could not find evidence of a wound care plan for someone with a pressure ulcer.

Safeguarding

- Staff were able to describe situations in which they would raise a safeguarding concern and how they would escalate any concerns. They told us the trust's safeguarding team managed the referral to the local authority and they received feedback from them following referrals.
- A care record we reviewed documented a concern raised by staff which had been referred to the safeguarding team.
- Two social work teams covering Hertfordshire and Essex were based at the hospital. This facilitated liaison and multi-disciplinary working.
- There were bi-monthly safeguarding meetings chaired by the director of nursing and a daily report which highlighted any safeguarding issues which was reviewed by senior nurses.
- Patients told us they felt safe in the hospital. One person said, "I feel completely safe, completely at ease." Another person said, "I have no concerns about any of the staff."
- Safeguarding training was included in the trust's mandatory training programme. We saw most staff had completed adult safeguarding training with a compliance of 99% for medical services.

Mandatory training

- Staff on the medical wards said they had good access to mandatory training and the ward managers monitored compliance of nursing staff. Mandatory training was being reviewed and the mix of e-learning and face to face training re-considered. We were told there was a move towards some mandatory training being completed every two years rather than annually.
- Notes from the medical services patient safety and quality group indicated training had been cancelled between January and March 2015 due to operational pressures.
- When we looked at individual compliance rates with mandatory training we found compliance did not always meet the trust's targets. For example, there was a compliance of 56% for equality and diversity training, 81% for dementia training and 74% for infection control training. However staff on Harvey ward had completed 100% of the mandatory training.

Assessing and responding to patient risk

Medical care (including older people's care)

- The National Early Warning Score was used to identify patients whose condition was deteriorating. We found the score had been calculated each time vital signs observations had been completed and the scores had been calculated accurately.
- The criteria for escalation were printed on the patient observation charts and staff we talked with were aware of the escalation process. Most staff told us that when they escalated to medical staff they used the Situation, Background Assessment Recommendation tool to ensure a structured report and they said medical staff responded promptly. One member of staff who worked predominantly night shifts told us medical staffing levels at night meant delays sometimes occurred and the outreach team did not work after 8pm. They told us of an occasion when they had escalated to medical staff who did not seem to recognise the urgency of the referral and had not been able to respond immediately. They felt the patient was peri-arrest and therefore put out an arrest call to ensure the patient received prompt attention;
- We found an inconsistent approach to escalation on Locke ward where we saw one patient whose national early warning score had risen to the trigger level and there had been a two hour delay in the critical care outreach team being called. We could find no evidence of a medical review in the patient's notes. Two additional patients had national early warning scores which should have triggered escalation but there was no evidence of escalation in the patients' records.

Nursing staffing

- There were checklists to ensure checks had been completed for agency staff prior to working on the wards. Staff told us that because agency staff were unable to deal with infusion pumps, and diabetes machines due to a lack of training and unfamiliarity with the documentation, their contribution was limited and the pressure on the permanent staff was not reduced.
- We were told staffing levels had been reviewed and had been increased on some wards. Ward managers told us the safer nursing care tool was being used on the wards but were unaware of how the decisions on staffing levels had been made.
- The medical wards were experiencing significant shortfalls in their nurse staffing levels due to a large number of vacancies. Data provided by the trust indicated that three wards had more than 10 whole time equivalent vacancies (Winter Ward, Harold Ward and the Stroke Unit), a reduction of approximately 33% in March 2015.
- The position had not changed significantly at the time of the inspection and we were told as a result of difficulties in recruiting registered nurses, the numbers of healthcare assistants was being increased. While staff appreciated the increase in health care assistants to help with basic care, some felt it was not tackling the underlying skill mix issue.
- The trust identified steps it had taken to recruit registered nurses but the turnover of staff resulted in little progress being made to the overall numbers of nurses in post. The trust had a plan in place which included a number of initiatives but progress was protracted.
- We found most wards had registered nurse vacancies which impacted on their ability to achieve the agreed staffing levels. The impact of this on the safety of care was limited on some wards where there was a core of experienced staff and excellent ward managers. We found instances where ward managers were working a considerable amount of additional hours and prioritised clinical work at the expense of management tasks. However, they flagged the impact it had on their availability to talk with relatives, the ability to support student nurses, and a reduction in the number of quality audits they were able to undertake.
- On Winter ward, the ward manager had been moved from another ward and to support the provision of leadership on Winter ward until the new Manager started; this was scheduled for September 2015. The number of permanent nurses available during the week of the inspection was not sufficient to provide a registered nurse on every shift due to vacancies, annual leave and sickness. The ward was covered by moving staff at short notice from other wards. This impacted on the continuity of care for patients. On the second day of the inspection there were no permanent registered nurses rostered on duty. The situation had been escalated to the matrons and senior staff when the roster was completed and the previous day but remained unresolved at the start of the shift. This left other wards below their core agreed staffing levels.
- The trust had closed Locke ward prior to the inspection as they had identified concerns regarding the impact of staffing levels on patient safety. At the time of the

inspection Locke ward had been re-opened with a reduced number of beds and with a remit to care for patients who needed transitional care or were close to discharge. However, agreed staffing levels were not being achieved and capacity issues resulted in pressure to admit additional patients.

- One person said, "Being moved to cover other departments is demoralising for staff and impacts on patient safety." Nurses were very aware of the difficulties in recruitment and when asked if they had raised their concerns one person said, "Yes but their hands are tied. They have to do what they can to cover the hospital and consider safety in other departments."

Medical staffing

- The medical staffing skill mix was broadly in line with the England average, except there was a lower percentage of registrars/specialist registrars and a greater number of middle career doctors (Health and Social Care Information Centre Sept '04 –Sept '14).
- The senior managers identified the challenges they were experiencing in attracting consultants to the trust. The impact of this was most marked in the stroke service where there were no permanent stroke consultants currently employed and the trust were utilising two locum consultants. This impacted on the leadership and development of the service.
- There had been no consultant attendance on Fleming ward from Monday to Thursday during the inspection visit. Medical staffing had been informed but it was unresolved. The trust stated that a consultant was available to provide advice to the senior doctors or review patients as necessary. A proportion of patients on Ray ward under the care of a consultant who we were told, reviewed the patients on an "ad hoc" basis. We were told a permanent consultant had left the trust in June and there was no locum replacement. Ward staff had escalated to the chief medical officer the previous week and they had attended the ward at the weekend to review the patients, an indicator of the fragility of the situation. These wards were care of the elderly and chest medicine. On Harvey ward there was no medical entry for three days suggesting the patient had not been reviewed by a doctor for this period. We were not assured that daily ward rounds occurred on medical wards.
- There had been no junior doctor rotation to Ray Ward since April 2015 and locums had been utilised for these posts since that time. In some areas junior doctors told us they missed training due to the pressure of work.
- There was high locum staff usage between June 2014 and March 2015 with levels between 17% and 31%, averaging at 19%.
- There was no specialist cover out of hours for cardiology or stroke. Medical services were covered with a registrar and two junior doctors at night. Specialist stroke cover is provided daily via a Telemedicine link with the stroke network.
- The medical leads had identified the need for additional medical staff at weekends and told us they had put in a business case for an additional 13 FY2 doctors to make weekend cover safer. They were also three to four registrars short to enable a compliant roster and utilised locum registrars at night and at weekends to provide the required staffing.

Major incident awareness and training

- The ward managers we talked with were not sure of their role in a major incident and staff had not been involved in any practices. We were told the wards had not been involved to reduce the pressure on them and matrons would advise the wards of the action to be taken in the event of a major incident. The trust stated that assurances were provided through the major incident plan as directions would be given from the operational Bronze or Matron.

Are medical care services effective?

Requires improvement

Medical services required improvement to ensure that patients receive an effective service. Medical services participated in all the national audits relevant to their specialty and national peer reviews. However, performance was below the England average in some of these and robust action plans were not in place to ensure improvement. We had particular concerns in relation to stroke services.

There was a lack of consultant oversight in several specialties. Consultant ward rounds were not undertaken

daily and weekend provision of support services was reduced. There is a formal trust wide arrangement for the provision of out of hours radiography via an on call system.

Patients gave their consent for care and treatment and were involved in decision making. The Deprivation of Liberty Safeguards was being adhered to and we saw evidence of mental capacity assessments being undertaken when people lacked the capacity to make some decisions themselves.

There was a multi-disciplinary approach to care and treatment and good communication between teams. We saw some examples of effective pathways and a multi-disciplinary approach to care in the ortho-geriatric unit.

Evidence-based care and treatment

- Staff were aware of National Institute for Health and Care Excellence guidance relevant to their specialty and we saw they had access to the guidance via the trust's intranet.
- Local protocols were in place in line with National Institute for Health and Care Excellence guidance. In particular we found there were well written protocols and pathways for use in the ambulatory care unit which were followed by staff.
- Integrated care pathways were also used in cardiology and stroke services to ensure adherence to national guidance.
- A range of locally produced guidelines were available on the trust intranet, however, we saw staff had some difficulties in locating these in a timely way.
- We saw local audits were undertaken to assess adherence to best practice and identify areas for improvement and we were told of action taken to improve the service provided based on the outcomes of the audits. These included hand hygiene, stool audits and sharps audits.

Pain relief

- The nursing assessment tool used within medical services included an assessment of patients' pain using a standardised tool. Pain levels were recorded on the National Early Warning Score chart.
- We observed staff asking patients if they required pain relief during medication administration rounds.
- A patient told us they felt their pain was well managed. Other patients told us staff responded in a timely manner when they asked for pain relief.
- There was a policy in place for safety and sedation during endoscopic procedures. This policy had no footer indicating author, date or review date and was quite difficult for the staff to find when asked.

Nutrition and hydration

- Patients' nutrition status was recorded within the nursing assessment tool. However, there was no formal assessment of hydration in place.
- Food and fluid charts were in place as necessary, but they were not fully completed and kept up to date.
- Patients had access to water in jugs at the bedside. Drinks were mostly placed within patients' reach but on Henry Moore ward, a drink had been left out of the patient's reach and the patient asked the inspector to move it to allow them to access it. There were hot drink rounds at intervals during the day and we saw patients being helped with these. We observed tea being offered in the middle of the afternoon on the Stroke Unit. There were a variety of teas to choose from and biscuits were offered.
- We observed the lunchtime meal being served on Henry Moore ward and saw all staff were involved during the mealtime but the consultant continued with their ward round. We observed a person being assisted to eat and saw staff talking with them and checking with them. They left the person briefly to assist someone else, but explained what they were doing and returned within a minute. On Ray Ward we saw a bell was used to signal the start of the meal to staff and they promptly attended to the serving of the meal.
- We talked with two volunteers who helped at meal times as "Meal time Buddies". They came in regularly and provided assistance to patients who required help. They told us they had received training prior to starting this role.
- We talked with a speech and language therapist who was allocated to the Stroke Unit three days per week. We found they were newly qualified and had not completed the full training to enable them to carry out full dysphagia assessments. There were vacancies within the team and as a result it was difficult to provide a timely response to referrals in some circumstances.

Patient outcomes

Medical care (including older people's care)

- We saw evidence of participation in national audits such as the Sentinel Stroke National Audit Programme, the Myocardial Ischaemia National Project, Chronic Obstructive Pulmonary Disease audit and the National Diabetes Inpatient Audit.
- The Sentinel Stroke National Audit Programme (Oct 2013-Sept 2014) gave the Trust an overall rating of 'D' on a scale of A to E with A being the best. The trust had scored level 'D' in every re-iteration since December 2013. The team-centred rating and the patient centred rating were both rated 'D'. Specialist assessments and standards by discharge were rated the worst at 'E'. This meant that the percentage of patients who were seen or assessed by the specialist stroke team was at the lowest end of the range. The percentage of patients receiving assessments required prior to discharge was also at the lowest end of the range. We found stroke patients were being seen by the general medical teams out of normal working hours. We found stroke patients were being cared for in other areas whilst the Stroke Unit was caring for patients with who had not suffered a stroke. Staff had not been able to maintain a ring fenced bed for thrombolysis patients. The trust recognised its problems in providing a hyper-acute stroke service and had plans to discontinue the service. However we found there was a lack of understanding of the detail behind the audit performance amongst senior staff and a lack of leadership of the service. The ward manager was newly appointed and was committed and enthusiastic but there were no permanent consultants in post.
- The trust had a worse than average performance in the Myocardial Ischaemia National Project (2013/14) but improved against the results of 2012/13 in two out of the three measures. The trust's performance had worsened from 96% to 84% of patients being seen by a cardiologist but admission to a cardiac ward and access to an angiogram had improved from 13% to 39% and 69% to 86% respectively.
- In the National Diabetes Inpatient Audit (2013) the trust had performed better than the England average in 13 of the 21 measures and worse in seven. Overall satisfaction with the service was at 77% whilst the England average was 86%./ Only a quarter of patients were seen by the multidisciplinary team as opposed to the England average of 60%.
- In the Chronic Obstructive Pulmonary Disease audit the trust was in the lower quartile for overall scores. The trust performed well on treating patients with non-invasive ventilation and respiratory failure. However the trust was in the lower quartiles for access to specialist care and senior review on admission.
- There was evidence of participation in the national peer review programme for cancer services and trauma services.
- Average lengths of stay for both elective and non-elective admissions were shorter than the England average in medicine. However, cardiology stays were longer than the England average for both elective and non-elective admissions. We found cardiology consultant led ward rounds did not occur on a daily basis and this may have had an influence on length of stay.
- The risk of readmission was higher than the England average (2014) in non-elective geriatric medicine and elective haematology The hospital episode statistics for 2013-14 on Standardised Relative Risk of Readmission indicate how services compare nationally in providing care that is effective, such that patients recover and do not require a return visit to hospital.
- We asked the medical management team about issues affecting readmissions to medicine and they told us they were carrying out an assessment of re-admissions to gain a better understanding of the issues. However, they felt data coding issues were a contributory factor.

Competent staff

- Clinical staff told us they had annual appraisals and ward managers told us annual appraisals were due the following month. They said there was a trust wide approach to the appraisal timetable.
- The trust's own appraisal data indicated a wide variability in appraisal rates. For example, Henry Moore ward showed 100% appraisal for nursing and midwifery registered staff, additional clinical services and for administrative and clerical staff, whilst the Stroke Unit indicated less than 30% of staff in any group had had appraisals in the year from April 2014 to March 2015.
- Junior medical staff we talked with said they felt there was good support and supervision from more senior doctors. Some junior doctors said they had difficulties attending training sessions due to the pressure of work and lack of cover on the wards.
- There was good access to nationally recognised training for healthcare assistants including apprenticeships and the care certificate.

Medical care (including older people's care)

Multidisciplinary working

- There was a multi-disciplinary approach to record keeping with all professions contributing to the ongoing record of care.
- We found evidence of the input of dieticians, speech and language therapy, occupational therapy and physiotherapy in patient records.
- We saw multi-disciplinary team meetings occurring with attendance from medical staff, occupational therapy, physiotherapy, and a ward nurse. We saw a structured multi-disciplinary team meeting led by the ortho-geriatrician with all members of the team contributing.
- Staff told us multi-disciplinary working was good. One staff said, "The multi-disciplinary team is very good here. Everyone is friendly and approachable." However, on Lister ward which cared for people with complex care needs, nurses sometimes felt overruled in relation to decisions related to enteral nutrition within the multi-disciplinary team meetings.
- Referrals to speech and language therapy were made through leaving a telephone answerphone message. However, staff told us they did not always receive the referrals and a better process was needed particularly after hours.
- There was no unified referral process to other specialties and teams. It was reliant on staff ringing or using a fax. We were told it was particularly difficult to make referrals to surgeons as they were often in theatre. Staff said they would ring the Consultant if urgent.
- Two social work teams covering Hertfordshire and Essex were based at the hospital. This facilitated liaison and a multi-disciplinary approach.
- A patient told us they had a rare condition and had been referred for investigations and specialist input at a specialist trust. However, they had experienced difficulties in communication between the two trusts. They said medical staff had had problems in contacting the consultant at the specialist trust to follow through after the investigations had been completed.
- From the notes we reviewed and the staff we talked with, it was apparent there were waits of up to a week if a person was referred to mental health services. Senior managers told us they had initiated a monthly meeting with staff from the mental health trust to discuss issues and improve working between the two trusts.

Seven-day services

- Therapy services were reduced at the weekend.
- There was cover from a speech and language therapist or an assistant at weekends for the stroke unit only. The stroke specialist nurse and some ward managers had been trained to undertake swallow screening and these staff could carry out an initial assessment of patient's ability to swallow following a stroke but a full assessment by a speech and language therapist was available only during normal working hours.
- There was no specialist consultant cover out of hours and at weekends for stroke services.
- In cardiology, there was no formal specialist medical cover at night and consultant cover at weekends was "ad hoc" with consultants often not being available.
- There was no formal interventional radiography rota at weekends. There was a reliance on informal contact and good will.
- There was a reduced service for phlebotomy at the weekends. Junior doctors told us 50% of the phlebotomy had to be undertaken by them at the weekend and the samples had to be taken physically to the laboratory, which was a drain on their time. They said they had raised it with their consultant but no action had been taken.

Access to information

- There were issues with the availability of patient records as these were stored off site. We were told it normally took a couple of days to obtain the record. During the inspection we observed large numbers of temporary folders in use to store the current record until the permanent record was obtained. This meant there was limited information available to staff within the first 48 hours of admission about the person's past medical history.
- The use of a multidisciplinary record, facilitated communication between the different professional groups and ensured information was available to all those involved in the patient's care.
- On our visits to the medical wards we saw there was good access to computer terminals for staff.
- An electronic system for discharges had been recently introduced as part of the new patient administration system. Whilst staff were generally positive about an electronic system some staff told us they felt it was very cumbersome and difficult to navigate. They said there

were problems with logging into the system and frequently being logged out and a lack of information technology support to rectify the issues in a timely way. One staff said, "I would rate it two out of ten."
- Discharge summaries were sent to GPs electronically and patients were given a copy to take home with them.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We observed providing care to patients. Staff explained what they were about to do and checked the person's wishes prior to providing care. Patients told us staff sought their consent prior to providing care and treatment.
- We saw documents were in place for consent to diagnostic scans and interventions. These were completed appropriately to show that patients understood the procedure and relevant risks.
- We asked staff about the Deprivation of Liberty Safeguards. These safeguards protect the rights of adults using services by ensuring that if there are restrictions on their freedom and liberty these are assessed by professionals who are trained to assess whether the restriction is needed. Staff understood the safeguards and was able to identify if any patients on their ward had a deprivation of liberty safeguard authorisation in place.
- We saw two patients who had a deprivation of liberty safeguard authorisation in place with appropriate documentation and care plans to support this.
- Mental capacity assessments had been carried out for some people when they were unable to make decisions for themselves. For example, a capacity assessment had been completed for someone who was unable to make their own decision about whether they wanted to be resuscitated if they suffered a cardiac arrest. We also saw a capacity assessment followed by a deprivation of liberty safeguard application for someone who wanted to discharge themselves but did not understand the implications of this for their health and well-being. However, we found an instance where bed rails had been put into place and there was no evidence of consent being obtained or a capacity assessment having been undertaken.

Are medical care services caring?

Good

Care was provided by staff that were kind, caring and compassionate in their approach. People's privacy and dignity was respected and they were involved in decisions about their care. Patients praised staff for their professional approach and friendly manner. One person said, "This hospital is like an old friend and I have always been well looked after."

Patients told us staff explained everything to them and provided emotional support when it was needed. We saw staff spending time with people when they were anxious or distressed, providing reassurance and explanations.

Compassionate care

- Nursing assessments were structured around the word compassion and as a result staff were constantly reminded of the priority the trust gave to this.
- The number of responses to the Friends and Family Test survey was slightly lower than the England average, at 27%, with ward response rates varying from 18% on Winter Ward to 59% on Harvey Ward between March 2014 and February 2015. The average score obtained from the friends and family test for June 2015 for the medical wards was 77 out of a possible 100.
- Patients without exception told us staff were kind and caring. One patient said, "The best care you could possibly wish for. Staff are so sweet and caring and always very calm." Another said, "The caring is outstanding."
- There were also positive comments about individual staff groups such as, "All the care assistants are fantastic. There's not a bad one amongst them."
- Patients told us staff were always willing to help them when they needed it. For example, one person said, "I don't feel anything is too much trouble for them (staff). If I ask for help they always help."
- We observed staff showing empathy towards patients and talking to them in a kind and reassuring manner. We spoke to the relatives of two patients who were confused who stated, "The ward and staff are exceptional."
- We observed staff protecting people's privacy and dignity. A patient said staff pulled the curtains round their bed and they felt this was adequate for privacy.

They went on to say they felt respected and their dignity was preserved. Another person valued the fact staff had given them a single room with an en-suite toilet as it enabled them to maintain their independence which would not have been possible otherwise. Patients told us maintaining their independence was very important to them.

- We heard staff asking a person when they first arrived on the ward, what they preferred to be called and a patient commented "Staff are friendly and know you by name." However, we also heard staff referring to patients by their bed number rather than their name on some wards.
- The national inpatient survey scores for questions related to doctor' communication with patients and confidence and trust in doctors was at the lowest end of the range compared with other trusts. Actions to address this had been identified and were being taken forward.
- The trust carried out a survey of dementia carers during 2014 and action identified to improve carer's experience including a flexible approach to visiting, provision of information on dementia screening and ensuring there was communication on a patient's progress to their carer.
- At the time of the inspection the Endoscopy Unit was being redeveloped. The area was cramped and there was no ability to provide single sex accommodation. Patients were in three mixed bays and separated by curtains which could lead to potential issues with maintaining a patient's privacy and dignity.

Understanding and involvement of patients and those close to them

- Most patients we talked with said they felt staff communicated with them well and kept them up to date with what was happening. One person said, "I'm completely aware of what is happening from the Accident and Emergency department through to the ward."
- Another person told us they were involved in their care and the care planning.
- A person told us they did not understand why their condition kept recurring and the senior doctor's explanation was not clear, but they said, "I feel as though I get an honest answer from the consultant and he explained everything."

Emotional support

- We saw staff providing reassurance and support when people were anxious. An older person who had just arrived on the ward was very distressed and confused and we observed a nurse explain to the person where they were and what was happening. They sat with the person and held their hand for a few minutes and gave lots of reassurance in a very empathetic way.
- All of the wards had a "quiet room" where people could spend some time away from the hustle and bustle of the ward and where staff could talk to them in private. We saw the room being used by a doctor talking to the family of a patient.
- The ward manager on Lister Ward identified the negative effects of over stimulation for people with confusion and dementia. The ward were also using their quiet room as an area in which to use reminiscence aids for people with dementia, providing a calm environment for patients who were anxious and distressed.
- The chaplaincy service provided spiritual and emotional support to patients and their families.

Are medical care services responsive?

Requires improvement

Medical services required improvement to ensure that services were responsive to the individual needs of patients. There was evidence of service planning to meet the needs of local people and the trust was working with stakeholders to identify solutions across the health community. However, there were significant capacity issues and patients were not always placed in the specialty most appropriate to their diagnosis.

We could not be confident the referrals to treatment times were meeting national standards as the trust had not submitted data since September 2014. A significant proportion of patient moves and discharges occurred after 8pm.

An initiative to improve services and support to people with a learning disability had been developed and there

were some examples of good practice in relation to the care of people living with dementia. Patients concerns and complaints were listened to and action taken to improve.

Service planning and delivery to meet the needs of local people

- The ambulatory care unit had been developed to enable local GPs to refer people who might otherwise have been admitted to hospital. We were told less than 2% of people attending the unit were admitted to other wards.
- An ortho-geriatric consultant had been appointed and this enabled people admitted to hospital with a hip fracture to be transferred to their care following surgery, and to be cared for in an environment tailored to their needs.
- Meetings were held with the Clinical Commissioning Group regularly to discuss transfers of care, where additional capacity was needed and ensure care was delivered as close to the patient's home as possible.
- The trust were working with the Clinical Commissioning Group to develop a frailty rapid access service for older people.

Access and flow

- The hospital admitted a high number of medical admissions through the emergency department, making flow unpredictable. There was a daily meeting attended by the ward managers from the medical wards to discuss discharges and patient flow.
- During the week of the inspection there were significant capacity issues. We did not see evidence of consultants who had patients on medical wards being engaged and responding to these pressures by increasing the frequency of reviews of patients.
- When patients were admitted to a medical ward they were placed under the care of one of the consultants covering the ward and, in order to reduce bed moves for patients, they remained on that ward unless their medical condition was such that it was felt they needed to move to a specialist ward or there was a requirement to move them to a ward providing transitional / pre-discharge care. Therefore, if they were not placed on the ward most appropriate to their clinical condition initially, they may not be transferred following admission. As a result, there were considerable numbers of general medical patients on the stroke unit and stroke patients on other wards. In the same way, cardiology patients could wait for some days in the emergency assessment unit or could be admitted to other wards.
- The stroke consultant and specialist nurse visited patients on other wards daily where possible to provide advice and input.
- We found medical patients were placed on the midwifery birthing unit on the first day of the inspection due to capacity issues. This was an inappropriate environment for medical patients who could hear maternity patients in labour and increased the risk of cross infection for women and their babies whose immunity would not be well developed. We expressed our concerns to the chief executive and director of nursing and the patients were moved to alternative wards.
- A large proportion of bed moves in medicine occurred out of hours. 36% (number: 5171) of bed moves occurred between the hours of 2000hrs and 0800 hrs between December 2014 and July 2015. We saw examples of two patients who were transferred to Locke Ward from other wards at 22.20 and 23.30hrs during the week of the inspection. This can be disorientating and unsettling for patients.
- Over 50% of patients were not moved from their original ward during their admission however over 10 % of patients were transferred twice or more within their admission.
- A plan had been put into place to manage winter pressures but it was acknowledged that this had not prevented ongoing issues associated with a lack of capacity. Ward managers attended a 9am meeting daily to discuss discharges and capacity issues. We did not see evidence of consultant engagement on the wards in relation to the management of capacity and daily consultant led ward rounds were not taking place in several wards. Junior doctors on one ward told us they felt they were pressured into discharging patients early.
- We saw evidence of discharge planning in the care records we reviewed and this began shortly after admission.
- An electronic system was used to produce discharge summaries and monitor flow of discharge medications and transport. A discharge team had recently been established to improve discharge flow.

Medical care (including older people's care)

- 12% (1,326) of all discharges in medicine were out of hours (between 2000hrs and 0800hrs) in the same period.
- The trust had not submitted data on referral to treatment times since September 2014. At that time the reported data indicated 18 week referral to treatment times targets were being met in all medical specialities with the exception of rheumatology.
- The 62 day cancer referral to treatment standard was being met in 81% of referrals.

Meeting people's individual needs

- The hospital had introduced a learning disability liaison nurse role and undertaken work to improve the identification of people with learning disabilities using the trust's services and the improve their care and experience of care.
- We found variable knowledge of the learning disability services amongst staff. Some staff were aware they could contact the nurse for advice if they had a person living with a learning disability on the ward, whereas others were not. One member of staff told us they had not had any training in learning disability but would look for a hospital passport. If the person did not have a passport or a carer to stay with them, "They would have to do their best." They did not know about the liaison nurse post.
- The trust had a dementia strategy group and there was a ward manager who was a member of the group. The ward manager had a master's degree in dementia and was committed to improving care for people with dementia. This was evident within the ward where we saw a number of changes had been introduced to improve the experience of people with dementia. There was also a large notice board on the ward with information about dementia for staff and visitors.
- 81% of staff on medical wards had completed mandatory training in dementia. In addition staff on Henry Moore ward had undertaken an external accredited module in dementia.
- Staff were aware there was access to interpretation/ translation services if a patient was unable to speak English. They told us they would access the service through the patient advice liaison service.
- We saw information leaflets were available on the wards. These included general generic trust information on topics such as infection control, and some relevant diagnosis/ condition specific information.
- We saw intentional rounding was in place two hourly for patients to ensure they were checked and their personal needs attended to.
- Most patients told us the food was good and they were offered a good choice of meals. One person said, "I am very impressed with the food. The choice suits me." Another person said, "I am very happy with the food, except I think there should be an option of a side salad with sandwiches in the evening." They went on to say they weren't provided with much fruit or vegetables. One person told us some meals were tasty but some lacked taste.

Learning from complaints and concerns

- We found there were leaflets entitled, "Listening, Responding, and Improving your Patient Experience' were available on the medical wards. These provided information about the Patient Experience Team, patient advice liaison service, how to make a complaint and the Friends and Family Test. However, for patients who wanted to make a complaint, the content of the leaflet may not have been apparent at first glance.
- A patient we talked with said they had not received any information about how to make a complaint but they knew from previous experience they could contact the patient advice liaison service. Another patient said they would not know how to make a complaint.
- Patients were happy with the care provided and said they would feel able to speak to staff if they had a complaint or a concern.
- Staff told us if a complaint or concern was reported to them they would try to rectify the issue if they could and would escalate to the nurse in charge or matron if they couldn't deal with the issue themselves.
- Complaints were identified on monthly ward 'Exception Reports" which identified quality issues and concerns and were discussed at the patient safety and quality group.
- Ward managers were able to tell us about recent complaints on their ward and the action taken to improve as a result. For example, the ward manager of the stroke unit told us of the introduction of a checklist for patients being discharged with enteral feeding in place.
- We did not find a high level of complaints in medical services compared to other trusts.

Medical care (including older people's care)

Are medical care services well-led?

Requires improvement

The leadership of the medical services required improvement to ensure that the issues highlighted in this report were addressed in a timely manner. The lack of robust bed management to ensure that patients were on the speciality wards, the lack of clinical oversight and the movement of staff were not being addressed at the senior management team level for this service. There was a lack of engagement with the matron level as staff felt that they were not listened to when reporting concerns. However there was excellent leadership at ward level from experienced and enthusiastic ward managers.

There was a clear governance structure, framework and evidence of review of the risks to the service and there was a commitment towards continuous improvement. There was good staff and public engagement.

Vision and strategy for this service

- The medical leads told us their strategy was to further develop and re-patriate medical services over the next five years. They wanted to harness the enthusiasm of newly appointed consultants to develop services such as polyclinics for gastroenterology and sleep studies for respiratory services. They were committed to working towards the trust's overall aim of becoming an integrated care organisation; however, they identified the need to resolve the issues with the recruitment of medical staff first.
- Staff were aware of the trust values of being caring, respectful, committed and responsible and staff had attended training which focused on the trust values, standards and behaviour.
- We saw medical services had produced a quality and governance strategy outlining their approach to improvement over the next five years.

Governance, risk management and quality measurement

- The quality dashboard for medicine supplied by the trust was for February 2015 and at that time, although quality indicators had been identified, reporting of performance against some of these was not yet in place.
- There was a clear structure for governance within medical services which had been implemented within the last year. Medical health care group and patient safety and quality meetings were held monthly which reported to the trust patient safety and quality committee. Ward and department patient safety and quality group meetings were held monthly and there was a framework to ensure review and escalation via exception reporting. The medical leads felt the structure was becoming embedded and was effective.
- A quality improvement programme called "Clinical Fridays" where individual topics or groups of cases were discussed to identify learning, had been introduced, with attendance from nurses and medical staff across a range of seniority, along with clinical nurse specialists and non-clinical staff.
- Medical leads told us of learning which had been identified following a deteriorating patient who required admission to the intensive therapy unit. The serious clinical incident review group had identified issues and following a root cause analysis it was taken to the scrutiny panel. As a result of the findings, they had started work on 'Sepsis 6', an initiative to ensure patients with signs of sepsis were identified and given antibiotics within an hour of arrival.
- Key performance indicators had been identified for wards within medical services. Display boards in every ward gave an indication of current performance in relation to key quality indicators and infection control indicators.
- Ward managers completed a patient safety and quality audit on a monthly basis. This involved auditing five sets of patient records to assess compliance with vital sign observations, and standards in relation to infection control, falls, medicines, pressure ulcers, nutrition continence and patient experience. In addition hand hygiene audits were carried out monthly. Ward managers had previously had responsibility for completing a range of other audits including monitoring compliance with infection control high impact interventions but the managers told us these had been discontinued as a result of the high nurse vacancy levels as their management time was reduced.
- The medical division had a risk register where risks were documented, and a record was maintained with the

action taken to reduce the level of risk. However some of the risks we identified were not on the services risk register such as patients being on the correct wards and consultants reviewing patients on a daily basis.

Leadership of service

- We found nursing leadership at ward level was strong in medical services. We met ward managers who demonstrated excellent leadership skills and who were committed to delivering a high quality service. They mitigated the effect of high vacancy levels by utilising resources as effectively as possible and provided support to their ward teams. Band six nurses also showed good leadership skills and were knowledgeable about issues relating to their ward.
- Staff we talked with told us they felt well supported by their ward managers. They used adjectives such as, 'Excellent', and 'Outstanding' and one person said, "(Name of Manager) gives 100%." A member of staff said about another ward manager, "The ward manager is very good. If (name) sees the potential in someone they are very supportive. (Name) likes us to develop."
- A patient told us the ward manager on their ward had introduced themselves and the nurses did an introduction at each handover. They knew the ward manager's name and who they were.
- Student nurses said they felt well supported on the ward and that everyone worked well together as a team.
- The combination of strong leadership from the ortho-geriatrician and ward manager on Harold ward was visible throughout the ward in the quality of the documentation, communication and the care provided.
- There was less positive feedback from staff about more senior management support. One person said, "We are not listened to as they are too busy on discharges." There was variability in the visibility of matrons on the wards and the support staff received from them. Staff on some wards said they did not see the matron each day and when they visited the ward, "They pop on and off the ward." They did not feel the matron provided support and said issues such as a lack of equipment were not addressed. A band six nurse said, "In the absence of the ward manager we cannot get support from the matron. Other staff told us their matron was supportive and they escalated issues when they could not address them.
- Staff said they knew who the director of nursing was but a ward manager told us they did not think they would recognise the chief executive or chairman.

Culture within the service

- Staff showed considerable loyalty to the trust and were committed to improving services for patients. They told us this was their local hospital and they and their relatives used the services.
- Staff we spoke to were proud of the work they had done to improve the quality of care and patient experience.

Public engagement

- Medical leads told us of the patient engagement day they had held in May 2015.
- The trust had developed a patient and carer panel to engage with patients and carers to review and improve services.
- The patient and carer panel had been involved in several projects to improve care within medical services such as discharge, nutrition, and dementia care.
- There were a range of patient user groups within medicine including user groups for stroke and colitis.
- The trust had written to patients attending the endoscopy unit during the refurbishment process to inform them that works were being undertaken.

Staff engagement

- There were weekly staff briefings within medical services.
- Ward managers produced newsletters for staff on a bi-monthly basis. There was a programme of monthly staff meetings but ward managers found it difficult to maintain these due to staffing issues.
- Staff showed understanding of the recruitment issues faced by the Trust and accepted the issues were not easily resolved. They were aware of the action being taken by the Trust to improve recruitment.

Innovation, improvement and sustainability

- A system resilience group met bi-monthly with representatives from the trust's health economy partners.
- The hip fracture unit was an example of a development to improve services for patients which had been

successful due to strong leadership and a multi-disciplinary approach with clear pathways based on best practice. As a result, 71% of admissions qualified for the best practice tariff payment.

- Medical leads were enthusiastic about the work being done to provide a frailty service which would allow rapid access to specialist care without the need for admission to hospital.
- There had been investment in endoscopy to provide a clinical environment that will gain JAG accreditation and the refurbishment of two theatres within main theatres was reaching conclusion.

Surgery

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

Information about the service

The Princess Alexandra Hospital NHS Trust provides a range of acute and specialist services to people living in West Essex and East Hertfordshire. Surgical specialties include general surgery, elective and trauma orthopaedics, ophthalmology, ear, nose and throat, oral surgery, orthodontics, urology and dermatology.

The service consists of five surgical wards, which are divided into elective and emergency admissions. There are several areas within the service which are designed to improve patient access and flow through the hospital and allow flexibility in service provision. The surgical assessment unit is situated on Melvin ward, there is a same day admissions unit situated on Nettleswell ward, and the Alexandra day surgery unit which accommodates day surgery. There is a pre assessment unit, nine theatres within the main theatre suite (with an additional two theatres under refurbishment) and sterile services are on site.

During this inspection we visited nine areas within the surgery service including the elective and emergency surgical wards, theatres and day surgery. We spoke with eighty members of staff, including medical and nursing staff, thirteen patients and six relatives. We also reviewed twelve sets of medical records and information requested by us and provided from the trust.

Summary of findings

Surgery services required improvement overall. There were concerns relating to safety with nursing staffing identified as a significant risk. Staff had escalated these concerns however reaction to respond and put adequate measures in place had been slow. Incidents and risk assessments were not always managed consistently. There were variations in the management, identification of outcomes and shared learning across the surgical wards. Incidents were not updated to ensure risks were monitored and managed appropriately and there was no robust system in place to ensure policies were updated, in line with best practice and with ease of accessibility for staff.

Melvin unit (SAU) is a nine bedded unit designed to be a surgical assessment unit but at times of peak pressure admission criteria are not always maintained and patients with higher acuity are admitted and stay longer that the 24 hours period. Local audits could be improved by ensuring benchmark measures were set and feedback and outcomes communicated effectively. There was no provision of ear nose and throat (ENT) or ophthalmology out of hours or at weekends at the hospital. However there is an ENT Emergency Clinical Pathway and ophthalmology patients are re-directed to a specialist hospital. One ophthalmology patient stated that they would have preferred to have been made aware of out of hours arrangements prior to attending the Princess Alexandra Hospital only to be sent elsewhere for treatment and support.

Surgery

There were good initiatives such as the enhanced recovery programme and multidisciplinary communication between the surgical teams and ortho-geriatrician. There was a good system of discharge planning involving a multi-disciplinary team that extended to ensuring care and support in the community. Two patients on different surgical wards told us that they felt they were treated with compassion, dignity and respect, and that they were well informed regarding their care plans.

At a local level staff felt supported by the immediate senior nursing team on the wards and in theatre and by the matrons however pressure to maintain immediate clinical care meant that wider clinical oversight was not possible. There was limited sharing across the various areas when good initiatives and practice was happening.

Are surgery services safe?

Requires improvement

Safety in surgery required improvement. Nursing staffing was a challenge across the surgical division with specific areas of concern in Saunders ward and Melvin ward. Staff had escalated these concerns however reaction to respond and put adequate measures in place had been slow. There was a heightened risk for patients due to the high proportion of agency use, with some shifts only having one substantive member of staff and no consistent induction in place to ensure competency of temporary staff. The concerns with nurse staffing on Saunders ward were raised with the trust during the inspection and action was taken to reduce bed capacity and review admissions from the intensive therapy unit (ITU). Incident reporting and risk assessments were not consistent across all of the surgical wards. Incidents were reported but were not always updated in a timely manner to ensure risks were monitored and managed appropriately. This meant that investigations, outcomes and shared learning were inconsistent. Medicine management could be improved as there was inconsistency regarding controlled drug stock checks and adherence to local antibiotic guidelines. We were not assured that policy and procedures were fit for purpose. There was no system of monitoring to ensure that the most recent guidelines were in place and staff repeatedly could not access policies for reference.

Incidents

- A system and process for reporting of incidents was in place. Staff understood the mechanism of reporting incidents, this was confirmed verbally, both at junior and senior level. The incident reporting form was accessible via an electronic online system, between 1 January 2015 and 22 July 2015, there were a total number of 1067 incidents reported for surgery. The areas with the highest number reported were Saunders ward, Kingsmoor ward, main theatres and Penn ward with 186,161,140 and 119 respectively.
- Incidents were reviewed at weekly scrutiny panels and learning was discussed at team meetings. Minutes were emailed to staff and displayed in staff rooms. Staff confirmed that learning from incidents was discussed.

An example of change in practice from an incident was where bed and chair sensors and crash mats had been purchased following a patient fall that had resulted in injury.

- Feedback was not consistent across all the surgical wards and we were not assured that all incidents were investigated and learning outcomes identified in a timely manner. In some areas incidents were reported but remained on the system pending outcomes. For example, on Kingsmoor wards there were 107 incidents open on the system awaiting further action or investigation whereas on Melvin ward there were five incidents pending action.
- Staff in theatre were able to inform us of the shared learning following a never event that had occurred in January 2014, including changes in practice to lower the risk of reoccurrence.
- Under duty of candour the trust makes contact with patients and families. Following review by the Serious Clinical Incident Group (SCIG), the patient is kept updated with steps taken to prevent a reoccurrence and received an apology.

Safety thermometer

- Quality indicator boards were displayed in all surgical wards across the trust including the Alexandra day surgery unit. Safety crosses were displayed for Methicillin Resistant Staphylococcus Aureus, Clostridium difficile, falls and pressure ulcers.
- The quality and safety dashboard in February 2015 showed compliance for safety thermometer harms (pressure ulcers) as 97% compliance on Kingsmoor, 93% on Saunders and 100% for Tye Green and Penn wards. Data in April indicated improvement for Kingsmoor, Saunders and Tye Green all achieving 100% and a drop to 86 % for Penn ward. Data submitted showed that between July 2014 and June 2015 there had been a total of seven hospital acquired pressure ulcers reported on Saunders ward.
- Patient quality and safety audits were completed on the wards monthly and included hand hygiene, environmental audit and venous thromboembolism. Audit results were displayed on each ward as information for patients and relatives. In the month of June Saunders ward had been 100% compliant with hand hygiene audit, 95% compliant with environmental audit and 85.7% with the venous thromboembolism audit.
- The quality and safety committee report, 17 June 2015, escalated to the board that assurance could not be provided that all aspects of the safety thermometer data was correct due to a data information transfer issue. The report however stated that the harms data was accurate and could be assured.

Cleanliness, infection control and hygiene

- The surgical wards were visibly clean and uncluttered. “I am clean” stickers were visible on equipment such as electrocardiograph machines and resuscitation equipment.
- Staff adhered to trust policies and guidance on the use of personal protective equipment, and to the 'bare below the elbow' guidance, to help prevent the spread of infection. There was adequate provision of gloves, aprons and visors throughout.
- Infection rates across surgery services were low. Data from April to June 2015 showed that across surgery there had been no cases of Methicillin Resistant Staphylococcus Aureus, Escherichia coli or Meticillin Susceptible Staphylococcus Aureus and only one case of Clostridium difficile on Kingsmoor ward .
- There was a strict admission criteria to the ward with all patients being swabbed and cleared for Methicillin Resistant Staphylococcus Aureus prior to admission as well as being screened for Clostridium difficile, other infections and any open wounds or sores.
- Side rooms were available and in use for any patients requiring isolation due to infection. Personal protective equipment, such as gloves and aprons, were in place outside the room for staff to use and a clear notice was in place on the door as a reminder for staff and to inform relatives of infection control processes in place.
- There were daily checklists for cleaning of side rooms on Tye Green ward which were signed and dated. Three patients confirmed that the ward was kept clean and tidy. However on Galen house pre-assessment there was a mop and bucket stored in the staff toilet and when this was brought to the attention of staff there seemed no understanding of the concern or potential infection control risks.
- Sharps bins were labelled on assembly and closure and were completed with dated, signature and location or origin identified on the label.
- Surgical site infection surveillance data was collected for patient’s post total hip and total knee replacement and collated by the orthopaedic clinical nurse specialist.

This was then disseminated to the nursing and medical teams and the board. The trust results for 2013/14 for hip replacement surgery was 0.8% and for knee replacement 0.45% which was in line with the national average.

Environment and equipment

- Staff carried out daily checks of resuscitation trolleys and emergency equipment within the surgical wards and theatres. These checks were consistent across all areas. Checklists were in place and all dates in July had been completed in Tye Green ward, Saunders ward, Alexandra day surgery unit and theatres. There was a standard operating procedure in place for the resuscitation grab bag on Tye Green ward that was attached to the trolley and had been updated.
- Laser equipment used in main theatre was serviced, visibly clean, documentation records were appropriate and there was a policy in place. There was a laser protection supervisor for theatres and the hospital had a laser protection advisor who advised and assured protocols were in line with national guidance. Documentation was in place to monitor staff training and record nominated users.
- There was a rolling refurbishment programme within theatres. The operating tables had been highlighted on the risk register and investment had been approved for replacement. Theatre operating lights in theatre six and seven had been identified as beyond their serviceable life span. This had been risk assessed and a contingency plan was in place to utilise the operating lights in theatre nine (currently one of the theatres under refurbishment) should the need arise.
- There was a bespoke gym situated on Tye Green ward for Orthopaedic elective patients to use and receive therapy support post-surgery. This meant that patients had access to equipment in a safe purpose built environment.

Medicines

- Medicines were stored correctly and securely throughout the majority of surgery wards and theatres. There was a system in place where medications stored within drug fridges on the wards and in theatres was monitored and recorded daily. This included details of the acceptable temperature ranges and actions to be taken should the temperature fall out of this range. We were assured that staff were monitoring drug fridge temperatures effectively. However the monitoring of ambient room temperatures in areas where medications were stored was not consistent
- We brought to the attention of the theatre matron that there was no record of monitoring temperature levels on the warming cabinets and fluids were not dated. There was a risk that fluid could be kept warmed at a higher temperature or for longer than recommended as no checks were in place. Action was taken immediately and quotes were being obtained for replacement of the cabinets that were affected and a process planned for recording and monitoring.
- Controlled drugs were stored appropriately, but staff had not always followed the hospital policy in recording stock checks. Controlled drugs are medicines which are stored in a special cupboard and their use recorded in a special register. It had been recorded as an incident that on Saunders ward controlled drugs have not been checked for lengthy periods over the past year. There have been three occasions since January 2015 that they were not checked for over a month. There was no check completed between 19.01.15 and 03.03.15. This was not compliant with the trusts standard operating procedure for controlled drug management which requires a check at the end of each session / day.
- In theatres the administration of controlled drugs was recorded and included a stock balance of each individual preparation along with specific amounts of supplied, administered and discarded doses. Daily checks of stock were in place twice a day and additional checks were recorded at the end of each list e.g. between morning and afternoon lists. These specific controlled drug record log books were not in use across all areas.
- The hospital used a comprehensive prescription and medication administration record chart for patients which facilitated the safe administration of medicines. The hospital policy for recording the reason for prescribing an antibiotic, and the number of day's treatment, was not always followed, so we could not be sure that local antibiotic guidelines were being followed. Medicines interventions by a pharmacist were recorded on the prescription charts to help guide staff in the safe administration of medicines.
- We reviewed the prescription and medicine administration records for 11 patients on two wards. There were appropriate arrangements in place for

recording the administration of medicines. These records were clear and fully completed. The records showed people were getting their medicines when they needed them, any reasons for not giving people their medicines were recorded. This meant people were receiving their medicines as prescribed.

- There was a pharmacy top-up service for ward stock and other medicines were ordered on an individual basis. This meant that patients had access to medicines when they needed them while in hospital. Staff told us there was often a delay in obtaining medicines for patients to take home.
- The pharmacy team visited all wards daily. We saw that pharmacy staff checked that the medicines patients were taking when they were admitted were correct, that records were up to date and the medicines were prescribed safely and effectively. We noted that they were not able to see every patient to provide this service.

Records

- We reviewed 12 patient records and VTE assessments, patient care rounding, dementia screening for patients over 69yrs age, care plans with post-operative instructions were completed correctly with bleep numbers recorded for the medical team to enable easy contact by nursing staff.
- In three sets of notes on Tye Green ward it was noted that fluid balance charts were not completed at night, despite one patient having had a urinary catheter in situ. We raised this with the sister in charge who confirmed that she would bring this to the attention of the night staff.
- Patient medical records were brought to Nettleswell admissions unit the day before admission and were organised ready for use the following day. The room where the records were stored was not locked and we were not assured that access to this room could be monitored effectively during busy times. The unit itself was open between 6:30am and 14:30pm. When closed the unit was locked and access out of hours was restricted via a key code.
- Records for pre-assessment were clear and concise with separate paperwork provided for patients having day surgery.
- Medical records and other information were available when required. There were separate pathway notes in place for orthopaedic patients which were merged with general notes on discharge to ensure continuity of care.
- There was no system in place to organise medical notes into volumes. This was an issue specifically in urology where some notes were extremely large. This had been addressed elsewhere, for example, within orthopaedics note folders for integrated pathways had been created for patients who had knee and hip replacements. The team also had a sticker for the notes which indicated the current page which meant staff could easily turn to the current day's page. This was efficient and although shared across other areas was not being consistently used.
- Trust policies and procedure were available via the trust intranet however the system was not easy to navigate. Staff were aware that policies were on the system however when asked it was timely to search through and find specific information.
- Not all policies were reviewed regularly and updated when required and some lacked a footer attachment to indicate approval, author, date of creation and review date. On Tye Green ward the infection control policy on the intranet was dated 2011 with a review date of 2013. Matron informed us that this was currently being reviewed by the infection control lead nurse. We were not assured that staff could access policies quickly or that the most recent guidelines were in place.

Safeguarding

- Safeguarding training is mandatory for all staff. Data provided for surgery services stated that 97% of staff had received safeguarding training overall. 98% had received adult safeguarding training, 98% children level one, 95% children level two and no staff had received children level three.
- All ward staff were provided with a small safeguarding adults' handbooks which provided safeguarding information and referral details for quick reference and staff were able to identify how they would raise a referral and had an understanding of their role in raising safeguarding concerns.
- Daisy champions had been identified across the service as staff who could give additional advice and support.
- NICE guidance issued in March 2014 outlined best practice in relation to delivering health services to individuals who have experienced or are at risk of being

victims of domestic abuse. The trust launched the Daisy Project, a service which meets the NICE guidance in supporting people who disclose domestic abuse. In April 2015, the Trust also introduced a two day vulnerable patient course which incorporates adults, children's, safeguarding, domestic abuse, deprivation of liberty safeguards, mental capacity act, PREVENT and conflict resolution training. One member of staff on Nettleswell explained the course and her role as a daisy champion to give advice and support to patients and colleagues across the service.

- There is an alert system on the electronic records system ,which alerts staff to vulnerable adult patients including learning disabilities, domestic abuse and safeguarding cases.

Mandatory training

- Mandatory training for staff included information governance, equality & diversity, basic life support, safeguarding vulnerable adults' level 1, values training, fire, Infection prevention and control and manual handling.
- Compliance was variable across the service; data reported for surgery services total compliance for mandatory training was 77% in May 2015 overall against a target of 95%.
- There was a mandatory training study day allocated for all wards with regard to pressure ulcer care and prevention.

Assessing and responding to patient risk

- The national early warning system (NEWS) was in place across the surgical areas to identify any change in patient condition and ensure timely appropriate escalation for deteriorating patients. We reviewed 12 sets of adult notes and in all cases the scores were recorded correctly.
- The 'five steps to safer surgery 'procedures were utilised by theatre staff which incorporated the recognised national world health organisation (WHO) checklist. Briefing paperwork was used to record full team briefing before and after the operating list. There was effective communication between the team. Theatre records were completed and a printout was obtained from the electronic theatre system and attached to the patients notes which included all details from the perioperative phase.
- The WHO checklist was audited monthly via the electronic system with 100% compliance achieved in the month of June. The WHO has been integrated within the electronic theatre system and therefore required completion for each patient. No observational audits had been undertaken to provide assurance of the quality of the check completed.
- Appropriate checks were undertaken to account for all items including, swabs and instruments before, during and after surgery and records were completed. The instrument checklist was used for reference during the count however completion of the columns for recording against each item were not completed consistently. This meant that there was a risk that the complete check for each item had not been undertaken at all times.
- A waterlow score (pressure ulcer risk assessment tool) was undertaken and included within the theatre documentation. The patient had an assessment and score at pre-assessment and a pressure relieving mattress was pre-ordered prior to surgery for those patient identified as a high risk. This meant there was no delay with provision of specialised equipment and helped reduce the risk of a pressure ulcer.
- It was reported in the June 2015 trust performance exception report for Melvin ward that patients had been admitted with an expected departure date of over 48 hours which had impacted on the ability for the unit to function as a short stay surgical unit. There had also been inappropriate admissions which had included a medical end of life patient, and a patient with a serious medical condition.

Nursing staffing

- Nurse staffing numbers and vacancy rates were a concern across surgery services and the trust. Two areas for concern were Saunders and Melvin wards which were highlighted as risks with the executive board. According to the June 2015 trust performance exception report only 14 of shifts were fully compliant for staffing on Melvin ward (42% of the roster was unfilled) and only 23 out of 60 shifts (38%) were fully compliant for staffing on Saunders ward.
- Staffing on Saunders ward had been raised as an incident and staff had been encouraged to report staffing concerns in this way. However the June 2015 exception report stated that incident reporting did not

always take place, therefore the system was not an accurate record of all staffing shortfalls. Staffing was impacting on patient safety, and three staff informed us that they considered the ward was not safe.

- Levels of staffing and vacancies were displayed on boards throughout the surgical wards. Two senior nurses that had previously been employed in project work and not working clinically had each been allocated one day shift a week on Saunders to help support critical staffing numbers. This had been happening for four weeks at the time of our inspection. Both members of staff had been completing basic clinical training and competencies on the ward to ensure safety.
- Agency use across the service was variable. On Saunders ward where there was a 65% shortage of substantive trained nursing staff, which was due to increase to 74%. At times it was only possible to ensure that one member of the trained nurses was a substantive member of the team on each shift with the rest consisting of agency staff or staff relocated from elsewhere, this included night shift.
- We were informed that there were six trained nursing staff due to start, two of which were from the recent recruitment in Italy, and two band five nurses were being moved from Penn ward to Saunders ward. The associate director of nursing for surgery confirmed that ongoing nurse staffing was a concern. There was a daily meeting to review numbers and skill mix and staff were reallocated depending on areas of greatest need.
- During the unannounced inspection on 30 July 2015 the trust had closed 16 beds on Saunders ward in response. The ward was calm; staff were positive and said they now felt that they had time to give care to each patient. We were informed that the restriction to beds would remain in place until sufficient numbers of staff had been recruited.
- On Saunders ward there had been two occasions where the ward manager had questioned the credibility of agency staff. One member had arrived with no uniform and a long sleeved top ready to work and another had an unrecognised uniform on. When challenged the uniform being worn was not the uniform of the agency the individual stated they worked for and they did not have personal identification. In both instances the ward manager correctly challenged the individuals, escalated and reported appropriately and did not allow them access to the ward or to participate in patient care.
- Following this the ward manager devised a bespoke induction checklist for the ward as the trust standard induction document was out of date (April 2008). This was only updated July 2015. The flexible workers orientation checklist was approved for Saunders ward however this had not been cascaded across other surgical wards.
- Induction for agency staff varied across the areas: one member of staff on Tye Green ward confirmed that they had received a local induction; however they did not know the correct number to call for cardiac arrest.
- Nurses recruited from the European Union have thirteen consecutive days of induction. Following on from this the nurses work under supervision and begin to work through the pre-registration elements of the Trust preceptorship programme until they are in receipt of NMC registration. Staff awaiting registration wore the same uniform as health care assistants to clearly identify their role and ensure only duties they were competent to undertake were assigned.
- There were frustrations amongst staff when required to move locations to provide help across the trust, this was mentioned by staff on Nettleswell admissions unit and Tye Green ward. Staff on the Nettleswell admissions unit felt that the unit was used as an escalation pool and were approached as the first port of call when staff were required to support elsewhere.
- Staff recruitment was ongoing within theatres and at the time of inspection there were eight vacancies in total from the current establishment. Two theatres were closed undergoing refurbishment. Originally the staffing establishment figures for theatre were for 83 sessions per week however there had been an increase in operating with the unit reaching 105 sessions a week at peak periods. The theatre senior team were aware of the implications on staffing from the increased workload and were beginning to formalise plans to increase staffing levels to match the requirement when theatres eight and nine reopen.
- On Tye Green ward a full handover was observed at the patient's bedside, upon return from an invasive procedure in radiology, which ensured continuity of care for the patient.

Surgical staffing

- The trust had an ongoing recruitment plan for additional medical staff. There had been a second consultant urology appointment which had enabled a revised schedule for urology to improve capacity for patients in this specialty.
- In some specialisms there was only one individual providing consultant cover. For example there was one ortho-geriatrician, one orthopaedic surgeon specialising in foot and ankle surgery and one specialising in thyroid surgery which was a challenge during annual leave and sickness. Where it was difficult nationally to fill posts the team were looking to work with other providers for support. For example the consultant breast surgeon was due to retire and the aim was to try and appoint a replacement that may link with a nearby provider.
- Locum staff confirmed that they received a one day induction when starting at the trust. At the time of inspection, surgical services had 15 medical staffing vacancies; two in urology; three in general surgery; one in oral and maxilla facial; one in ears, nose and throat; two in ophthalmology; and six in orthopaedics. Three locum staff were provided in urology; two in general surgery; one in oral and maxillo facial; one in ears, nose and throat; one in ophthalmology; and five in orthopaedics.

Major incident awareness and training

- Staff were not consistent with their knowledge on a major incident plan within surgery services. Staff were generally vague as to the process and described that the duty team would inform switch board to contact staff with notification and patients would be prioritised due to clinical need however no formal process or action cards were known to staff.
- On Melvin ward staff looked for the policy on the electronic system but this could not be found, a hard copy of the policy was produced one hour later.

Are surgery services effective?

Good

Surgery services were rated as good for effective care. There was an enhanced recovery programme in place for certain surgical specialties with the intention to open out wider as the programme progressed. The hydration card system aimed to ensure patients were not fasted for surgery for extended periods of time.

Participation in national and local audits took place and patient reported outcome measures (PROMs) data indicated that the overall trust was in line with the England average against all measures. There was an excellent patient pathway for patients following a fractured neck of femur which ensured that all patients were transferred to Harold ward under the consultant ortho-geriatrician. Multidisciplinary communication between the teams, alongside the care from clinical nurse specialists and therapy staff ensured best possible outcome for this group.

Local audits were being undertaken however there was no robust process in place to benchmark, feedback and ensure learning outcomes were implemented and shared which meant that this was ineffective in measuring quality and improvement.

Evidence-based care and treatment

- There were monthly ward and departmental manager audits undertaken where the auditor review five random sets of patient records to assess for compliance against standards such as vital sign standards, pain relief standards, pressure ulcer and nutrition standards. This meant that there was ongoing monitoring to drive quality standards.
- The trust undertakes sentinel lymph node surgery to treat patients with early stage breast cancer. A radioactive isotope is injected to locate the sentinel node. There was a trained radiation protection supervisor (RPS) within theatre and local rules and monitoring of radiation levels were in place and recorded following sentinel surgery. There was an identified protocol in place which included secure storage should equipment and clinical waste be of a sufficiently high level to require storage until levels had reduced. The radiation safety policy had been reviewed in April 2015 and outlined the use and disposal of radioactive sources.
- There was an enhanced recovery programme in use for colorectal and gynaecology specialities. The aim of an enhanced recovery programme is improving patient outcomes and speeding up a patient's recovery after surgery which results in benefits to both patients and

staff. Guidance was produced for pre-operative assessments in line with best practice, this was supported by the multidisciplinary team and documentation was in place.

- Benchmarks and audit outcome and feedback for local audits was not communicated effectively back to the ward areas. Staff on Kingsmoor ward stated that audit results were submitted to the associate director of surgery however feedback from the audits was not received.
- There were six local audits undertaken on Melvin ward on a rolling basis. These were hand hygiene, high impact interventions, medicines management, record keeping, exception reporting and patient safety and quality. Benchmarks were only in place for three of these audits, namely hand hygiene, high impact interventions and patient safety and quality. the high impact interventions audit was recorded as having met its benchmark of 100%, an action plan was in place for the hand hygiene audit where the 95% benchmark was missed by 2%, and the patient safety and quality audit performance was yet to be fed back to the ward so they were unsure whether they had met the benchmark of 100%. There were three audits, namely medicines management, record keeping and exception reporting where no benchmark had been set and no evidence of learning taking place.

Pain relief

- Patient records showed that pain scores were calculated and pain relief was provided appropriately to patients. Three patients stated their pain relief was administered promptly.
- There had been reported incidents where patients had delays in medication on both Melvin and Saunders ward. One medication issue had been reported from Melvin ward in June and two in Saunders ward which included lack of training for patient controlled analgesia equipment which resulted in a delay in pain relief being given and delay in medication due to lost drug chart.

Nutrition and hydration

- A system of hydration cards had been introduced across the surgery service following complaints from patients that were fasted longer than necessary. The anaesthetic consultant reviews the theatre list each morning and the hydration of each patient is adjusted as required and the cards are completed. Each card stipulates a time that the patient can drink clear fluids until.
- This hydration system was not fully consistent for all patients and was not used responsively in the admissions unit. Three patients were complaining they had been fasting for hours. The staff stated that not all anaesthetists were fully utilising the hydration card system and unless a patient had a hydration card staff were not allowed to provide drinks. One patient was having a procedure under local anaesthetic which meant they could have fluids however this had not been explained to them and the patient only received a hydration card when we escalated this to the nursing team. There was nowhere on the documentation or operating list where the type of anaesthetic was stipulated. This meant that patients undergoing local anaesthetic could be at risk of a prolonged fasting when this is not required.

Patient outcomes

- The trust participated in a number of national audits including the national hip fracture, national emergency laparotomy audit and the national bowel cancer audit. Bowel and lung cancer audits (2014) indicated that the trust was performing well when compared with the England average. One indicator that had fallen was for CT scan reported bowel cancer patients which, at 0.8%, were worse than the England average. We questioned this and were informed that this was incorrect, probably due to a data transferring error, and this would be clarified. A review of the data showed that of 136 cases of bowel cancer patients, 83% did have a staging CT scan performed.
- The hip fracture audit in 2014 indicated that the trust was performing better than the year before for seven out of the ten indicators with the biggest drop being admitted to orthopaedic care within four hours where the trust scored 30% compared to the England average of 48%. Data from this audit also indicated that there had been a significant drop for pre-operative assessment by geriatrician from 99.7%in 2013 to 0% in 2014. The falls and fragility fracture audit programme (FFFAP) from the National Hip Fracture Database (NHFD) commissioners' report 2014 revealed the actual figure to be 92%.

- Following surgery the patient pathway for patients with fractured neck of femur was clearly defined. All patients were transferred to Harold ward under the care of the consultant ortho-geriatrician. This was also the case for patients following knee and hip joint replacement, who went to Tye Green ward, which ensured that care remained consultant led and encompassed other medical conditions that some elderly patients having joint replacement may have. Support from the multidisciplinary team, including the clinical nurse specialists and therapy staff, was excellent and provided an opportunity to support patients to the best outcome.
- Patient reported outcome measures (PROMs) data indicated that the overall trust was in line with the England average against all measures.

Competent staff

- Competency folders were in place on Tye Green ward. Assessment tools were in place for additional training such as safeguarding, mental health needs, vital signs and infusion pump training. Information and training opportunities were displayed in the staff room.
- Overseas staff received induction and a preceptorship. Two overseas nurses on Kingsmoor ward stated they had received training, in addition to mandatory requirement, and support from colleagues and felt valued.
- The orthopaedic clinical nurse specialist carried out one clinical shift a week to support staff and patients and remain up to date with skills.
- The completion of staff appraisals was inconsistent across the surgery service. Tye Green ward were 75% compliant against a target of 95%. In day surgery there had been a period of four months where the manager post was vacant and appraisals had not taken place. The current manager had been in post for two months and since her appointment all staff had received an appraisal and the unit had 100% compliance. On Saunders ward the manager had recently returned from 14 months maternity leave during which time no staff appraisals had been undertaken.

Multidisciplinary working

- There were weekly multidisciplinary team (MDT) meetings. The MDT for urology cancer patients was well attended and clearly structured. There were full and open discussions for each patient reviewed amongst the multidisciplinary team. Access to radiology and pathology results were utilised and each patients summary and follow up decision was recorded electronically during the meeting before moving onto the next patient review.
- There were daily trauma meetings which were well attended by all the multidisciplinary team (MDT). These meetings were well structured to include teaching and planning of surgery for trauma patients.
- White boards were in use on all surgery wards to indicate patients and therapy received. There was a daily multidisciplinary team meeting held to plan care and to feedback and update on patients' needs.
- Effective communication between teams was in place. The surgical wards had been separated into either elective or emergency admissions. This resulted in a mixed specialty ward; Tye Green ward had patients that had orthopaedic surgery alongside general surgery for example. There was segregation of orthopaedics by the layout of the ward to help prevent the spread of infection however this was an example where the wider team worked and communicated together as different surgeries have different patient needs.
- Clinical nurse specialists gave support to the wards and staff expressed that they liked the variety of caring for different specialisms as it helped to maintain clinical skills. This meant that the medical teams also had to be responsive to support the nursing staff.

Seven-day services

- Physiotherapy and occupational therapy services were available seven days a week. In addition there was an on call service from the physiotherapy team.
- There was no provision of ear nose and throat (ENT) or ophthalmology out of hours or at weekends at the hospital. However there is an ENT Emergency Clinical Pathway and ophthalmology patients are re-directed to a specialist provider.

Access to information

- Nursing documentation and care pathways were completed in detail. Both medical and nursing staff wrote in the same care pathway which meant that a patient's care was documented chronologically and could be easily followed.

- Staff had access to documentation and care records for patients to ensure continuity of care. There were computers throughout the individual ward areas to access patient information including test results, diagnostics and records systems.
- Discharge letters were sent electronically to GPs to ensure continuity of care and patients were given a copy to take home with them.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Confirmation of consent was obtained on the day on Nettleswell admissions unit. We reviewed twelve sets of notes and consent was completed appropriately, with risks discussed and signatures obtained from the consenting surgeon and patient.
- There had been a potential serious incident reported on Saunders ward in June 2015 which raised a concern that staff had not acted in a timely manner to adequately assess a patients mental capacity to prevent harm. This incident was investigated and an action plan was in plan which included additional training.
- On 30 July 2015, on the unannounced inspection, there were two patients on Saunders ward that required a deprivation of liberty safeguard (DoLs). The documentation was in place and completed appropriately. Both patients were receiving one to one nursing supervision and additional staffing had been arranged for the night shift to ensure this would be maintained.

Are surgery services caring?

Good

Surgery services were rated as good for caring. Patients we spoke to stated that they were happy with the care that they received from nursing staff. Patient's individual needs were considered and preferences were sought in the provision of care, treatment and support. Patients felt informed about the care they were receiving and were kept updated as to the next steps for their treatment. Staff spoke with patients in a caring and respectful manner.

Data from the friends and family test (FFT) from December 2014 to June 2015 showed that 98% of patients would recommend this organisation to friends and family if they needed care or treatment.

Patients stated that their pain levels were well controlled and that they knew they could receive further care, treatment and support should they not be able to tolerate their pain levels.

Compassionate care

- Data reviewed from the Friends and Family Test showed for the period December 2014 to June 2015 that the majority of patients (98 %) scored the Trust's surgery services positively, with only Saunders and Tye Green wards showing a minority of those responding (0.43%) feeding back negatively and 1.23% of those responding either not knowing or remaining neutral about their feedback. The rate of response for this survey was not made available for the period December 2014 to June 2015, however the average response rate in the year prior was 51%. This meant that these results were likely to represent the views of approximately half of all patients treated within this speciality.
- The same Friends and Family Test data revealed that 63% of staff responding would be likely to recommend their own friends and family to be treated at the trust, and 16% of staff being unlikely to recommend the same. 22% of responding staff remained neutral or did not know what they would recommend.
- Administration staff delivering news that surgery had been cancelled did so with empathy and compassion.
- Patients were complimentary about the care that they had received, stating "that the staff can't do enough to help you and they make my stay as good as possible" and "I cannot fault them". Regarding the surgical assessment unit, one patient said the unit felt very laid back yet very efficient and that there was a calming atmosphere. Patients said that their consultants had informed them of what had been done regarding their treatment, results from their tests and investigations, and what the next steps were for their care.
- The adult's admission area on the Alexandra Day Surgery Unit was a small area where patients had to sit and face each other, with no facilities to make the wait more comfortable.
- Patients told us that they knew who their consultants were, and that nurses always introduce themselves and explained that they will be looking after them, showing good communication and involvement between the patient and their clinicians.

Surgery

- One patient treated in both theatres and Nettleswell ward stated that they had been supported physically to become more comfortable, and felt that staff had gone "the extra mile" for them.

Understanding and involvement of patients and those close to them

- One patient explained how one of the surgical matrons had made special visiting arrangements for her relative who could not attend during visiting hours, demonstrating understanding of the impact of care and treatment on the patient and their family and working with the family to create a solution.
- Patients confirmed that on admission they had been asked by the nursing staff what name they would prefer to be addressed by.
- Patients on Melvin ward and Penn ward confirmed that they had adequate pain relief and that they had been told to let the nurses know if they were to require further care, treatment or support.
- One patient stated that when they were admitted to Penn Ward they received a diagnosis from their consultant who also gave assurances that they would not be sent home until their problem was treated. The patient stated that this assurance gave them great relief that their health mattered to the consultant.
- One patient treated on Nettleswell ward stated that they had been given both information and time to consider their treatment and ask further questions about their care plan.

Emotional support

- The chaplaincy service is available for staff and patients at the trust. The chaplain has provided support to theatre staff as required after incidents or events.
- Patients confirmed that nurses often ask them if they are ok and if they need anything regularly throughout each day.
- One of the matrons was observed in a ward corridor talking to a member of staff in what could be perceived as an abrupt manner, this is not in line with the caring support given to patients

Are surgery services responsive?

Requires improvement

Responsiveness in surgery requires improvement. Patient flow from theatres into appropriate wards and units was disjointed. Patients were not always aware of which ward they would be admitted to after surgery. Capacity in the intensive care unit was not considered when planning theatre lists for those patients requiring intensive care after their surgery.

Referral to Treatment Times (RTT) for general surgery, trauma and orthopaedics, urology and ophthalmology were consistently below the England averages, preventing those who wait longer than 18 weeks from receiving the right care in a timely manner.

There is a historic trend over four years of cancelled operations that were not rebooked within 28 days being worse than the England average, showing a lack of support for people to have their care re-arranged in as quick a time as possible.

Service planning and delivery to meet the needs of local people

- There were no available one stop / same day pre-assessment services at the trust as clinics were on three different sites.
- A pilot was underway at the time of inspection to undertake a month of telephone pre-assessment to reduce the number of face to face appointments.

Access and flow

- Patients were admitted on the morning of surgery to Nettleswell Admissions Unit (NAU). All patients were required to attend at 7am for the morning lists, were admitted by the nursing team and then seen by the surgeon and anaesthetist and consent obtained. There were no staggered admissions throughout the morning which meant some patients had a significant wait. One patient had been admitted at 7am, and informed at 10:15am that they were eighth on an all-day list. Six patients told us they were unhappy with having to come in at 7am but did say that they had been informed that they may have a long wait depending on the order of the list.

Surgery

- Patients admitted to NAU did not always know which ward they would be admitted to following surgery. Staff informed patients once there had been an update from the bed manager with allocation of beds. If no decision had been made prior to the patient going to theatre, the relatives were given the units telephone number to ring. The unit closed at 14:30 after which relatives are told to ring the bed manager to enquire which ward their relatives have been admitted to. This meant additional concerns and worry for patients and relatives on top of a stressful situation.
- Patient belongings were labelled and delivered to the wards once locations were known. If the ward was not identified prior to the NAU closing then all bags were taken to Tye Green ward and secured in the sister's office to enable safe storage.
- There was a consultant nominated as surgeon of the week. These individuals cover admissions and are on call for the week including the weekend to ensure continuity of care. They have no clinics or theatre lists during this time so that every surgical patient admitted can be seen daily by their consultant, thus improving access for patients, relatives and carers as well as involving them in their care planning.
- Orthopaedic trauma patients were seen by the consultant of the day (24hrs) then their case was discussed with the team and consultant of the week responsible for ensuring surgery is carried out. Low risk minor trauma patients may sometimes be discharged home from the emergency department when clinically appropriate and booked for trauma surgery. Patients can be admitted to either of the emergency surgical wards. Staff informed us that both nursing and medical teams had asked for a dedicated trauma ward however there were no plans in place to take this forward.
- A theatre scheduling meeting takes place every Thursday to assist patient flow and to plan schedules. Additional theatre lists are arranged according to clinical need. There is a proactive approach to increase theatre sessions for specialties where there is a backlog of patients. Weekend lists are in place for urology, ophthalmology and trauma.
- Two theatres were undergoing refurbishment, which was managed through the project management team, with one due to be completed and re-commissioned by the end of August 2015 which will increase capacity and it was anticipated that this would improve performance against referral to treatment targets.
- At present there is a trauma list each day midweek (alternating half and full day lists) and a list on a Sunday. From August a pilot study has been planned to run an additional trauma list on a Saturday morning for five weeks. Theatre utilisation will then be reviewed to ascertain the impact of this additional list.
- Theatre cancellations were reported via a weekly situation report. All cancellations were classified and monitored and ranged between 6-10% a month. In the week before our inspection it was stated there had been 26 cancellations; eight were due to no beds. However, when reviewing the situation report for the week before our inspection, only three of the 26 cancellations were reported to be due to no bed being available, indicating a lack of consistency in reporting reasons for cancellations. Standard operating practice was to liaise with the anaesthetist and escalate to the manager of the day. There is a "bed buddy" who works alongside the bed manager and they liaise with the consultant secretaries and booking team to organise rebooking the patient and attempt to have an alternative date secured before speaking with the patient.
- The trust had just begun to outsource some patients from general surgery, urology and orthopaedics and administration staff supported the process by contacting patients, transferring and tracking on the system. Whilst this was a positive step, the trust had been aware of the increasing referral to treatment time and had been slow to recognise the need to take action on this issue, with the decision only being taken during the inspection.
- The patient access policy needed to be reviewed and updated. It was due for review in December 2014 and does not support a robust process for transfer of patients to other providers including the use of an inter provider transfer form which was not in place at the trust.
- Between January 2015 and March 2015 11 patients had their operations cancelled and not rebooked within 28 days which had increased in comparison with two to three patients every three months in the year before this. Data from April to June 2015 showed a significant improvement with only one patient out of 74 cancellations not being rebooked within 28 days.
- On Penn Ward discharge planning started on assessment for admission. Handover sheets included every patient's needs regarding social care,

physiotherapy, occupational therapy, mobility and whether they are alone at home or not. An electronic system is used for current care and treatment and discharge planning. Meetings were held every morning on the ward and were attended by physiotherapists, occupational therapists and nurses. A hospital social worker attended once a week to help with discharge planning. Social workers were allocated to set wards and acted as a single point of contact.

- A ward manager told us that doctors need to be present at the meeting to give expert opinion on, and to be fully informed about, the discharge process. However they do not attend due to the wide range of surgical specialties on the ward and the demand of the doctors across all of the surgical wards. If an urgent need arises from a discharge meeting then a doctor will be bleeped to attend.
- A different electronic system was used as the electronic patient file or record, which did not link with the discharge system which created extra work and increased the potential for error for those inputting and obtaining information from both systems.
- The discharge team (also referred to as the delayed discharge team) for the hospital liaise with social care and deal with complex discharges. The surgical ward managers and matrons rotate the management of beds on the emergency surgical wards, attending three to four bed meetings per day. Referrals are made to social care as soon as a need for it is identified, with social care getting involved at the point of discharge (either from the re-enablement team for Essex or the enablement team for Herts).
- 18 week referral to treatment (RTT) time was on the surgery risk register as data showed that from December 2014 to June 2015, on average the trust was meeting 18 week waits in only 63% of admitted cases showing that performance against this measure had consistently been below the England average. The trust had to work with two local clinical commissioning groups (CCG's) and weekly RTT meetings were held with the CCG's to monitor the situation.
- For admitted cases, breast surgery performed at 97%; general surgery at 57%; gynaecology at 85% and trauma and orthopaedics at 55%.
- Due to the trust embedding a new data management system, RTT data had not been submitted to NHS England although the trust still monitored this internally. However, the monitoring of specialities was not consistent so we could not see performance for all specialities.

Meeting people's individual needs

- There was a team dedicated to support patients with learning disabilities. The wards displayed a poster which gave a telephone number for the team to be contacted if required.
- When patients with learning disabilities are admitted to hospital, the learning disabilities team are informed with the details and location of the admission so that additional support can be given to these patients.
- There were dementia champions across surgery, staff with additional training to support patients living with dementia. There was a quieter section allocated in the theatre holding area for any patients known to be living with dementia, and quieter clocks had been sourced as during the training a ticking clock had been highlighted as disturbing for patients living with dementia.
- A translation service was available for staff to access when required through the PALS office. Staff informed us that they also utilised Google Translate in extreme circumstances.
- The pre-assessment unit liaise with individual ward areas if there is a patient who has individual needs, such as at risk of falls, pressure ulcers, or if they are living with dementia or with a learning disability.
- There was a separate paediatric play area within the Alexandra Day Surgery Unit for children waiting for surgery. This area was bright and suitable toys were available to cover most age ranges.
- Patients that had received a hydration card and were allowed to drink were moved to a second waiting area, separate from those fasting to provide some privacy and prevent fasting patients sitting in view of patients drinking.
- Another patient explained that they were nil-by-mouth the day prior to our inspection as the surgeon was hoping to add them on to their existing list. The consultant had sent another member of staff to the patient on the surgical assessment unit to advise that it would not be possible to complete their surgery that day gave assurance that they had been put on a list in three days' time as a priority case, with an apology. The patient confirmed they were happy with this plan and felt they had been treated appropriately.

- Some specialties provided written information to patients at first appointment however this did not occur for all specialties. Patients informed us that the information provided was excellent and gave adequate explanations.
- Parents in the Alexandra Day Surgery Unit informed us that information had been provided prior to admission with their child. Although information regarding admission and surgery was adequate they felt that logistical information regarding car parking and the actual location of the unit could be improved.

Learning from complaints and concerns

- Duty of candour details were displayed on posters on the surgical wards. These posters outlined the requirements and actions the trust would take to communicate with patients and families following incidents.
- Patient feedback cards were available throughout the surgical wards and complaints data was displayed as part of the quality indicator information.
- Welcome packs for patients were seen on both Kingsmoor and Melvin wards, containing feedback forms which the patients can complete at any point during their stay. These feedback forms are submitted to the Patient Advice and Liaison Service who inform the relevant ward or unit of the feedback received.

Are surgery services well-led?

Requires improvement

Surgery services required improvement in well led. The risk to patient safety from staff shortages, both nursing and medical, were identified. There was limited oversight at a local level to assess areas of individual risk and we were not assured that risks were being identified, reported and managed in a timely manner. Pressure to maintain immediate clinical care meant that wider clinical oversight was not possible.

Staffing concerns were well known to the leadership team, with subsequent safety concerns raised. Action was taken in response to concerns raised during our inspection and, by 30 July 2015, 16 beds had been reduced on Saunders ward. This could have been addressed in a more timely manner and we were not assured that consistency could be maintained. The service had bent to capacity pressures in the past when bed closures were not maintained on Saunders ward.

At a local level staff felt supported by the immediate senior nursing team on the wards and in theatre.

Staff expressed that they felt the senior management team would listen to concerns but that minimal actions would be taken. The lack of attention to policies and procedures being maintained meant there was a potential risk of patient safety, there was no assurance that local policies were in line with most recent guidance and this was not focused as a concern to be addressed. Small local improvements were not communicated and shared to benefit colleagues and patients.

Vision and strategy for this service

- Each surgical ward displayed a mission statement and the trust values. The trust had five strategic goals that were excellence in safety and outcomes, patient and carer experience, operational performance, value and staff morale. Staff said that the overall aim was to provide excellent care.
- There were four value statements; caring, committed, respectful and responsible and these were displayed in all the surgical wards. These had been introduced across the hospital and theatre staff stated that the chief nurse regularly attends the quarterly theatre staff meeting and had personally introduced the values and behaviours to the team.
- Senior staff on Melvin ward stated that the unit itself had no mission statement or clear strategy at time of our inspection. The associate director of nursing for surgery had written a standard operating procedure (SOP) for the ward but this had not yet been finalised.

Governance, risk management and quality measurement

- There were monthly trust performance exception reports which included a summary of establishment numbers, incidents, key risks, quality audit update and complaints. These reported into the surgical governance meetings and quality and safety committee.

Surgery

- There was a surgical risk register and staff at a local level were able to state that the greatest risk was nurse and medical staffing. However there was not a consistent oversight on a local ward level of risks occurring in individual areas.
- The lack of attention to policies and procedures remaining up to date meant there was a potential risk of patient safety and we were not assured that this was a focus to be addressed.
- The operating theatre had a good management structure in place which reflected the needs of the department. The clinical matrons and consultant of the week initiatives all contributed towards quality of care.
- There was a senior surgical nurse meeting every Thursday with a set agenda and minutes taken. Staff informed us that it was used as a supportive environment.
- Staffing concerns on Saunders ward were known to the senior team. Team meetings minutes were recorded where the issue had been raised and the ward manager had highlighted her concerns with the staffing as early as March, to the associate director of nursing for surgery, following one of her "keeping in touch days" during her maternity leave.
- Staff from Saunders ward stated that they felt the ward was unsafe at times due to the staffing situation which was compounded by the number and inconsistent quality of agency nurses. Two staff said they felt that the ward was "losing good people as the structure was not there for long term support to improve patient safety". Staff said they were under huge pressure and worked extended hours repeatedly to try and cover the ward. Staff were supportive of the ward manager and stated these issues had been raised however support from senior management had been limited.
- Staff were able to express concerns and felt listened to but did not feel that appropriate actions were followed through. For example staff on Saunders ward had reported that support from the on-site duty team was poor. Staff had given examples to the ward manager of situations where they were made to feel "helpless and stupid" and had been intimidated by the duty team. This was reported to the Matrons as an issue but there had been no feedback given as to actions taken to resolve this.

Leadership of service

- Leadership at a local level was supportive. The majority of staff said that matrons were visible and would visit clinical areas daily. All senior staff on the wards supported and worked clinically alongside the ward staff. In theatre the matron and manager both remained clinical and worked alongside the team regularly.
- Team meetings were attempted across all surgical wards and theatre. Theatre utilised the audit day to enable a meeting however in some areas, such as the pre-assessment unit meetings could be quite difficult to arrange due to clinical need.
- There had been a break in leadership on Saunders ward due to maternity leave. During this time twenty staff had left the ward (either redeployed elsewhere in the trust or left the trust altogether). Some reasons stated by staff for resignation included delayed preceptorship and limited long term support by senior management.
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Culture within the service

- There was an open culture across the surgical services with staff stating that issues could be raised and staff were aware of the whistleblowing procedure and how to raise concerns. One member of staff did state that, having raised an issue, she had been disappointed with the handling of the situation and felt that whilst the process was in place it was not always transparent and impartial.
- Dementia and learning disability champions informed us that they were proud to be given the role and to be able to improve patient care.

- There was a lack of cohesive communication between the upper management and local staff view on reasons for staff leaving from Saunders ward. Three staff informed us that some of the reasons were staff were exhausted, tired of being short of staff, left in charge, having no breaks and working extended hours. Communication from senior management was due to development opportunities, redeployment and moving out of area.
- We found staff to be passionate about their roles, one member of an administration team said she was "proud to work for the NHS" and had been a member of staff for 11 years.

Public engagement

- Staff stated that there was an open door policy of the senior executive team and that engagement could happen when it was requested. For example senior staff had requested a meeting to discuss staffing issues, which included recruitment, utilisation of bank and agency staff and overseas recruitment. This had been attended by the chief executive, chief nurse and the director of workforce.
- There were patient information leaflets across the surgery wards and in every area feedback cards were available for patients.
- There was an active patient panel that was involved with joint projects working alongside staff. One example was the 100 day project that had been challenged to increase the discharge process. Staff said this had transformed how staff engaged with the local community and felt it was important that the patient panel should be recognised. Alongside estates staff and local voluntary stakeholders the patient panel had also been involved in assisting the redesign of the courtyard area which has provided a more comfortable environment for those receiving chaplaincy support.

Innovation, improvement and sustainability

- Staff stated that there was no focus at present on innovation as the main concern was staffing and maintain care in the current situation.
- Initiatives such as the sticker to indicate current note page, which was simple but highly effective, and the specific controlled drug log utilised in theatres was not shared widely across the service which was a missed opportunity to share best practice.

Critical care

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

Information about the service

The critical care unit at the Princess Alexandra Hospital has seven beds in an Intensive therapy unit, which is for level three patients who require one-to-one care. There are five beds in a high dependency unit for level two patients who require complex care but on a less intensive basis. In April 2015 the trust agreed the funding for an additional two beds in the intensive therapy unit, which are being opened in a staged process as more staff are recruited. The critical care unit has one isolation room that can also be used for negative pressure therapy. There are eight Consultant Intensivists who work between the hours of 8am to 10pm on site Monday to Friday and 8am to 4am with evening ward rounds over the weekend.

Out of hours a general anaesthetic rota of registrars and intensive care specific registrars and staff grade doctors covers the unit. All consultants are anaesthetists. A separate post-anaesthesia care unit is used for additional capacity when the critical care unit is full. There are two beds that can be used for level two patients and one bed for level three patients, who will be cared for by a recovery-based anaesthetist and senior nurses.

A critical care outreach team of six nurses work between the hours of 7.45am to 8.15pm, seven days a week and assist on the management of critically ill patients across the hospital.

We spoke with twelve members of staff including nurses, doctors and support staff, two patients and five relatives. During the inspection we observed care and treatment and we reviewed care records. We received comments from our listening events and focus groups. Before and during our inspection we reviewed performance information from, and about, the trust. Between January 2014 and March 2015, 792 patients were admitted to the critical care unit.

Critical care

Summary of findings

The critical care services required improvements to ensure the responsiveness and leadership of the service.

Patients were cared for in a clean environment in which staff showed good awareness of reducing the risk of infection. The units did not meet the minimum requirements of the Department of Health's infection control in the built environment guidance in respect of the space around each bed. On the day of our inspection staff were very busy, with one senior nurse having been deployed elsewhere in the hospital on bed management duties and a matron on a non-clinical shift but helping in clinical areas. We observed a well-coordinated team of permanent and agency staff delivering a good standard of patient care and safety.

There was evidence that staff used learning from incidents and complaints to improve practice and deliver safer, more effective care. Consultant input was good and junior doctors were adequately supported to provide safe treatment and assessment. Physiotherapists, microbiologists and pharmacists were spoken of highly by staff and were available at short notice when needed.

Relatives and a patient spoke very positively about their experience of care and treatment. We found some evidence of efficient and responsive multidisciplinary involvement from a range of medical specialties although medical staff said that this was variable and they could not always depend on it. Staffing overall was cited as a risk by staff, including the high turnover of nurses and the lack of development and progression opportunities available.

The critical care service was not responsive to patients needs as access and egress from the unit was delayed due to capacity issues within the hospital. There was a lack of a dedicated bed manager who could liaise across the hospital to ensure that beds were available for patients requiring complex care. The theatre recovery area used to support patients who following surgery required admission to critical care areas. Whilst the trust had taken action to mitigate the risks to the patient they remained under the care of the anaesthetist and admitting team and did not have direct access to critical care specialists.

Staff spoke of leadership and culture on the unit variably and some staff were afraid to speak out due to the pressures from the senior leaders. Whilst staff took action to mitigate risks to the department these were not owned by the senior leaders and longer term planning and strategic oversight was not in place.

Critical care

Are critical care services safe?

Good

In the critical care unit there were appropriate systems and procedures in place to protect patients from avoidable harm. Weekly meetings were used to discuss morbidity and mortality and included the involvement of multidisciplinary medical professionals. The electronic Datix reporting system was used to track and respond to incidents, which we saw were used as learning experiences by senior staff.

There was evidence that cleaning and infection control procedures had been followed, However, staff on the unit did not always adhere to the 'bare below the elbow' requirements of the trust in clinical areas. The bed spaces in the unit were not compliant with Department of Health minimum space requirements. As the unit was also introducing additional intensive therapy unit capacity, it was not clear how the unit planned to address the problems of space.

Staffing levels were problematic and we found that there was pressure on qualified staff because of the number of vacancies on the unit. Medical staff told us that the ratio of doctors and consultants to patients was maintained at safe levels, including outside of weekday working hours, when on-call anaesthetists would cover the unit. Nursing staff said they were happy with the quality of training but not with the opportunities for progression.

Medicines were stored and administered appropriately and patient records were detailed and included evidence of multidisciplinary consultation.

There was a need for significant improvement in staff knowledge and understanding of major incidents and evacuations. We found that training had been planned and that senior staff were aware of the need to ensure each member of staff understood their role in the event of an emergency.

Incidents

- Weekly morbidity and mortality meetings took place and were used to discuss deaths on the unit. We found that the meetings had been used to improve practice and treatment, such as a better system for obtaining blood products. Nurses were not usually able to attend the meetings as they overlapped with handovers.
- Staff told us that they were encouraged to report incidents using the Datix system and that the Duty of Candour was included as part of this process. The senior team was responsible for discussing incidents with relatives and patients as part of their adherence to the Duty of Candour. Staff told us that Datix reports were always followed up.
- A monthly staff bulletin outlined the lessons learnt from incidents and was used as a strategy to include nurses in the information given at morbidity and mortality meetings.
- In the past year (2014/15) to our inspection, there had been no incidents described as never events in the critical care unit.

Safety thermometer

- The NHS safety thermometer is an improvement tool to measure patient harms and harm free care. It provides a monthly snapshot audit of the prevalence of avoidable harms in relation to new pressure ulcers, patient falls, venous thromboembolism and catheter-associated urinary tract infections.
- A safety thermometer display was in place in the unit. It displayed data for the calendar month prior to our inspection and showed that the critical care unit had no recorded falls, new pressure ulcers, new blood clots or new urinary infections. The display indicated that for the month prior to our inspection, the unit had been 100% harm free for patients. From looking at unit records, we saw that in the year to our inspection, there had been no falls, one catheter urinary tract infection and six pressure ulcers.

Cleanliness, infection control and hygiene

- The intensive care unit was visibly clean and maintained to a good standard. This also included the sluice room and a kitchen that was used to prepare drinks and meals to patients and relatives.
- Cleaning staff were visible at regular intervals and adhered to appropriate hygiene and infection control guidelines. Cleaning schedules were not displayed but were available on asking and documented when unit cleaning had taken place.

- During our inspection the matron worked in clinical areas, including attending the medical handover and we noted they were wearing long sleeves and jewellery. This did not adhere to the trust's 'bare below the elbow' policy.
- We found that isolation facilities in the unit were inadequate. There was one dedicated isolation room and other areas were controlled with the use of disposable curtains. However between January to March 2015 the unit had not reported any cases of Methicillin Resistant Staphylococcus Aureus or Clostridium difficile.
- We did not find evidence that hand hygiene audits had taken place.

Environment and equipment

- The space around each bed was in breach of the Department of Health's Health Building Note 00-09, which dictates a minimum standard of space for effective infection control. We found that this was included on the unit's risk register.
- We checked the condition and contents of the resuscitation trollies on the unit, as well as the blood gas machine and intubation trolley. In all cases equipment was in good working order and there was documented evidence that they had been maintained and checked daily, except for the blood gas machine which did not have a documented check dated past September 2014. We asked a nurse about this who told us that a biochemist attended the unit on a daily basis to check the machine.
- The unit did not have a dedicated equipment technician.
- Bed spaces were colour coded and staff wore personal protective equipment (such as aprons) in that colour so that they could be easily identified as working with a particular patient.
- A relatives' room was available for visitors that provided a quiet area for reflection and waiting. The room enabled direct access to the unit and we saw it being used effectively during our inspection.

Medicines

- The cupboard used to stock controlled drugs was locked and the items inside were stored in alphabetical order. We looked at the documentation of controlled drugs and found that staff followed the guidelines that drugs be double-signed on administration. Overall the controlled drug process was excellent and demonstrated compliance with policy, including in the safe disposal of controlled drugs.
- Fridges used to store medicines had temperatures checked and recorded daily.
- Each patient had a drug administration chart accessible at his or her bedside. The charts did not include specific dosage time on them, only a general time of day, such as 'Lunch' or 'Tea-time'.
- A pharmacist visited the unit on a daily basis in the morning and there was provision for when they were on holiday.

Records

- Patient risk assessment packs were comprehensive and robust, with evidence of consistent completion. Care plans for high dependency unit patients were particularly good. Risk assessments were sometimes completed by student nurses or health care assistants but were always checked by a registered nurse.
- Patients had been monitored using Waterlow scores and the Malnutrition Universal Screening Tool and there was evidence of two hourly intentional rounding checks.
- Body maps were available for the assessment of skin integrity but these had not always been completed. Falls risk assessments at been completed.
- We saw that the recording of cannula insertion was not always accurate. For instance, a person had a visual infusion phlebitis score completed and their cannula had been in situ for five days but their treatment record indicated it had been in place for only three days. The insertion of a new cannula had not been correctly documented.
- Patient notes were detailed and contained appropriate information. For instance, patients had a signed and dated venous thromboembolism assessment on the front page of their file. Allergies were highlighted clearly in red. Multidisciplinary records were also clear and detailed, such as an example we saw where a patient had needed clinical input from a respiratory doctor, a critical care outreach team nurse and an intensive care consultant.
- Transfer documentation was used consistently and adhered to the guidance of the Essex critical care network.

Safeguarding

- All staff working on the unit had been trained as a minimum to safeguarding level two. Two annual study days were allocated to nursing staff, which included training on the Safeguarding of Vulnerable Adults and dementia care.

Mandatory training

- Some mandatory training had to be completed online, using an e-learning system. Staff told us that this was difficult to manage because their shift patterns did not include protected time. For example, nurses worked twelve hour shifts that did not include any overlapping time with the next shift, meaning that they were required in clinical areas at all time.
- To encourage compliance, staff were offered the option of substantive hours to be taken off a future roster or to be paid as bank hours. Staff gave us negative feedback about this and felt that it was inappropriate to be increasing their time on site for the sake of e-learning. We spoke with human resources about this, who were unable to confirm the practice.
- 86% of the critical care outreach team had completed mandatory training.

Assessing and responding to patient risk

- Unit registrars offered advice and care plans for patients who were deteriorating on hospital wards. The Critical Care Outreach Team could also be bleeped by any member of staff at the hospital who was concerned about a deteriorating patient.
- The National Early Warning Score system was used on the unit but not in the case of ward transfers. This meant that patients who remained on the unit benefited from a consistent approach to the monitoring of deterioration.
- A monthly patient safety group meeting took place and included GPs and community medical officers and was used as a hospital-wide tool to discuss risks and standards of treatment and care.
- The theatre recovery had been utilised as a high dependency area when there was no bed availability in the intensive care unit. Oversight of these patients was provided by the anaesthetist and the theatre recovery staff. There were two dedicated bays within recovery which were fully equipped for monitoring of level three patients. The anaesthetist remained in recovery for the duration. Theatre was staffed with a night team and there was an on call system for an additional recovery team member if a level three patient remained overnight to ensure one to one nursing care. Recovery staff undertake a care of the ventilated patient course and complete competencies before participating in the on call rota. Capacity of critical care services and the impact on theatre was highlighted on the theatre risk register.

Nursing staffing

- During our inspection, senior nurses were very busy due to the acuity of the unit, capacity and demand issues. The matron was visible and supported unit staff.
- At the time of our inspection there were nine whole time equivalent nurse vacancies. This placed additional pressure on staff who said that they regularly worked overtime.
- Two recruitment campaigns were in progress. One was called 'Home to Harlow' and was aimed at staff that had left the area, with the intention of encouraging staff to return to the hospital. The second was an overseas recruitment campaign that encouraged suitably qualified applicants to relocate to the area.
- The unit had regularly been staffed by up to 50% agency or bank nurses, which was in excess of the recommended 30% maximum. We looked at a shift fill performance report for May 2015. We found that 1000 hours of nursing time was needed.
- We spoke with agency nurses who were on duty. They told us that they received orientation of the unit and an induction had been provided along with a familiarisation of equipment. They had also been shown how to access policies and procedures and had never been asked to take on more responsibility than they were able to. One nurse said, "There's a clear process to follow in the event of an inappropriate allocation but it's never happened." Only agency nurses with extended training in intensive care nursing and assessed as competent to administer intravenous medication worked on the unit.
- A nurse in charge was always on shift as a supernumerary member of staff and there was a healthcare assistant available across the unit to assist as necessary.
- On initial recruitment, nurses were always supernumerary for their first four weeks on the unit as part of a four week starter programme.

Critical care

- Relatives told us that they felt there were enough staff on the unit. One person said, "[Relative] gets one-to-one care. Staff even tell us when they're going for lunch and who will take over from them."

Medical staffing

- The unit was staffed by two staff grade doctors and two consultants. The numbers of trainee doctors was variable and depended on allocation from the Deanery. We were told that none of the consultants worked exclusively within unit and that they had to cover anaesthetics as well.
- Medical staff told us that when doctors were on annual leave, cover was not always arranged, which meant that the unit did not always meet its own minimum standard of doctors in addition to consultants.
- Two consultants were dual trained in intensive care medicine and anaesthetics, as recommended by The Royal College of Anaesthetists. As part of a retention strategy for trainee doctors, a director told us that their future strategy was to ensure that all medical staff were given the option to be dual trained.
- Two daily handovers took place but did not combine all available staff. One handover included nurses and one included two consultants, two FY1 grade doctors, two trust doctors, the matron and a senior sister. Critical Care Outreach Team nurses attended as appropriate.
- Admissions were only ever approved by a consultant, who was available twenty four hours a day on call.

Major incident awareness and training

- The results of a staff survey indicated that 38% of respondents did not know what their responsibilities were in the event of a major incident.
- None of the staff we spoke with were able to tell us about a major incident, evacuation or treatment continuity plan. We spoke with the Emergency Planning and Resilience Officer about this. They said that the unit had access to evacuation lifts that could be used to transport patients in the event of a fire and that they were surprised staff did not know about these. They told us that based on staff feedback, dedicated training sessions were being offered in major incident awareness and all unit staff should be aware of the 'cascade list', which would be used to contact senior staff in the event of a major incident.
- The High Dependency Unit and the Intensive Care Unit were compartmentalised and the emergency planning and resilience officer told us that the matron and sister in charge would make any decision to order an evacuation.
- The emergency planning and resilience officer told us that they expected the unit staff to be aware of their specific fire plan and how to contact the hospital's incident control room because a single emergency folder was kept on the unit and included all pertinent information.
- None of the staff we spoke with could tell us how they would contact the control room in an emergency or where the emergency folder was.
- The matron and the emergency planning and resilience officer had worked together with consultants to decide how best patients could be supported during an evacuation or forced move.
- Senior staff on the unit were responsible for briefing locum doctors and agency or bank nurses on emergency procedures.

Are critical care services effective?

Good

Care and treatment was provided following best practice guidance from the Essex critical care network, National Institute for Health and Care Excellence and the Royal College of Surgeons. Nutrition, hydration and pain management protocols were established on the unit although use of these was variable.

The unit contributed to national safety auditing tools, indicating a low level of unexpected deaths and unplanned readmissions. 65% of nursing staff had intensive nursing certification, which was above the minimum national level and 64% of nursing staff had undertaken an appraisal in the previous year. The unit did not have a dedicated clinical nurse educator but we were told this post had recently been filled.

Multidisciplinary working was evident and staff were able to ensure rapid and appropriate specialist referrals and care on demand with physiotherapists and dieticians.

Critical care

Although the demand for some multidisciplinary services sometimes meant that efficient access to specialists could be time-consuming, staff were able to overcome this problem effectively.

Capacity assessments were used for ventilated patients as appropriate and staff had an awareness of their responsibilities under the Mental Capacity Act (2005). Staff were provided with protected time on an annual basis for specialists training in mental capacity and the Deprivation of Liberty Safeguards.

Evidence-based care and treatment

- The unit used the East of England indicators for nursing performance monitoring and care bundles were regularly audited but we could not find evidence that internal quality monitoring indicators were used.
- Discharge and transfer protocols were used from the Essex critical care network.
- Medical staff told us that because of the problems in achieving appropriate patient discharges, inappropriate care was sometimes provided. For example a patient had been referred from a vascular ward to an orthopaedics ward to the intensive therapy unit, which had ultimately resulted in an amputation because of the delay in receiving accurate assessment and treatment.

Pain relief

- Each patient had his or her pain needs assessed on admission and these were acted upon. For example, analgesia was prescribed on admission to the unit and Medicine Administration Record charts and observation charts demonstrated that medication was administered and pain scores were routinely measured.
- Venous Thromboembolism risk assessments were in place and prophylaxes had been prescribed and were being administered appropriately.
- Where an epidural was in place, epidural block level observations were in line with trust policy and best practice guidance, with safety precautions in place. For instance, naloxone and intravenous fluids were prescribed in case of an emergency.

Nutrition and hydration

- Malnutrition Screening Tool risk assessments were in place and patients were weighed on admission. Patients received the most appropriate type of nutrition and hydration dependent on their condition, i.e. naso-gastric (through a tube into the stomach) or total parenteral nutrition (a special formula of nutrients inserted through a cannula directly into the blood stream).
- High dependency patients had access to the regular menu or special diet if required and a dietician was available on call.
- There were no formal audits conducted of nutrition but the minutes from an undated staff meeting sent to us indicated that there was disparity between the advice given to staff by dieticians and critical care guidance. It was not clear if this issue had been resolved in the best interests of patients.
- Fluid and food intake was recorded as appropriate to ensure the patients were receiving adequate intake and there was a clear pathway in use for nutrition plans for patients being discharged or transferred.
- A Percutaneous gastrostomy tube (inserted directly into the stomach) protocol was in place, which staff were aware of.

Patient outcomes

- Cardiac arrest failure to rescue rates had decreased by 50% in the year (2014/15) to our inspection. This meant that patients were more likely to survive a cardiac arrest than previously.
- The unit contributed to the Intensive Care National Audit and Research Centre database and to the Critical Care Minimum Data Set for all patients admitted to the unit.. The unit was four weeks behind in their data reporting for Intensive Care National Audit and Research Centre monitoring.
- The unit participated in national discharge process and delirium audits. The results of audits were used to improve practice and standards in the critical care unit, such as the introduction of End-Tidal CO2 monitoring across the organisation.
- Between January 2015 to March 2015, there had been no early or unexpected deaths and two readmissions.
- The unit was within the expected range of mortalities for the period January 2015 to March 2015.

Competent staff

- The unit only employed staff with a minimum of one year's acute experience that included one month as a supernumerary. Overseas nurses had been recruited through a robust process than ensured their competence and English language fluency.

- 64% of the nursing staff in the critical care unit had received an appraisal in the last year, which were led by band 7 nurses.
- The quality of appraisals was variable and band seven and some band six staff had been trained in this over one year before our inspection. A member of staff told us, "Appraisals are constructive and supportive, they look at your time again in the unit and where you want to progress to".
- All of the band six and band seven staff had completed a specialist intensive care course and 65% of the staff overall had this certification.
- We were told that the unit's education budget had been cut by 50%, which meant that only one member of staff could take the intensive care course for the following year. Staff told us that they were aware of this. A nurse said, "There are very limited opportunities for education here and there are very few opportunities for progression. No-one from the senior roles moves on and the more junior staff leave too quickly so you don't get to develop yourself".
- At the time of our inspection there was not a dedicated clinical nurse educator in post. A nurse had been recruited externally for this post and was due to start in August 2015. In the interim, a band 7 nurse had led the nursing team in learning and development.
- Agency and bank staff had to sign a document at the beginning of each shift to indicate that they understood the requirements around hand hygiene, body maps, the handover process, intravenous drug administration competence, National Early Warning Score indicators and Situation, Background Assessment Recommendation stickers. Although there was a designated folder with this information in it, there was no tracking or auditing system to indicate that every member of temporary staff followed the checking process.
- Patients told us they had confidence in the skills of staff. One person said, "They are on the ball all the time." All medical staff had undergone End-Tidal CO2 (ETCO2) training.
- Trainee doctors received appropriate clinical supervision and education from consultants.

Multidisciplinary working

- The critical care outreach team, which cared for patients with acute pain and those with a tracheostomy, supported the nursing skill mix. Outreach nurses were able to escalate deteriorating patients to the critical care registrar and also followed up with discharged patients as part of a rehabilitation pathway. Between January 2015 and March 2015, 94% of discharged patients had been seen by the critical care outreach team.
- Doctors told us that communication between the critical care outreach team and the emergency department was very proactive but due to the pressure on intensive care services, patients in resuscitation were not reviewed in a timely manner.
- A consultant and a band seven nurse led a number of 'body systems teams', which focused on developing staff and conducting audits in different areas of treatment. The teams included respiratory, neurology, renal and skin. A senior nurse told us that this approach worked well and that a new approach to haemofiltration had been introduced as a result of one work stream.
- Doctors told us that the ease of getting specialist support was inconsistent. For example, getting a scan or a neurological consultation was very fast but getting a respiratory consultant was very difficult. One person said, "Getting help seems to depend on knowing the specialist involved personally."
- A team of five physiotherapists were available to care for patients in the critical care unit. At least one physiotherapist attended the unit each day as well as the Monday and Friday handovers. The lead physiotherapist was taking forward a programme to involve the team more consistently in weaning.
- We were told that outside of the critical care unit, there was no on-site access to non-invasive ventilation or to tracheostomy care. Doctors told us this meant that patients stayed on the unit much longer than was necessary. Critical care outreach nurses were able to provide non-invasive ventilation support to staff in the emergency department and one nurse told us that they were providing non-invasive ventilation training to respiratory nurses.

Seven-day services

- Outside of the hours of 8.15pm to 7.45am, there was no critical care outreach team available. The intensive care registrar covered patients in need of critical care outreach team services. The unit had plans to establish a twenty four hour critical care outreach team provision.

- A physiotherapist attended a ward round on a Friday or on request at other times. Dieticians did not attend ward rounds routinely due to a lack of staff and a microbiologist was available on request only.
- At other times a physiotherapist was available on call although there was not enough staff to attend daily ward rounds.

Access to information

- Medical and nursing staff had access to information through the IT system to pathology reports and imaging results. We noted that there were no issues with this system and that information was available when needed.

Consent and Mental Capacity Act (include Deprivation of Liberty Safeguards if appropriate)

- Staff we spoke with had some understanding of the Deprivation of Liberty Safeguards and the Mental Capacity Act (2005) and doctors we observed practiced with good awareness of their application. There were no clear guidelines or protocols for patients in the unit with respect to these.
- Two annual study days were allocated for staff to attend training in deprivation of liberty safeguarding and the Mental Capacity Act (2005). A senior member of staff told us that this training was too basic and that they were consulting with the critical care network and the medical director to source training more appropriate to critical care.
- Patients who would be ventilated for more than four days underwent a capacity assessment by a multidisciplinary team.

Are critical care services caring?

Good

Patients and their relatives were cared for by a staff team who demonstrated a high level of empathy and understanding of complex emotional situations. There was private space available on the unit for relatives to have quiet reflective time with or without staff and an overnight residential area enabled family members to stay on-site.

All of the relatives we spoke with told us that they were very happy with the level of compassion and commitment of staff and they felt their relatives were in good hands.

In all of the interactions we observed between staff, patients and relatives, we saw a consistent approach which was open and honest. Communication was sensitive and empathic.

Compassionate care

- We observed caring and compassionate care of patients in the high dependency unit by nurses and healthcare assistants.
- All of the relatives we spoke with said that they felt staff were compassionate and caring. One person said, “Everyone tells you their name and introduces themselves personally. The communication is clear and transparent and I think our expectations have been managed very well.” Another family member said, “[Staff] are exemplary in here. The consultants make time to speak to you and the nurses are fantastic. I can ask them anything and they’ll give me a straight answer. They talk very clearly and keep you informed. Their professionalism is in a different league from the other wards I’ve come across at this hospital.”
- A patient told us that they had benefited from a good team spirit amongst staff on the unit. They said, “The nurses are all brilliant, mine has worked their socks off looking after me.”
- During our inspection a previous patient returned to the unit to personally thank a critical care outreach team nurse who had cared for them.

Understanding and involvement of patients and those close to them

- A relative told us that they had been actively included by the intensive care consultant in the decision to move their family member to the unit. They said, “Once the decision was made it took some time, about 24 hours but the level of care, the level of information we’ve been given and the access to [relative] is brilliant.”
- When a patient was admitted, family members were given a named contact person who they were available to speak with by phone. Relatives told us that this worked well and that contact was straightforward. One family member said, “I can phone whenever I want. [Staff] are very aware of our feelings and show great empathy.”

Emotional support

- We observed nurses talking with relatives about a difficult prognosis and saw that they were able to adapt

their communication technique and language appropriately to support people. Relatives we spoke with told us that the information given to them had been detailed, accessible and appropriate.
- Relatives using the accommodation told us that the service had reduced their stress and worry significantly and had helped them to spend more time with their family member during a critical time in their treatment.

Are critical care services responsive?

Requires improvement

Capacity and flow in the intensive care unit were problematic. We saw that staff were very busy and that additional pressure was added to their workload because of the lack of a dedicated bed manager who could liaise across the hospital.

Bed management within the intensive care unit needed to be more responsive. Patient admissions to the unit were often delayed and the theatre recovery area used to support these patients. Patient discharge from the unit was often delayed due to bed pressures in the main hospital. However action was taken to minimise the impact of mixed sex breaches, which occurred due to a lack of flow from the unit and the regular 100% occupancy rate.

The unit received very few complaints and staff had been able to deal with minor issues on an individual basis. The NHS complaints procedure was followed when needed and there was an established relationship with the Patient Advice and Liaison Service that ensured patients and their relatives could be assured of appropriate investigations in the event of a problem.

The unit had provided an overnight relatives' room on demand that meant that travel and accommodation costs and pressures for family members from some distance away could be mitigated.

Service planning and delivery to meet the needs of local people

- Bed management was inconsistent because of the lack of a dedicated surgical bed management manager. This meant that service capacity and availability did not always meet the needs of people.
- A relatives' overnight room had been provided based on feedback from people who had to travel a significant distance to the unit. This meant that people could stay on site to be near their family member without financial pressure arising from the need to find local accommodation.

Meeting people's individual needs

- Mixed sex breaches were minimised within the unit. Where a mixed sex breach occurred in either of the units, privacy was supported with movable screens.
- A translation service was available twenty four hours a day and could be arranged by phoning the main switchboard.
- The unit had a dedicated learning difficulties nurse who used individual 'passports' to help staff meet the needs of each patient as well as to involve their family or carer appropriately.
- Patients and their relatives were offered detailed information on conditions and procedures routinely on admission. This was followed up by the critical care outreach team who used a rehabilitation pathway to give people a continuous level of information on demand regardless of where they were in the hospital.
- Post-treatment contact was encouraged by the critical care outreach team with patients and their relatives. This mechanism was used to refer people to appropriate counselling or community services where necessary.
- An excellent information board for relatives was on display in the unit, which clearly identified staff roles along with lines of responsibility and specialism. For instance, nurses were organised into teams of specialism and there was at least one link nurse for each area, such as dementia and nutrition.
- The information board also included details on what to expect in the critical care unit as well as where people could go to obtain more detailed information.
- Staff were able to refer patients to appropriate psychology teams during their admission to support with mental health needs or for help with depression. The unit did not routinely use a depression screening tool but if depression was identified during initial delirium checks, staff were proactive in obtaining support for the patient quickly.

- Liaison with care homes and community health providers was very good and where a patient was admitted directly, staff used 'hospital passports' supplied by the care provider to ensure the person was cared for appropriately.

Access and flow

- Bed occupancy at the time of our inspection was 103%, with the majority of patients admitted for elective surgery. Elective patient treatment was cancelled in the event of no bed availability and only after a meeting between the consultant, the clinical specialist lead, the matron and an on-call director. In the week leading to our inspection, 7% of elective operations had been cancelled because of a lack of capacity.
- The Trust is performing about the same as other Trusts in five of the seven case mix programme indicators in the ICNARC Annual report. The Trust is performing worse than expected in two indicators in the case mix programme in the ICNARC Annual report. These indicators are 'Out of hours discharge to the ward' and 'Delayed discharges (12 hour delay)'.
- The senior team was aware of the problems with transfers and discharges and a lead nurse was about to start a pilot project to explore how this could be more effectively managed.
- Several staff told us that the problems with out of hours and delayed discharges occurred because of cultural problems with the bed management team and others said that this was mostly due to available ward beds being released at the end of the day. From January 2015 to March 2015, 78% of discharges were delayed, 62.5% of which for less than two days.
- On 71 occasions between 1st January 2015 and 22nd July 2015 theatre recovery had been utilised as a high dependency area when there was no bed availability in the intensive care unit. Since January there had been 30 occasions when level two or level three patients had remained in recovery for at least one night.
- A band seven nurse was deployed every two weeks to support bed management and flow across the hospital. A senior medical member of staff told us that this could be more efficiently and appropriately managed by a dedicated surgical bed manager. They said that the use of band seven staff in this manner removed them from essential clinical care. A dedicated bed manager told us that it was an "institutional" decision to use band seven staff in this way.
- Admission processes were well established and robust and ensured that a consultant to consultant referral process was used to establish treatment criteria.
- The post anaesthesia care unit was used as an overflow when the critical care was at capacity. This was indicative of broader flow problems elsewhere in the hospital. For example, at the time of our inspection, two patients in the critical care had been assessed as suitable to be discharged to a ward but could not move because the wards were full. This meant that a level 3 patient was being treated in the post anaesthesia care unit and that recovering patients were being kept in an inappropriate environment, particularly as the intensive therapy unit was often noisy with activity whilst staff treated patients and there was no toilet for patients to use.

Learning from complaints and concerns

- There was a robust complaints procedure that all staff were aware of and was in line with the NHS complaints procedure. The unit received very few formal complaints and there was evidence that these had been discussed at mortality and morbidity meetings.

Are critical care services well-led?

Requires improvement

There was a lack of vision or strategy for the critical care services. Staff talked variably about this and the visibility of the senior team. There was a risk register in place but it did not reflect the non-compliance of the building environment with regards to minimum bed space and infection control. The unit did not use a quality dashboard indicator for nursing. The senior leadership of the department was challenging and staff were afraid to speak out. Morale in the unit was low due to this and the pressure of work.

Staffing shortages were managed by a leadership team that demonstrated good awareness of the needs of their team but that did not always show an ability to manage staff morale. Human resources had implemented a dedicated role to monitor staff turnover and to use information from exit interviews to improve retention amongst existing staff. Despite staffing shortages, staff spoke with us about a supportive and friendly working culture within their peer group in which they felt able to deliver a high standard of care.

Critical care

Staff were routinely engaged in the running of the service through a survey and changes were made based on this, such as the provision of major incident training.

Vision and strategy for this service

- We spent time speaking with staff about the vision and strategy of the trust and their unit. However staff were unaware of the vision or strategy for either the trust or the unit.
- When asked about the visibility of leadership a nurse said, "The organisational nursing leadership is not visible, they can't translate their vision to our unit and to front line staff."

Governance, risk management and quality measurement

- The bed environment in both the intensive care unit and the high dependency unit was very cramped and we found was not complaint with the Department of Health's Health Building Note 00-09. Despite this, the lack of space was not on the unit's risk register.
- The unit did not use a quality dashboard or nursing quality indicator.
- Staff gave us conflicting information about the frequency of unit meetings. The last set of staff meeting minutes available to us were from March 2015. A member of staff told us that two meetings had taken place in the seven months prior to our inspection but that attendance was difficult because the unit was so busy. They said, "Really, if you want to attend, you need to come in on your day off, there's no way you could leave the unit to attend a meeting."
- We reviewed the minutes of meetings. We found that attendance was sporadic and inconsistent. Actions were identified but were not always followed up and it was not clear whether changes to the service had been made as a result of the meetings. For example, one set of minutes stated that it was not possible to discuss the outcomes of the previous meeting because it had taken place so long ago.

Leadership of service

- The unit was led by a matron who ran two clinical shifts per week. At other times the clinical areas were led by band seven and band six nurses.
- The unit was very busy and we saw some evidence of the pressure on staff, such as the abrasive manner in which a senior member of the team spoke to a colleague, which was of concern.
- Staff told us that there was little involvement from trust executives or senior staff. One clinician said that they rarely see the chief nurse and that they had never seen the chief executive visit the unit. This was not reflected by others. One member of staff said, "Everyone feels that they know the chief nurse. There has been an explosion of information since they started. The chief nurse is involved and inspirational, even getting to know the student nurses who are here for a short time."
- Staff told us that morale generally was low because of the pressures associated with short staffing. A nurse said that more training was needed to support complex patients and that nurses without the intensive care nursing certificate was not given enough training and support.

Culture within the service

- Staff spoke positively about the culture of the unit. A healthcare assistant said, "This is a really fantastic team. It's a rewarding environment to work in – you never stop learning." Medical staff told us that where there was a disagreement between a referring consultant and an intensive care consultant, they would seek a third external opinion as a matter of best practice.
- Some staff told us that the working culture was not open to challenge and discussion as senior managers were challenging. For example, one individual wanted to tell us about the risks associated with infection control in the unit. They told us that they would get into "serious trouble" if they spoke up about issues the trust were already aware of but were not acting on.

Public and staff engagement

- To address the on-going shortfall of nursing staff, an exit interview system had been implemented. This meant that leaving staff could fill in an anonymous questionnaire online that helped human resources and the unit managers to understand the reason for people leaving.
- Data from 17 questionnaires prior to our inspection indicated that staff had cited positive working

relationships in the department but they had chosen to leave because of the lack of career progression opportunities, a stressful working environment and pressure at work.

- We spoke with a human resources manager about this. They said that a retention advisor was now in post and was responsible for meeting with staff who wanted to leave, as a strategy to try and overcome any concerns and encourage them to stay. This was part of a broader action plan for staffing in the unit.
- The unit used agency staff regularly, who told us that they felt a part of the wider team. One agency nurse said, "All of the team are very friendly and the nurses are supportive of us as agency staff. We're made to feel a part of the core team and we're included in what goes on here."
- Staff organised an annual critical care conference to present and discuss new treatment and care approaches. The last theme for the conference had been 'current concepts in critical care'.

Innovation, improvement and sustainability

- The critical care outreach team were working on a two year delivery programme of the Commissioning for Quality and Innovation (CQUIN) framework, through a development of hospital at night services.

Maternity and gynaecology

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

Information about the service

The Princess Alexandra Hospital offers antenatal, labour ward, birthing unit facilities and postnatal care. Community Midwifery services are also provided by the trust to women in the Essex and Hertfordshire areas. Between April 2014 and March 2015 the service delivered 4,207 babies and had a slightly higher than average multiple birth rate with 1.7% of all births being more than one baby compared with a national average of1.6%.

The gynaecology service provided a dedicated range of services, including hysteroscopy, colposcopy, early pregnancy and termination of pregnancy services. The trust had six gynaecology beds on Penn ward, which provides general surgical care to women, and on average the trust has between five and 15 women admitted as inpatients for gynaecological reasons daily. The trust does not have a dedicated gynaecology ward.

During this inspection we examined the patient records of eight women in maternity and eight women in gynaecology. We spoke with 10 women, 29 members of nursing, midwifery and support staff and nine doctors ranging from consultant to first year trainees. We also spoke with the leadership team for nursing, midwifery, operations and the lead clinician for the service.

Summary of findings

We rated maternity and gynaecology services as services as Good overall. We rated the services as Requires Improvement for being safe, as Good for being responsive, well led and effective and Outstanding for being caring.

The midwife-to-birth ratio was higher than the recommended average. The environment in the unit was not secure and meant that there was a risk of child abduction. The gynaecology service had very clear processes for the delivery of a safe service across all recognised gynaecology pathways. Records management and completion within gynaecology was excellent.

The number of medical staff and consultant hours are in accordance with Royal college of Obstetricians Good Practice No 8 recommendation (March 2009) to be provided to deliver the maternity and gynaecology services which was positive. This meant that women were safer because medical staff were available to offer advice and treatment.

The outcomes for women who used The Princess Alexandra Hospital were outstanding, being consistently better than expected when compared with other similar services. The Termination of pregnancy process followed all elements of national guidelines and legislation and was an outstanding function within gynaecology.

Maternity and gynaecology

The service had a robust process for auditing, learning from national reports and recommendations as well as keeping up to date with current guidelines.

The maternity and gynaecology service provided outstanding care to women. Feedback from people who use the service, those who are close to them and stakeholders was all positive about the way staff treat women. Women thought that staff went the extra mile and the care they receive exceeded their expectations. The CQC maternity survey results were in line with the England average on all areas and the Friends and Family Test was consistently above the England average for scores in all aspects of antenatal, birth and postnatal care. The service consistently received more compliments than complaints.

The maternity and gynaecology service was responsive to the needs of women because it had planned how to manage the fluctuating and increasing demand on service capacity. The service had developed the gynaecology provision into a standalone service within women's services, which had a significant benefit to the quality of cares.

The service was stretched for capacity and demand and as a result the trust had changed a postnatal bay in the midwife-led birth unit into a medical bay for female medical outliers, which was not acceptable. The trust took immediate action to address this and changed their escalation policy so that it would not admit medical outliers to this area again. The future delivery of the service to meet the needs of the local population had not been planned out and left some uncertainty regarding the future because the facilities to provide the services were small and in need of expansion.

The maternity and gynaecology service leadership locally was good. The medical midwifery and operational leadership team were respected. Staff spoke highly of the clinical leads for the service and how involved and approachable they were, which created an open culture. It was evident that staff worked well together. Governance and risk management systems within maternity and gynaecology services were robust and well established which provided a level of assurance to the trust on the provision of maternity and gynaecology. Work was required to assure the future of the service because there was no clear strategy for service delivery.

Maternity and gynaecology

Are maternity and gynaecology services safe?

Requires improvement

Safety in maternity services required improvement because the environment within the unit was not secure and meant that there was a risk of child abduction, which the service had not identified. On the labour ward the resuscitation trolleys were not always checked in accordance with trust policies. The temperature of fridges where medicines were stored were not always checked and when they were checked appropriate action was not always taken when temperatures were too high. This meant that the service could not be assured of the efficacy of medications. Management of medicines in relation to allergy status recording and monitoring for administration of antibiotics in maternity also required improvement. This meant that women were not assured that they would not be given a medicine to which they were allergic. .

The midwife-to-birth ratio was higher than the recommended average, as was the supervisor of midwife-to-midwife ratio. However women were cared for by a sufficient number of staff who were appropriately supervised. There was a clear process for the reporting, recording and investigation of incidents. Lessons were identified and shared throughout the service and the Duty of Candour was implemented where the incident severity required it. Note: The Duty of Candour means that providers of healthcare services must be open and honest with service users and other 'relevant persons' (people acting lawfully on behalf of service users) when things go wrong with care and treatment, giving them reasonable support, truthful information and a written apology.

The gynaecology service had very clear processes for the delivery of a safe service across all recognised gynaecology pathways. The management and completion or records in gynaecology was excellent. The number of medical staff in the service enabled a higher number of consultant hours than recommended by national guidance to be provided to deliver the maternity and gynaecology service, which was positive. This meant that women were safer because medical staff were available to offer advice and treatment.

Maternity and gynaecology services were provided in a clean environment with equipment that was serviced, calibrated and tested, although the emergency theatre in the labour ward required some improvement to ensure that it met infection control guidelines.

Incidents

- The trust had an electronic incident reporting system in place. Staff we spoke with about incident reporting who told us that they could access the hospital's incident reporting system through any hospital computer. Staff understood their responsibilities to report incidents. Staff were able to describe to us what constituted an incident and when they would raise one.
- The maternity service had reported six serious incidents between May 2014 and April 2015. The six events included three unexpected baby admissions to the Neonatal Intensive Care Unit (NICU) and one unexpected adult admission to Intensive Care. There were two serious incidents classified as 'other' which related to a retained swab/ item after delivery. Both of these incidents were classed as 'Never Events' which are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.
- All serious incidents were investigated using root cause analysis techniques and lessons to learn were identified. We spoke with staff about the serious incidents and all staff members we spoke with including midwives, doctors and members of the leadership team were able to provide examples of changes to practice as a result of these incidents.
- Where incidents and serious incidents occurred we saw through the investigation records that duty of candour had taken place with the patients and families being informed of the incident, investigation and the outcome. Note: The Duty of Candour means that providers of healthcare services must be open and honest with service users and other 'relevant persons' (people acting lawfully on behalf of service users) when things go wrong with care and treatment, giving them reasonable support, truthful information and a written apology.
- We reviewed minutes from the monthly perinatal mortality and gynaecology meetings which contained discussions and case reviews by multidisciplinary team members. The minutes also highlighted any changes in practice needed to improve outcomes for patients.

- We were concerned that the number of incidents reported for this service was low when compared with other trusts delivering a similar sized service. We examined the maternity dashboard which showed that potentially there were other incidents, for example eight Incidents of major haemorrhage, four went to the critical care services so were escalated through the trusts Serious Clinical Incident Group, the remaining four were case reviewed. However these potentially could have been defined as serious incidents.

Safety thermometer

- Maternity services used the maternity specific NHS Safety thermometer. A Maternity Safety Thermometer allows service providers to determine harm-free care indicators but also records the number of harm(s) specifically associated with maternity care.
- We reviewed the maternity dashboard and found that there was monitoring of key areas of staffing, post-partum haemorrhages and caesarean section rates.
- The maternity dashboard was not as up to date. When we inspected in July 2015 the unit was displaying information related to May 2015. This meant that the up to date information was not available to staff or patients.

Cleanliness, infection control and hygiene

- The service had reported only one reported Clostridium difficile infection and no MRSA Bacteraemia cases in the previous year (2014- 2015).
- There were cleaning schedules in place and we observed cleaning taking place throughout the inspection. The maternity and gynaecology services we visited were visibly clean.
- Staff were compliant with the trust's infection control polices and protocols. Staff practiced good hand hygiene, used personal protective equipment appropriately, and were bare below their elbows.
- Every unit within the service had a monthly hand infection control and hand hygiene audit. The results from March and April 2015 showed that the services achieved 100% compliance.

Environment and equipment

- The maternity unit was not secure. There was a swipe access point at the main entrance but there was free access throughout the service without restriction. The exit doors were also not secure. This meant that the service was at risk of a person absconding from the unit or entering the unit without permission. We brought this to the immediate attention of senior managers at the trust. The trust ensured that a review was undertaken of all areas within the maternity unit. A security Guard was positioned on the exit door which led to the car park from the birthing unit whilst electronic access could be assured. When we returned on our unannounced inspection we found that whilst a magnet had been placed on this door we were able to push the door open without releasing the magnet. Following this inspection the trust immediately placed a stronger magnet on the door which was resistant to being pulled apart without being released by the button. The trust has since installed further electronic security in all areas of the maternity unit.
- There was one maternity theatre within the labour ward which was used for emergency procedures. The theatre was small; there was no separate scrub area or preparation area. Within the theatre there were trolleys which contained equipment which would be used for procedures and which were uncovered. Both these issues presented a risk of cross contamination of infection.
- There was an additional room nearby known as 'room 9' which was an old theatre and has not been used since 1988. The old theatre light hangs low in the middle of the room and presented a risk of harm to people who may walk into it. The room is currently used for storage and was on the risk register for the service. We were informed this room was not used for deliveries.
- Blood gas analysers had been replaced and were being monitored. A log was kept of each time the equipment was used and when it did not work. Errors or malfunctions were reported to biomedical engineering on an incident form. As there were a number of blood gas analysers in the department there was no impact to the care of women.
- We reviewed three resuscitaires for babies on the labour ward. We found that they had been checked regularly, were fully stocked and visibly clean.
- **Cardiotocography** equipment (a machine that recorded the **fetal** heartbeat and the uterine contractions), blood pressure machines, blood glucose machines and electronic weighing scales had been tested for electrical safety. There was a record of calibration and servicing for each item.

- **Cardiotocography** equipment was readily available throughout the service.
- We examined the resuscitation equipment in antenatal clinical, maternity foetal assessment unit and labour ward. The trust policy is for checks to be undertaken daily with a full stock audit to be undertaken weekly. The trolley in the antenatal service had been checked daily and weekly in line with trust policy. In labour ward the resuscitation trolley had not been checked for 19 days in June and for seven days up to the 22nd July 2015. On the maternity foetal assessment unit the resuscitation trolley had not been checked for six days up to 22nd July 2015. However the weekly audit had been completed.

Medicines

- Records confirmed that medicines which are known as "controlled drugs" were checked regularly. Medications for resuscitation were checked at the same time as the emergency equipment.
- Medicines were stored securely throughout the directorate. We checked fridge temperatures and were assured that they were being monitored appropriately with the exception of labour ward.
- On the labour ward the daily record of temperature checks on fridges, where medicine and blood products were stored, were not always undertaken. The fridge had not been checked daily for six days in March, three days in May, 10 days in June and five days in July up to our inspection on 22 July 2015.
- The fridge temperatures should be recorded at or below 8°c. The fridge temperatures were recorded above 8°c on 14 days in June and five days in July up to the time of our inspection. The highest temperature recorded was 10.2°c. We found no evidence that these high temperatures had been reported or acted upon.
- We examined eight medicines records. Of these one record was not stored with the notes and could not be located. In two the allergy status had not been recorded. In three history of medicines had not been taken. In one it was recorded that the woman had an allergy to penicillin but was given a penicillin based medicine after having her baby. The woman was wearing a red allergy band for penicillin however the checking process failed to identify the allergy prior to administration. The woman did not have a reaction however we raised this to the midwife. The midwife completed an incident form, informed the midwife in charge and commenced an investigation. This was an appropriate response to take for this incident.

Records

- We examined the records of eight women in maternity and eight women in gynaecology. The records in the majority were well organised, clear, and easy to navigate and written in detail which provided a clear view of the person's care plan.
- The detail recorded in six of the eight gynaecology women's records was excellent. The pathways of care were clear and all discussions with the woman and other professionals were clearly documented.
- The recording and documentation regarding the termination of pregnancy in three notes examined was excellent. The service was easily able to demonstrate how they met the requirements of the Abortion Act 1967 and associated guidelines through the recording of care.
- Risk assessments for **venous thromboembolisation** were not competed in six of the eight cases of women being admitted into the maternity service.
- Records examined showed that full medical histories, including previous pregnancies, were undertaken in seven out of eight records. The final record showed that no previous history had been taken.
- Record keeping champions have been instigated by a Supervisor of Midwives. These had been very well received by all members of the maternity staff. The initiative had been rolled out across the rest of the trust as a result of this positive feedback.

Safeguarding

- Within maternity and gynaecology services 96% of staff had received training in safeguarding adults. 96% of staff had received safeguarding children level 1, 89% safeguarding children level 2 and 77% safeguarding children level 3. The trust's target was 95%.
- There were up-to-date safeguarding policies and procedures in place which incorporated relevant guidance and legislation. Staff demonstrated that they could access these via the intranet. Staff were knowledgeable as to what constituted a safeguarding concern and knew how to raise matters appropriately. We were provided with one example of where staff had appropriately managed a safeguarding incident following the birth of a child.

- We reviewed the minutes of the Princess Alexandra Hospital Safeguarding Children and Adults Quarterly Report for the period of January to March 2015 (Quarter 4). The minutes demonstrated that serious safeguarding cases were discussed at each meeting. There had been an increase in the reporting of safeguarding children concerns with the trust. In quarter 3 the trust had reported 18 concerns compared to 34 concerns in quarter 4.
- A 'Daisy champion' has been introduced in maternity services. Daisy champions support staff with recognising reporting and dealing with cases of domestic violence. Within maternity services 96% of staff have received training in domestic violence awareness as part of the safeguarding adults training session.

Mandatory training

- There was 75% compliance with mandatory training across the maternity and gynaecology service against the trust's target of 95%. Mandatory training subjects included safeguarding adults and children, moving and handling, infection control, health and safety and information governance.
- Areas where the service was not meeting the trusts target for attendance included infection control (69%), equality and diversity (25%) and information governance (63%).
- Maternity staff received additional mandatory training which included obstetric emergencies, domestic abuse, breastfeeding and **cardiotocography** training. This was delivered annually. Records confirmed that 90% of staff had completed this training in 2014-2015.

Assessing and responding to patient risk

- The trust has a critical care outreach service to enhance the care of acutely ill patients in hospital. The team are available seven days a week 08:00 - 20:00. Staff were aware of the team knew how to contact them.
- Gynaecology patients were placed throughout the hospital on surgical wards. In these wards the National Early Warning Score (NEWS) system had been implemented. We examined the records of three women who were admitted with gynaecology concerns and found patient observations and scores accurately completed.
- In maternity services the Maternal Early Warning Score (MEWS) and Paediatric Early Warning Score (PEWS) system were in place for women and babies. We examined the MEWS of eight women through their records and found that the scores had been correctly calculated in seven cases.
- In one case the score had been poorly completed. A fast heart beat (tachycardia) had not been escalated appropriately.
- The Trust are to pilot the obstetric ALERT (Acute Life Threatening Emergency Response and Treatment) course in the January 2016 to further emergency response training for maternity staff.
- The 'World Health Organisation (WHO) Surgical Checklist, Five Steps to Safer Surgery' was in place in maternity, gynaecology and on the wards where gynaecology women were placed. The four safer surgery checklists we examined were appropriately completed.

Midwifery staffing

- The midwife to birth ratio (1:33) was worse than the nationally recommended workforce figure (1:28). The Royal College of Obstetricians "Safer Childbirth; Minimum Standards for organisation and delivery of care in labour, 2007" standards state that, "The minimum midwife-to-woman ratio is 1:28 for safe level of service to ensure the capacity to achieve one-to-one care in labour". However the trust had plans in place to reduce this to one midwife to every 29 births. The midwife to birth ratio had not impacted on the delivery of 1:1 care during labour, for the months of June and up to 22nd July the service had achieved 100% of deliveries with 1:1 care.
- The midwife to birth ratio is assessed monthly and reported to the board. The trust uses a nationally recognised matrix for assessing the ratio based on the numbers of births expected in the unit, as well as the number of multiple or high risk births expected.
- There were 14 whole time equivalent midwife vacancies at the time of the inspection. The highest vacancies were for community midwives. The trust had recruited to the majority of the vacant positions with a plan to continue recruitment to maintain a stable establishment level.
- he trust had recruited four midwives for the European Union and were phasing them into the midwifery numbers. The trust planned to phase the start dates of the 11 newly qualified midwives to ensure the staff were

trained, supervised and supported to undertake their roles. However the skill mix with a large number of newly qualified or new staff coming into the unit was variable with some shifts having less skilled staff.

- The ratio of midwives to Supervisor of Midwives (SoMs) was 1:17 which was higher than the recommended guideline of 1:15. This meant that there was adequate provision of supervision for midwives within the unit.
- Within the antenatal service there is 1.8 whole time equivalent midwives working within the service which is the correct whole time equivalent which covers the 0.6 whole time equivalent midwife who is on maternity leave.
- A morning multidisciplinary meeting occurred at 8:30 each day on Labour Ward. Participants at this meeting discussed the previous day's events, incidents, learning and any potential risks for the day ahead.
- We observed three midwife handovers during the course of the inspection. These were led by the coordinator and were detailed and comprehensive about all women on the unit.
- Where agency staff were used to cover vacant shifts these staff were provided with a comprehensive induction by the shift coordinator. This was documented and agency staff were assessed as suitable to work on the unit. The majority of agency midwives had undertaken regular work on the unit and were familiar with the environment and procedures.
- There are four staff vacancies within the gynaecology services. The service had recruited to these posts and were waiting for the staff to commence work.
- The staff sickness ratio for Family and Women's Services overall was 3.01% at 31 March 2015, which is below the Trust average (3.47%). Sickness absence rates for Chamberlen ward were 6.16% and Labour ward 5.67% in the same period. There is a sustained downward trend in sickness rates across the Trust.

Medical staffing

- The directorate employed 34 whole time equivalent medical staff and there was a good skill mix on duty at all times.
- The service had 26% of junior medical staff which is higher than the national average of 7%. Registrar rates were 40% against the national average of 50% and middle grades were 6% against the national average of 8%.
- The service was meeting the guideline issued by "The Royal College of Obstetricians: Safer Childbirth; Minimum Standards for organisation and delivery of care in labour, 2007" standards which state that units with between 2500 and 6000 births a year or classed as high risk should provide at least 40 hours a week of consultant presence.
- On average The Princess Alexandra Hospital had 4,200-4,400 deliveries per year and an average of 60 hours of consultant presence was provided per week. However the service flexed medical staffing to meet periods of high activity.
- Between September 2014 and January 2015 the average hours per week had increased to between 100 and 102 hours. The service had not provided less than 44 hours of consultant cover since October 2013. Therefore the trust was exceeding the standard recommended.
- We spoke with the lead consultant about the ratio of junior staff present on the unit. They felt that having higher numbers of junior staff was mitigated by the availability of consultant staff available to provide training and support. The junior doctors we spoke with were very complimentary about the access they had to senior colleagues.
- Consultant medical and anaesthetic cover was available 24 hours a day seven days a week for both maternity and gynaecology services.
- There was an allocated consultant and anaesthetist for elective caesarean sections which took place weekly.
- There were two dedicated consultants who provided gynaecology services each day. They supported the delivery of the early pregnancy unit, termination of pregnancy and the emergency gynaecology unit. The two consultants undertook daily dedicated ward rounds for women admitted to the hospital with gynaecology concerns.
- There was an allocated consultant for termination of pregnancies which took place weekly for both medical and surgical procedures. This was supported by trainees and a senior registrar grade.
- We observed a handover between medical staff which was well-structured and detailed the needs of the women in their care. This meeting was well-attended by all grades of staff.

Major incident awareness, training and child abduction

Maternity and gynaecology

- Maternity and gynaecology services followed the trust's major incident and escalation policy. Major incident information was available for all staff to access on the trust's intranet.
- The trust's policy on child abduction was dated 2007 and was currently under review but had not been approved at the time of our inspection. There had been no training exercises or tests around baby abductions from the units.
- We found that the security of babies on the maternity unit, in particular in the birthing unit, was not safe. New born babies were not security tagged and there was limited CCTV throughout the unit and outside the buildings. There was a risk assessment for the security of babies however it did not identify that the doors for the units were not secure or monitored. As outlined above under Environment and Equipment we raised our concerns about the security of the service to the senior management and trust executive team who immediately reviewed the risk and agreed that additional security arrangements were required.

Are maternity and gynaecology services effective?

Good

The maternity and gynaecology service at the Princess Alexandra Hospital was Good because outcomes for women who use services are consistently better than expected when compared with other similar sized services. The termination of pregnancy process followed all elements of national guidelines and legislation. The service had a clear focus, plans and procedures in place to deliver a natural birthing pathway to all women. Women were encouraged and supported to deliver naturally and commence breast feeding post birth. The breast feeding and natural vaginal delivery rates were the best in the East of England and comparable with the national average for England.

The service had a robust process for auditing, learning from national reports and recommendations as well keeping up to date with current guidelines. Staff working within the service went through regular supervision, appraisal and personal development with the option to progress within their careers. All staff, both medical and midwifery, we spoke with were satisfied with the level of supervision offered for their roles.

Staff worked well within the multidisciplinary team, particularly in the gynaecology service. Teams across the service worked well together and with other teams including community services.

Evidence-based care and treatment

- There was a clear process in place for prioritising audit activity. The directorate had an audit data base which enabled staff to identify the project lead and progress of the audit.
- The service undertook more than 25 local audits annually. Topics included still birth, ante natal records, post-partum health records, antenatal management of reduced fetal movement, management of multiple pregnancies, management of 3rd and 4th degree perineal tears and consent in termination of pregnancy.
- The findings from these audits are shared at wards meetings, daily handovers, governance and audit meetings held within the service. The learning and discussion around audit in this service was outstanding. The evidence of shared learning throughout the service was on notice boards and when speaking with staff.
- The Maternal Newborn and Infant Clinical Outcome Review Programme (MBRRACE) Report for 2014 had been reviewed by the maternity team. Lessons learnt from the review were shared at the trust audit committee, the quarterly women's division meeting and at local governance meetings.
- The East of England Local Supervising Authority annual audit report: Monitoring the Standards of Supervision & Midwifery Practice from April 2014, showed that the service needed to improve on four of the six standards around ensuring visibility and support from the Supervisors of Midwives.
- We checked on the progress with these standards and whilst the service was waiting for review by the Local Supervising Authority they could demonstrate through discussion and action plan improvements on all standards identified.
- All policies and procedures used within gynaecology and maternity were in accordance with the National Institute of Health and Care Excellence guidelines or those from the Royal College of Obstetrics and

Gynaecology. The standards and newly issued guidelines were discussed at monthly audit and governance meetings which were minuted to demonstrate how the service met the minimum national standards.

- We reviewed the minutes of meetings for January to April 2015 and saw evidence of how updates with national guidelines were maintained. These demonstrated how the service linked this to national and local audit programmes.
- After each change in guideline the service undertook a baseline audit to identify what work was needed to improve the service. All audits were presented by the team to the audit meeting for shared learning and action plan monitoring.
- The trust's cardiotocography policy reflected the "The National Institute of Health and Care Excellence; Intrapartum care 2014" guidelines. Staff were prompted to ensure their practice was in line with the policy, through risk newsletters and team meetings. We found that staff were familiar with this guidance.
- We reviewed the care records of three women on cardiotocography monitors within ante natal care and found that the monitoring was undertaken in line with the trusts policy.
- The maternity service is adhering and closely monitoring The National Institute of Health and Care Excellence standard number 32: Caesarean sections. Caesarean sections were discussed at monthly audit and governance meetings and monitored through the maternity dashboard. The service achieved a rate of 22% for the month of June.
- Of the eight records examined four women were receiving post-natal care. The care received was in accordance with 'The National Institute of Health and Care Excellence quality standard number 37: post-natal care.' Care was monitored through the maternity dashboard.
- We examined the notes of two women receiving antenatal care and specifically looked at the compliance with 'The National Institute of Health and Care Excellence quality standard number 22: Antenatal care.' The service had a clear process for booking women into the antenatal service and checking them at the required phases throughout their pregnancy. In the cases we examined both had been seen in accordance with the standards.
- Within gynaecology staff assessed patients and provided care and treatment in line with recognised guidance, legislation and best practice standards. In gynaecology the termination of pregnancy care was delivered in line with the "Abortion Act 1967" and supporting guidance issued by the Department of Health.
- The process for the undertaking of termination of pregnancy at The Princess Alexandra Hospital was outstanding. All aspects of the required guidelines and legislation were being adhered to. Evidence presented to us included audits, policies and service reviews. The staffs understanding of requirements was excellent.
- We examined the records of three women in the termination of pregnancy service. We found that the care provided met the requirements of the national standards relating to procedure, pre care, consent and support and advice to women. The evidence in the records was exemplary and we were assured that women using this service received care in line with national standards.
- The head of midwifery for the service was involved in the external Kirkup review into women's services at the University Hospitals of Morecambe Bay NHS Foundation Trust. Learning from this review and implementation of actions had commenced to improve the care for women and babies.

Pain relief

- We spoke with 10 women about their pain. They told us that staff assessed their pain regularly, offered them choice of pain relief when required and that these medicines were given in a timely way. When we looked at care records we found that pain scores were being used to assess pin and monitor the effectiveness of any analgesia given.
- Within gynaecology, pain relief was regularly recorded as being discussed with women. This included women admitted through the emergency gynaecology or pregnancy route as well as when having a termination of pregnancy.
- Within the hysteroscopy service pain relief was administered alongside a general anaesthetic. However there were plans to move to offer women the choice of local anaesthetic with pain relief.
- Gynaecology patients were provided with pain relief and provided with guidance on pain management on discharge.

- Staff confirmed that anaesthetists responded promptly to staff requests for specialist pain relief, such as epidurals. Specialist anaesthetists trained in obstetric care were available 24 hours each day.
- We observed birthing plans in maternity care records. These included discussion about analgesia in labour.
- Entonox was available to labouring women who required it once assessed. Entonox is a pain relieving gas which can be used in labouring women.

Nutrition and hydration

- Antenatal records confirmed that staff discussed infant feeding choices with women prior to birth and after. There was an infant feeding midwife who worked full time to support women when making these choices.
- Midwives reported that they were very proud of the rates of women who commence breastfeeding after delivery. In June 2015 the breast feeding rate was 65% and for the year April 2014 to March 2015 the breast feeding rate was 77% which was higher than the England average of 66%.
- We checked the refrigerators for the storage of expressed milk and found that this was stored, labelled appropriately and was in date.
- The post-natal areas of the labour suite and birthing unit provided group sessions for mothers on breastfeeding with the midwives. We observed one of these groups taking place during our unannounced inspection which was full with mothers and partners attending.

Patient outcomes

- There were no outliers relating to maternity and gynaecology care. An outlier is an indication of care or outcomes that are statistically higher or lower than would be expected. They can provide a useful indicator of concerns regarding the care that people receive.
- The directorate participated in national clinical audits included multiple pregnancy, domestic violence and individualised post-natal care plan audits. The trust scored the same or better than the England average on all audits viewed.
- National Neonatal Audit Programme (2013) shows the trust performed better than the England average on four out of five measures. The measure they performed slightly worse than the England average on seeing a senior member of the neonatal team within 24 hours of admission for which the trust achieved 96% against the standard of 100% for 312 cases.
- Audit results for antenatal care demonstrated that 96% of women are seen within the required timeframes of this standard. Those that didn't were identified as out of area patients from Hertfordshire. Staff informed us it is more challenging to implement the process for appointments through their primary care services.
- The audits of the outcomes of patients who had undergone a termination of pregnancy showed that 90% had a positive outcome.
- The trust audit on consent for termination of pregnancy in 2014 showed 100% compliance with national standards and legislation.
- In June 2015 the maternity service had 366 deliveries, 72 of which were on the midwifery led birthing unit. The caesarean section rate was 23% and that all twin deliveries were delivered naturally.
- The following information represents the proportion of delivery methods from January 2014 to December 2014: elective caesarean section (11.1%); emergency caesarean section (15.4%); normal vaginal delivery (63.5%); low forceps (0.3%); other forceps (1.8%); ventouse (3.4%).
- The trusts total caesarean section (CS) rate for the past year was slightly above the England average of 26% with a rate of 26.5%. The trust had a higher than England average for standard vaginal delivery and strove to increase natural deliveries.
- From July 2014 to September 2015 the service had 637 deliveries for women who had planned to have a vaginal birth after having a caesarean during a previous birth (VBAC). The conversion rate for women planning to have a vaginal birth after caesarean (VBAC) for the 637 deliveries was 40% had a natural vaginal delivery.
- Between January 2014 and December 2014 there were 12 still births. Each birth was reviewed as part of the annual audit on still births. All identified clear reasons for the still birth and lessons to be learned. The processes for the review of still births and post-delivery bereavement were clear and robust.
- Of the eleven quality indicators set by the Royal College of Obstetrics and Gynaecologists The Princess Alexandra Hospital was performing in line with or better than the England average on 10 of the 11 indicators. The service performed better than the England average with 15%

emergency caesarean section rates (England average 17%), 11% Elective caesarean rate (England average 12%), 9% instrumental deliveries (England average 24%), 1% third and fourth degree tears (England average 7%) and 0.6% of emergency maternal readmissions within 30 days of delivery (England average 0.8%).

- The service performed worse than expected on the percentage of deliveries by forceps or ventouse delivery with 54% against the England average of 49%.
- From April 14 to March 15, there were 4233 deliveries. Of these 57 (1.3%) of these cases had a post partum haemorrhage (PPH) of more than 2000mls, 7 of which required a blood transfusion. The 57 did not trigger a trend over the year which was monitored through the department's maternity dashboard and through the incident reporting system.
- The service currently does not complete an audit for sepsis within maternity and gynaecology services.
- In 2014, there were 3 recorded cases of sepsis one antenatal case, one postnatal case and one gynaecology surgery case. All three cases were presented at the maternity and gynaecology mortality and morbidity meeting for learning.
- The service predicts approximately 1125 deliveries per quarter to maintain the establishment at a safe level. In the quarter from January to March the service had 1026 which means that capacity issues could affect the delivery of the service in the near future.
- Between April 2014 - March 2015 there were eight admissions of mothers to intensive care. All eight cases were audited and reviewed and identified natural reasons for the admission in six of those cases.
- Between April 2014 - March 2015 there were 197 unexpected admissions to the neonatal intensive care unit.

Competent staff

- Records confirmed that 100% of staff currently working in the service had completed an appraisal within the past 12 months. Of those that were not on the list and had not had an appraisal it was for reasons such as long term sickness or maternity leave.
- The annual Supervisors of Midwives (SoM) report for 2013-2014 showed that the ratio for SoMs to midwives was 1:17 compared with the recommended 1:15 making the trust not compliant with national expectations. However all staff we spoke with felt they could readily access a SoM if required 24 hours a day.
- Staff told us that they were supported to gain additional qualifications and to maintain their professional development.
- Whilst the trust did not have a dedicated gynaecology ward the gynaecology service has provided dedicated gynaecology training to the staff nurses on the female surgical ward Penn. This ensured that staff were able to meet the needs of women with a gynaecological condition.
- We spoke with newly qualified and student midwives who told us they had undergone a local induction including the completion of a competency framework and that they were allocated a mentor and SoM during this period. They told us that they felt well supported. The student midwives had no concerns about their training or supervision.
- The Supervisors of Midwives (SoMs) had improved the visibility of supervision within the unit for students and midwives. A board was displayed in the main area of each unit with photos of the SoMs and information about how supervision can provide help and support.
- The midwives had commenced monitoring and supporting midwives to go through revalidation with the Nursing and Midwifery Council (NMC).
- All medical staff within maternity and gynaecology were appraised and had undertaken revalidation with the General Medical Council (GMC).

Multidisciplinary working

- We observed that staff across all disciplines worked effectively together, both internally and in the community. There were detailed multidisciplinary (MDT) team meetings which ensured effective care and treatment plans and handover of patient care.
- Care and treatment plans were documented and communicated to relevant health care professionals, such as GPs and health visitors, to ensure continuity of care.
- We spoke with staff from other directorates and found that directorates worked well together and that support from maternity was good. Staff from children's services all participated in the monthly perinatal mortality meetings and communicated with one another regularly.
- The gynaecology service work exceptionally well with the rest of the hospital and had established links with all

surgical wards, the emergency department and paediatric services. This was supported with the gynaecology team attending ward rounds for their patients.

Seven-day services

- The midwife led birthing unit was open seven days per week and was co-located to the main maternity service.
- Medical staff were on call 24 hours per day. However through examination of the rotas we found that on Saturdays and Sunday the consultants were in the hospital delivering the service and providing support to staff during the weekend. Staff we spoke to said the consultants were usually in at weekends.
- There was an obstetric trained anaesthetist available on site seven days per week and on call out of hours at all times.
- Hospital antenatal services were available Monday through to Friday and available seven days a week by the community midwifery team. The early pregnancy assessment unit is open five days a week Monday to Friday but the service is looking to further increase its hours to offer a seven day week service. It was anticipated that this would be in place by October 2015.
- There was a supervisor of midwives (SOM) available 24 hours a day, seven days a week through an on-call rota system. This ensured that midwives had access to a SOM at all times.

Access to information

- Staff had access to computer systems including test results, diagnostics and records systems.
- IT access included access to policies and procedures for internal staff.
- Records were readily available to staff to refer to during the time of a woman's admission.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Consent to care and treatment was obtained in line with national legislation and guidance, including the Mental Capacity Act.
- Training on consent, the Mental Capacity Act, Deprivation of Liberty Safeguards (DOLs) and learning disability was part of mandatory training for all staff.
- The trust had policies in place regarding these subjects and they were accessible to staff via the intranet.
- There was a lead nurse for safeguarding and a lead midwife to support vulnerable women and staff who cared for these women.
- Within gynaecology we examined seven consent forms for women who were schedule to undergo either surgical or medical termination of pregnancy. This process occurred over two appointments and allowed the women to make an informed decision by allowing them time to think about their options.
- Of the seven consent forms examined all had followed the trust's policy on decision making, all were signed by the consultant and all were signed by the women. The women then had a further discussion with the doctor prior to proceeding with the procedure.

Are maternity and gynaecology services caring?

Outstanding ☆

The maternity and gynaecology service provided outstanding care to women who used the service. Feedback from people who use the service, those who are close to them and stakeholders was all positive about the way staff treat women. Women think that staff go the extra mile and the care they receive exceeds their expectations. In the one example of care not being good this related predominantly to emotional support and care provided staff in the surgical service.

The maternity survey results were in line with the England average on all areas and the Friends and Family Test was consistently above the England average for scores in all aspects of antenatal, birth and postnatal care. The service consistently receives more compliments than it does complaints.

We observed several times throughout the inspection that the staff providing both maternity and gynaecology care were dedicated, compassionate, caring and they consistently went beyond the call of duty to deliver the best experience possible for them. Women, their partners and families were active partners in their care and were encouraged through education and support to plan and prepare for their pregnancy, birth and their post birth experience. The services provided outstanding bereavement support to women who experience miscarriages and the loss of babies post birth. The

processes for emotional support to women who terminate pregnancies was also outstanding because staff had carefully considered the experience of women for their pathway of care to place them at ease.

Compassionate care

- The maternity service Friends and Family test was based on a response rate of 37.7% in July which was higher than the England average of 22.4%.
- The scores demonstrated that the service was consistently performing better than the England average with 100% scored on Antenatal care, 98% on post-natal care, 100% on postnatal care in the community and 98% on birth experience.
- The CQC maternity survey results published December 2013 showed that the trust performed about the same on all questions when compared to other trusts in England.
- We spoke with 10 women during the course of the inspection. All were highly complementary about the care that they had received in the maternity service, throughout their antenatal care, birth and post-natal care. Many said that they had been recommended to this service and that the service was their preferred choice to attend this service.
- We received one concern which related to a lack of empathy post birth when a mother was admitted to a surgical ward. The concern was around the care provided in the surgical ward and the limited support available from the maternity service.
- To deliver a kind compassionate gynaecology service the gynaecology team undertook a dedicated training of surgical nurses on Penn ward and because of the Penn ward is the preferred option for the gynaecological women. The training covers to holistic and emotional needs of women with gynaecological concerns and those who have miscarried.

Understanding and involvement of patients and those close to them

- Women were able to be actively involved in the development and preparation of their birth plans and were encouraged and educated to explore all their options for the birth plan. This included tours of the units and discussions with the teams in the community, labour ward and in the midwife led birth unit.
- The maternity nurses were also available to talk through the options available for feeding plans for the babies once they had been born.
- The maternity service put classes on throughout the service to cover ante natal birthing and post-natal classes including breast feeding classes and what to expect in the first eight weeks after the mother goes home.
- Within gynaecology the service provided women with the opportunity to meet the staff and discuss their case prior to making decisions regarding a course of treatment or termination. The women were then invited back in to further discuss and ask questions before agreeing a way forward which meant that it was clear what the patient wanted.

Emotional support

- During the inspection we observed that whilst the ward manager for ante natal services was working in their office there was a baby in a cot in the office with them. This baby was one of twins with the other twin being on the Neonatal Intensive Care Unit. Due to a medical emergency the family were placed in a very difficult situation and to help the ward manager cared for one twin whilst the arrangements were made to support the family. The staff also made arrangements to help and support the family to meet their needs. They arranged for food, counselling support, holistic support, sleeping arrangements to be close by and ensured the family got the rest they needed. This was an example of how staff regularly and through every day work went above and beyond the call of duty to help families.
- In another case we observed a mother was very emotional following the delivery of their baby who due to a complication needed to go to intensive care. The staff reorganised their workload recognising the women's need and ensured that they had one to one support until they were emotionally ready to visit their child in intensive care. The staff went to the intensive care unit with the mother, stayed and helped to answer questions with the Neonatal Intensive Care staff. The mother told us that the staff had helped her through the most difficult day of their life as they did not have anyone else.
- We observed many examples of kind, caring compassionate interactions by the midwives who were truly passionate and dedicated to delivering the care the women need before during and after their birth.

Maternity and gynaecology

- The services within maternity and gynaecology had dedicated staff who could provide emotional and counselling support to women who go through terminations, miscarriages or loss of a baby before or after birth. The service provision available to support the emotional wellbeing of women was very impressive with many of these midwives providing this service on top of their regular midwifery role.
- Within gynaecology and the termination of pregnancy service staff had thought and considered all aspects of emotional care and support that would be required to women who lost a baby. The staff showed us the pathways they set up to support women's emotional wellbeing which was outstanding.
- After any termination procedure either through the women's choice or for medical reasons the women is invited in to have an appointment with the consultant who provided their care to discuss any questions that they may have. We were told by one consultant that they hold the sessions to give the woman the opportunity to speak freely as it can help them in the long term. The medical staff felt that this was a rewarding part of their role.
- The same service is provided to any woman who loses a baby at any gestational stage. There was a clear focus to holistically provide emotional support to women to understand what happened to them.

Are maternity and gynaecology services responsive?

Good

The maternity and gynaecology service was responsive to the needs of women because it had actively planned how to manage the fluctuating and increasing demand on service capacity. The service had developed the gynaecology provision into a stand-alone service working within the women's directorate. This had a significant benefit to the care and pathway experienced by women using this service.

The services were delivered working in partnership with commission teams and community services within Essex and across the borders. Access to the service was through a simple route which enabled women to be seen by the medical teams soon after arrival. The waiting times for emergency and elective gynaecology were good and meant that patient's pathways were generally delivered within 18 weeks.

The service has a robust process for recognising investigating and learning from complaints. The service monitors its complaints and offers a personalised approach to investigating women's concerns to find a suitable resolution. The service consistently receives more compliments than complaints.

Service planning and delivery to meet the needs of local people

- The service was working with local health groups and commissioners regarding the delivery of the service. The service had calculated a limit of having 1125 births per quarter as a maximum it could provide care for. In the quarter ending in June 2015 had 1026 births so it is reaching the upper limits for capacity.
- The trust had worked with Saferplaces following the death of a Harlow resident to ensure that the trust was able to provide opportunities for women to disclose domestic abuse in health care settings. The Daisy project saw increasing numbers of women reporting domestic abuse within the emergency and maternity services. This service was designed and delivered to meet the needs of local people within the Harlow area.

Access and flow

- The maternity service has 9 labour rooms, 15 antenatal beds and 22 postnatal beds. There are 3 midwifery led birthing rooms with a further 12 postnatal beds. At the time of our inspection the six beds for the post-natal women in the birthing unit were not able to be used by women who had delivered their babies as the area was allocated to female medical outliers. However following our concerns this practice was stopped.
- We observed during the unannounced inspection that this bay was filled with post-natal women who were receiving support with breastfeeding prior to discharge. We were told by three staff that this had significantly improved the delivery of care to women.
- To alleviate the pressure on the theatre in the labour ward elective caesarean were undertaken in the day surgery unit or main theatres on designated elective lists. The maternity and gynaecology service has four dedicated days to undertake all elective procedures.

Day surgery is situated near to maternity and neonatal services which meant that services were closely situated and staff believed that this had improved patient experience.

- There is a separate emergency theatre allocated for emergency obstetric provision with a separate obstetric consultant anaesthetist and operating department practitioner allocated to ensure staff were available should an emergency occur.
- Both services had access to intensive care facilities should a woman's' condition deteriorate.
- Women knew to call the maternity unit to announce that they would be attending for delivery. This system ensured that the midwives were prepared for their arrival.
- We reviewed the audit data held locally which showed for the months of April, May and June 2015 100% of women who arrived within 30 minutes were seen by a midwife. 100% of women saw a doctor within 60 minutes 86% of these women saw a consultant. These results were very positive and increased the experience of women using the maternity service.
- Bed occupancy for the service was much higher than the England average since 2013 at 73% for quarter two in 2014/15 as opposed to 60%. The data for quarter one of 2015/16 showed a bed occupancy rate of 82% which is much higher than the England average of 65% for this quarter.
- Since April 2014 the Referral to Treatment Time (RTT) for both admitted and non-admitted gynaecological patients had been around 96% with the lowest percentage being 89% and the highest being 98%. RTTs mean that patients have the right to start their NHS consultant-led treatment within a maximum of 18 weeks from referral and the England benchmark to for each trust to achieve is 92%.
- The trust did not submit data for two quarters to the national reporting system. However data was available locally. The data had not been submitted due to IT system issues with the trusts IT system 'Cosmic.' The staff felt that without thorough validation the data may not be accurate so they chose not to submit the data.
- There was no dedicated gynaecology ward for this hospital. Penn ward is meant to have six beds ring fenced for the provision of gynaecology. However due to capacity demands in the hospital patients were admitted to any available beds. At the time of the inspection there were six patients with gynaecology conditions admitted into the hospital, of those six none were on Penn ward. We attended the bed meeting and found that there was no discussion, plans or arrangements to prioritise the movement of these women to Penn ward to receive the care they required.
- When we returned for the unannounced inspection the service had revised the pathway for gynaecology patients to ensure that they were prioritised and moved to Penn ward when a bed became available. Of the five gynaecology patients in the hospital that day all were inpatients on Penn ward. The service was reviewing further bed options on Tye Green ward to meet the needs of women.

Meeting people's individual needs

- The service was able to offer a range of birthing options to meet the needs of women. Home births were available and the service undertook 72 between April 2014 and March 2015.
- Water births were available and between April 2014 and March 2015. The service delivered 365 babies in this manner.
- The maternity medical and midwifery staff offered a range of specialist obstetric led clinics for women. This included all aspects of high risk maternity care.
- Women were further supported by specialist midwives such as safeguarding teenage pregnancy and a diabetes specialist midwife.
- The trust had 24 hour access to a translation service. Further support services were available for those who were visually impaired, blind or deaf. Staff were aware of how to access these services if needed.
- The service had a range of literature available for women to read in the maternity or gynaecology waiting areas and for them to take home to read as well. Information which provided links to websites and groups outside of the trust were also made available.
- There was information readily available through leaflets, posters and information boards in gynaecology services to support the women to understanding their concerns and their conditions.
- There were leaflets and pathway documents for reading as well as books available to women in all stages of pregnancy to support the understanding of women through pregnancy.

- Within the maternity unit there is a dedicated bereavement suite which met their needs and offered further privacy. The room was big enough that it allowed the partner or member of the family to stay with the woman should she choose.
- The termination of pregnancy service is medically offered up to ten weeks and then surgically up to 14 weeks. Terminations post 14 weeks were outsourced to a private healthcare service in the area. The service was reviewing the termination service at the hospital to reduce the number of women who had to use the private service. No plans had been agreed or formally discussed at the time of the inspection.
- The gynaecology service was made up of a team of dedicated gynaecology doctors and nurses with experience of working this this area. This has had a significant impact on the development and growth of the gynaecology service which was outstanding.
- The waiting rooms for the emergency gynaecology, emergency pregnancy and termination service were in the same area. However the service demonstrated to us the process that staff go through to check women into the service. This involves an assessment of emotional wellbeing. This meant that they account for the women's emotional state and anyone identified as being 'at risk' or concerned by this arrangement would be taken to another waiting area. This was very responsive to their needs.
- We reviewed the processes for the ethical disposal of products of conception as part of this inspection. An audit undertaken of this process demonstrated that in 100% of cases the service had agreed with the women what they would choose as a process for their product of conception.
- Options of cremation and burial were offered as options and where a woman chose not to be involved in the decision the trust chose cremation of remains as the preferred route.
- The service had been inspected by the Human Tissue Authority on the management of remains and products of conception. It has been identified that up to 2014 the service was not disposing of products of conception in line with national guidelines, however they service has complied with requirements during 2015.

Learning from complaints and concerns

- Between April 2014 and March 2015 the service received 20 complaints and 57 compliments. Each complaint was investigated locally between the midwife and a doctor where appropriate.
- For each complaint the person was invited in to discuss their concerns in detail and to try and find a resolution to the concerns being raised.
- We reviewed five complaint responses sent to the women who complained and each one had a clear and detailed investigation. The complainant was offered an apology, where appropriate, and answers to their questions provided.
- There were no open Parliamentary Health Service Ombudsman (PHSO) complaints at the time of our inspection.
- Lessons learned from complaints were shared at the daily risk meetings, monthly governance and audit meetings and at local team meetings and supervision meetings. We saw minutes of a selection of these meetings which assured us that learning complaints was a regular item of discussion for the service.

Are maternity and gynaecology services well-led?

Good

The maternity and gynaecology service leadership locally was good. The medical midwifery and operational leadership team were respected and staff spoke highly of the clinical leads for the service and how involved and approachable they were which created an open culture. It was evident that staff worked well together.

Governance and risk management systems within maternity and gynaecology services were robust and well established which provided a level of assurance to the trust on the provision of maternity and gynaecology. However the risk register was congested with many risks which are historic and mostly resolved still on the risk register for reference. The process for the adding and removing of risks from the risk register required review.

The service worked well with engaging with the women who live within the catchment area and link up with the

local and mother and baby groups to seek feedback on services provided by the hospital. The service was continually looking to improve the engagement experience of women who use the service.

There was a vision and strategy for the trust which was displayed throughout the hospital during our inspection. Though when we spoke with staff throughout maternity and gynaecology they were not aware of the trusts vision or strategy but they were all aware of the values that the trust adhered to. Work was required to assure the future of the service because there was no clear strategy for service delivery.

Vision and strategy for this service

- There was a vision and strategy for the trust which was displayed throughout the hospital during our inspection.
- We spoke with staff throughout maternity and gynaecology they were not aware of the trusts vision or strategy but they were all aware of the values that the trust adhered to.
- Locally the vision for the service was to move to a new hospital premises; a new premises just for maternity services or expand the current service. This was due to the facilities becoming too small to cope with the increased demand. The service was seeing a yearly increase in births which, whilst currently under the safe birthing limit, would exceed the safe birthing limit based on the predicted number of births within two years.
- There were no confirmed plans agreed, established or approved to arrange the move of the maternity service or expand the current facilities to meet the demands of the service in the future. This meant that the future strategy for the delivery of this service was unclear.

Governance, risk management and quality measurement

- The service undertook risk assessments for the care requirements of mothers as well as the functions of gynaecology. However the premises and facilities risk assessments were not up to date. The security risk assessment had not highlighted the concerns relating to the lack of security throughout the maternity service, in particular on the birthing unit, where it is possible that a person could abscond with a baby.
- The policies and procedures which related to The National Institute of Health and Care Excellence or Royal College guidelines were regularly updated.
- The service had a risk register and the one we viewed, dated April 2015, and contained 16 risks of which 12 risks were added in or before 2013 with the oldest risks dated back to 2011.
- The 2011 maternity specific risk was related to having only one maternity theatre which had been resolved but remained on the risk register. The trust had an escalation policy to mitigate this risk however it remained on the risk register.
- When we spoke with the leadership team regarding the risk register we were informed that further work was needed to review and identify what the current risks were for the service in the immediate and long term future. For example the higher rates of deliveries and lack of facilities to sustain the service was not included on the risk register despite business cases being submitted over the last two years to increase capacity and/or replace facilities.
- The established risk register in place demonstrated that the service, whilst aware of some risks had not highlighted the importance of other risks which required greater priority.
- The service holds monthly governance and audit meeting where incidents, serious incidents, the maternity dashboards, complaints and audit presentations are discussed. We reviewed the last six meeting minutes for these meetings which evidenced that the meetings were well attended and key agenda items discussed.
- We examined the reports submitted by the trust to the Department of Health on termination of pregnancies. All trusts are required when they undertake a termination to submit a form to the Department of Health, known as a HSA4 notification form. The report we examined demonstrated that the service routinely reported all required terminations to the Department of Health in accordance with the Abortion Act 1967.

Leadership of service

- The clinical lead, operational lead and head of midwifery were very respected amongst their teams and worked well together. Staff working within the units recognised who the leads for the service and clinical leads for specialties were.

- There was a level of matron management within the maternity service however when we asked staff within each area about the leadership team, to name them and how did they feel that they engaged with the service. Only the matrons for gynaecology, fetal assessment and the community matron were recognised as being leaders within the service. It was felt that the other matrons were not visible enough in supporting the teams to deliver the service.
- The leadership throughout the services at ward manager and coordinator level worked well together and it was evident that the leads communicated with each other and worked well together to deliver a good service to women.
- The executive team made a decision to change a postnatal bay in the midwife led birthing unit into a medical outlier bay for female medical patients. This was raised consistently as a concern to us by midwifes who felt that it was inappropriate for the service and unfair not only to the women in labour but also to those admitted medically.
- We established through reviewing minutes of meetings and communication that this decision was taken by the executive team. Whilst they believed it was the best thing to give the women a bed, those women were in some cases upset by being placed there and it caused them distress. The Executive team did not listen to the voices of the midwives or the patients who were being placed there inappropriately and this did not demonstrate good leadership.

Culture within the service

- There was a very open culture within the service and staff were very willing to speak freely about what worked well in their service and about what did not work well. There was a culture of willingness to listen to staff concerns within the directorate.
- We were provided with an example of where a staff member raised concerns about patient safety to the senior management of the maternity service and the senior management of the trust and this was acted upon swiftly. This related to the safety and care of patients and the evidence provided to us on action taken demonstrated that all levels of management acted appropriately in dealing with the concerns raised. The staff member was supported and praised for speaking openly and raising concerns when needed.
- There was a whistleblowing policy for the trust. The trust board has recognised that it is still in the process of building trust with the staff to enable them to speak openly. This encouraged anonymous reporting of concerns.

Public engagement

- The service worked with the local mother and baby groups to establish post birth support streams for women who use the service. The trust also utilised these groups to seek feedback about their experiences and how the services can be improved.
- Women, their partners, their families and carers were encouraged to engage with the service. There were posters displaying how to do this and suggestion boxes were observed throughout the units. People were also encouraged to complete the Friends and Family Test with points to do this displayed throughout the service. The Friends and Family test results for the service showed that on average the trust received on average 100 to 150 responses each month and the results, in the majority, were very positive about the service provided.

Staff engagement

- Staff were encouraged to contribute to the service by getting engaged in projects and learning opportunities which would benefit the service and their development long term. One example was using a range of people with different skills and backgrounds to partake in audits.
- Staff were encouraged to attend the morning risk meetings, monthly governance, audit and team meetings as well where information would be shared. Staff were also sent a maternity newsletter with up to date information to engage them in what was going on within the service.

Innovation, improvement and sustainability

- The set up and establishment of the standalone gynaecology service was innovative and completely responsive to the needs of women. The ongoing development and implementation of this service trust wide will ensure the sustainability and growth of gynaecology.
- The flexible and innovative way of managing the number of deliveries undertaken each year in such a small facility was outstanding. However to sustain the

future of the service not only is a long term plan required for the future but this should link to a short term intermediate plan to ensure that the service can be sustained over the next two years safely.

Services for children and young people

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

Information about the service

The service for children and young people was provided throughout the hospital but predominantly in the Children's ward named Dolphin, which had 20 beds. Sixteen of those beds were inpatient beds and four were ambulatory care beds, which were closed overnight.

Services for neonates were provided in the Neonatal Intensive Care Unit (NICU), which had 16 cots for new-born babies with complex conditions. The Princess Alexandra Hospital provided a level two NICU service and referred all level three cases to hospitals in Cambridge or London for more advanced treatment.

There were 1,761 inpatient child cases seen at the Princess Alexandra hospital between January and December 2014.

During the inspection, we spoke with two children and three relatives. We also spoke with four doctors, 12 nurses and support staff. We examined the records of four children in the Dolphin ward and the records of three babies in the NICU.

Note: The children's emergency service is covered in the urgent and emergency services report and the children's outpatient's service is covered by the outpatients and diagnostic imaging report.

Summary of findings

Services for children and younger people required improvement overall but the services were responsive. We rated the service as good for being caring to children and babies.

The Dolphin ward safeguarding children's procedures were not as robust or as embedded as they could be. Items of out of date breast milk were stored in the fridge and single-use items were not being immediately disposed of and could have been reused on patients. There were notable staffing shortages for registered staff in the Neonatal Intensive Care Unit (NICU) and on the Dolphin children's ward. There was a child abduction policy but it was out of date, there had been no tests on child abduction and the door to the NICU was not secure.

There was a lack of transitional arrangements for moving a child from children's care into young adult then into adult care, which meant the pathways for care, specifically on conditions such as epilepsy and asthma, were not clear. There were gaps in management and support arrangements for staff, such as appraisal, supervision and professional development in the Dolphin children's ward. Outcomes for children who use services were in line with expected ranges nationally, with the exception of diabetes care, which required improvement.

Care within the children's service and NICU was good. Feedback from all family members and children we

Services for children and young people

spoke with was positive about how the care was provided and the parents believed that staff could not do enough for their children. Children and their families were active partners in their care. We observed how families were actively engaged and encouraged to participate in the planning of care for the child.

The service was not responsive in meeting the needs of children's through outpatient services because there were delays in receiving an appointment in a timely way. The service was achieving 38.4% of patients being seen within 18 weeks of referral for treatment and there were notable backlogs and delays in ophthalmology services for children. Services were planned and delivered in a way that met the needs of the local population and plans to improve the service to meet the growing demand were being developed. In the children's ward they had indoor and outdoor play areas and for teenagers the 'teenage zone' was an excellent idea to support the needs of younger adults.

The vision for the future of the service had not been developed. The staff within the service were not all aware of the trust's vision or strategy. The arrangements for governance and performance management did not always operate effectively because the risk registers used to monitor performance did not clearly identify what the key risks for the service were. The local leadership teams within the services, which had undergone some changes, were good and demonstrated good leadership to their teams.

Are services for children and young people safe?

Requires improvement

Safety of the children's service required improvement because Dolphin ward safeguarding children's procedures were not as robust or as embedded as they could be. Whilst there was good practice noted regarding the safeguarding of children, procedures required review and quicker escalation of identified safeguarding cases was required. Items of out-of-date breast milk were stored in the fridge and single-use items were not being immediately disposed of and could have been reused on patients.

In the Neonatal Intensive Care Unit (NICU) there was good evidence of record-keeping, medicines management and the management of sepsis in babies. There were notable staffing shortages for registered staff in the NICU and on the Dolphin children's ward. Work was needed to stabilise the staffing base on these wards and reduce staff sickness rates.

There were processes and procedures for the reporting incidents and lessons learned from incidents were evident through newsletters. However, staff on Dolphin ward were not always clear about what incidents had occurred and what lessons had been learnt from them.

There was a child abduction policy but it was out of date, there had been no tests on child abduction and the door to the NICU was not secure. We were not assured that the processes and procedures relating to the security of children were robust.

Incidents

- There have been no Never Events and three serious incidents which required further investigation, which were two concerns about the safeguarding of vulnerable children and one delayed diagnosis. Note: Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented, so any Never Event reported could indicate unsafe care
- The Children's service reported 50 incidents through the online incident reporting system, called Datix, between April and June 2015. The most common reported

incidents were staffing levels not meeting the acuity and dependency of children, issues with the administration and recording of medicines and concerns about safeguarding.
- On review of the incident reports submitted, the action taken in response following investigation was often minimal. For example, an incident of short staffing on Dolphin ward had 'no further action' recorded in the 'action taken' section.
- Staff we spoke with were aware of the requirements of reporting incidents and what constituted an incident and they could clearly explain to us how to report an incident using the online incident reporting system.
- Incident learning was shared through staff information boards, staff newsletters and governance meetings.
- There had been no incident recently that met the requirements of Duty of Candour being required but the manager of each area was fully aware of the requirements of Duty of Candour and when this would be required. Note: The Duty of Candour means that providers of healthcare services must be open and honest with service users and other 'relevant persons' (people acting lawfully on behalf of service users) when things go wrong with care and treatment, giving them reasonable support, truthful information and a written apology.
- The managers of the Neonatal Intensive Care Unit (NICU) and Dolphin ward told us that they speak with the families involved in all incidents where appropriate as standard practice to be open with them.
- The medical and nursing staff in the service attended quarterly mortality and morbidity meetings. The last one was held in April 2015. The minutes of these meetings were shared with staff.

Cleanliness, infection control and hygiene

- Our observations during the inspection showed that the staff were mostly compliant with the trust's uniform policy and adhered to the 'bare below the elbow' requirements. However, we saw two staff nurses wearing rings with jewels, which is not in accordance with the trust policy.
- There were no reported cases of Methicillin-Resistant Staphylococcus Aureus (MRSA) or Clostridium difficile (C. diff) for children's and young people's services in the past 12 months.
- Screening for MRSA was audited for NICU and Dolphin ward in March 2015. The results showed no identified cases and covered all 26 cases audited.
- Testing for Respiratory Syncytial Virus (RSV) no longer takes place in the majority of trusts across England following a change in national guidance. The trust policy regarding this has been updated to reflect the change in practice.
- The trust's hand hygiene audit undertaken in February on both the Neonatal Intensive Care Unit (NICU) and Dolphin ward showed 100% compliance with trust hand hygiene practices.
- There were two side rooms in Dolphin ward that were predominantly used for children who were immunosuppressed. The use of the side rooms allowed them to be isolated from other communicable diseases.
- We examined the cleaning schedules for Dolphin ward and found that there was no record of when shower curtains were cleaned or changed. The shower curtains had no label with date and time indicating when they were cleaned and the staff members and domestic we spoke with could not tell us when the shower curtains were last washed. This presented a risk of infection.

Environment and equipment

- The environment leading up to Dolphin ward was lined with beds, trolleys and cages, which were either broken or not in use. Along the corridor we counted six cots, 24 beds and six cages. This meant that the environment leading up to Dolphin ward was potentially a hazard for children, parents and staff.
- The environment within the NICU area had been refurbished within the last few years and was more a modern environment than Dolphin ward.
- The equipment we examined in the NICU, including the resuscitaires, was serviced, tested, clean and in date.
- The resuscitation equipment in Dolphin ward had been upgraded at the beginning of July 2015 and was more specific and detailed for the children's service. The trolley had been checked in line with trust policy.
- There was a lack of storage space on Dolphin ward, which meant that items of equipment were stored in the main corridor areas and presented a falls risk to children.
- Equipment including monitors, blood gas analysers and TVs had been tested for electrical safety and passed all inspections as safe.

- We examined saturation probes outside one of the bays on Dolphin ward and found that the ends of the saturation probes (which are meant to be disposed of as they are single-use items) were still in place and could have been reused on children, which would have been unsafe. We raised this with the ward manager, who disposed of the items immediately.

Medicines

- Within the children's service there were daily pharmacist visits, which staff felt was beneficial. There was no specialist paediatric pharmacist but there was one pharmacist in the hospital who was knowledgeable about children and supported this provision.
- We examined the records of four children on Dolphin ward and three babies on the Neonatal Intensive Care Unit (NICU), which included the records of medicines administration. Medicines had been administered as prescribed by the medical team.
- There was evidence of a full medical history being taken, allergy status recorded and where appropriate allergy alert bracelets were used.
- On the NICU the records of medicines prescribing and administration was very clear. We examined the prescription charts in the three records examined and found no gaps or discrepancies.
- We examined three prescription charts on Dolphin ward and found that two were fully completed but one had no duration or indication recorded for an antibiotic as required by hospital policy.
- We undertook a check of controlled drugs on the NICU and Dolphin ward and found that controlled drugs were checked and accounted for in accordance with trust policy.
- Within the children's service there was a focus on medicines education, with third year students acting as the third person to check medicines stocks as part of their development.
- In Dolphin ward we checked the fridges where breast milk was stored for children's feeding and found that several items of breast milk were out of date. The trust's policy states that the milk should be disposed of within five days however the items we found were over five days old. We raised this with the ward manager, who disposed of the items immediately. We examined the records that showed the fridges had been checked and the milk had been signed off by staff as in date.

Records

- We examined the records of four children on Dolphin ward and three babies on the NICU.
- The records were well organised and easily accessible. The notes were clear, with writing that was easy to read.
- We examined the risk assessments required in both the NICU and Dolphin ward, including falls in Dolphin ward and skin pressure in the NICU, and found that all had been well completed and were being followed by staff.

Safeguarding

- There was a safeguarding children policy that was updated and displayed on the trust's intranet site. On Dolphin ward the information related to safeguarding children was out of date and required review. We brought this to the attention of the ward manager who told us that they would review the folder and ensure that it was updated.
- Since the introduction of COSMIC, the trust's electronic record system all children, subject to a child protection plan, were flagged.
- The children's service had undergone a change to the named nurse system for safeguarding children. The new named nurse would not commence in their role until September 2015 and this had delayed the improvement regarding awareness of safeguarding children.
- Between October 2014 and March 2015 the service had undertaken 398 children's safeguarding consultations, completed 30 referrals for child protection medical examination and referred 52 children to the children's safeguarding authority.
- In the children's service 73% of staff had received safeguarding children training level three, 78% had received the training to level two and 83% of staff had been trained at level one. Improvement in the provision and attendance of safeguarding children training for paediatric staff was required.
- The service had achieved 98% of staff receiving safeguarding adults training at level one.
- Within outpatient services 100% of nursing and medical staff had received safeguarding training at level 3.
- A child who was admitted to Dolphin ward had an injury that required a safeguarding vulnerable child alert to be raised. The team who identified the issue were slow to

report the incident to the local authority. The parents remained with the child and there were no formal plans in the documentation that demonstrated how safe observation would take place.
- When we returned to the ward later that day the family were in a bay that could be observed by the nursing staff and the appropriate referrals and care plans were in place.
- The consultant lead involved the junior doctors in the case to teach them about the identification of children's safeguarding issues and how to identify potential concerns about children.

Mandatory training

- The trust target for attending mandatory training topics is 95% but the children's service had achieved only 80%.
- Mandatory training was undertaken and includes topics such as infection control, Information governance, Equality and Diversity and moving and handling. Uptake of this training was as follows: infection control 71%, Information governance 78%, Equality and Diversity 71% and moving and handling 78%
- On Dolphin ward 58% of nursing staff have received fire safety training, which was a low level of uptake and required review.
- All nursing and medical staff in outpatients and in the inpatient children's area had received basic life support for paediatrics training.
- Within the inpatient children's ward Dolphin there was only one staff member that had received advanced paediatric life support (APLS). There was no provision for Emergency Paediatric Life Support (EPLS) training provided to either nursing or medical staff. We were informed by the management team that this was linked to funding and trainer availability but this training is required when providing care to children.

Assessing and responding to patient risk

- Within the children's service, the teams followed the Paediatric Early Warning Score system (PEWS), which is a type of monitoring system to alert staff to the potential risks that a child's clinical condition might deteriorate and allows for early intervention.
- On Dolphin ward there was a dedicated bay for high dependency children who required additional monitoring. The service did not provide intensive care to children and any child who required intubation, which helps the child to breathe, where appropriate was taken to the theatres recovery area where this was undertaken.
- We examined the records of two children who were scoring on PEWS at the time of our inspection both children were being appropriately monitored by nursing and medical staff and the scores had been calculated correctly.
- Sepsis bundles for children were used on both Dolphin ward and the Neonatal Intensive Care Unit for when a child was identified as at risk of having sepsis. Note: Using sepsis "bundles" simplifies the complex processes of the care of patients with severe sepsis. A bundle is a selected set of elements of care that when implemented as a group have an effect on outcomes beyond implementing the individual elements alone.
- The trust has arrangements set up for transfers urgently out to other hospitals in the region that can provide intensive care. There is a process and procedure for this and staff could tell to us what the process was.
- Within outpatients clinical reviews are undertaken on all children waiting for an outpatient appointment over 18, 40 and 52 weeks. The review includes identifying delays to pathways, reviewing the clinical risks and the need to escalate the patients' appointment and bring it forward, identifying if any child has come to any harm because of the delay.
- The review of all patients who have had to wait over 18, 40 and 52 weeks over the last 12 months has not identified that any patient has come to harm due to delayed appointments.

Nursing staffing

- The children's service was short of 20.28 Whole-Time Equivalent (WTE) registered nurses and 4.0 WTE support staff. The main vacancies were in the NICU, with 10.38 WTE nurse vacancies noted. The vacancies on Dolphin ward, with the exception of two posts, had been filled.
- Where there were gaps or vacancies on the rota, shifts were filled with bank or agency staff. The risks with agency staff is that it is likely the nurses may not be trained children's nurses.
- We examined staff rota, which showed that of the vacancies 3.18 WTE was covered by internal staff bank nurses and 1.24 WTE was covered by agency nurses.
- The skill mix of the paediatric area was the primary challenge due to the inexperience of new staff and also

the unknown experience of some agency staff. The lack of registered children's nurses at times can place the service at risk of a depleted skill mix, which is a recognised risk for the trust.
- All bank and agency staff go through an induction and competency check on the ward. A provisional list of what staff can and cannot do is provided to the nurse in charge.
- There were sufficient numbers of staff recruited to community neonatal services, new-born hearing and screening, and the child death rapid response team.
- The acuity and dependency of patients in the wards was assessed three times a day and staffing numbers can be increased dependent on the number of children and their level of need for care. .The numbers were reported to the operational site management team and director of nursing each day.
- Nursing handovers took place at the beginning of each shift between the nurses in charge. This involved going to each bay and bed to understand the needs of children who will be cared for on that shift.

Medical staffing

- There were 34 Whole-Time Equivalent (WTE) medical staff working in the service, of which ten were consultants.
- There was a smaller percentage of consultants in this service (29%) than the national average (35%).
- The trust has a higher than the England average of registrars (63% compared with 51%) and a higher than the England average of junior doctors 8% compared with 7%).
- This meant that that there were sufficient numbers of staff to provide a safe paediatric service.
- The paediatric consultants were available on site Monday to Friday till 2130 hrs and provide onsite cover on Saturday and Sunday both for the ward round and evening review. During times when a consultant is not on site there is a 24-hour on-call service available.
- We observed a handover take place on Dolphin ward, which was well structured, open and addressed all the issues of the day. The consultant engaged the entire staff group of registrars and junior doctors present. The nursing staff were also present and were involved in the handover and ward round.

Major incident awareness and training

- The children's service followed the trust's policy on major incidents, which was available to all staff through the trust's intranet site.
- There was an established business continuity plan for the service. The winter pressures plan was in draft format and going through the trust's validation process.
- The child abduction policy had not been tested and the version reviewed during the inspection was dated 2007. The trust has since informed us that they are reviewing the policy to ensure that it is updated.
- The security of the Neonatal Intensive Care Unit (NICU) meant that people were able to walk through the service and that it was not always secure. That meant that the business continuity and resilience plans for the service were not robust and required improvement.

Are services for children and young people effective?

Requires improvement

The service required improvement in effectiveness because there was a lack of transitional arrangements for moving a child from children's care into young adult care then into adult care, which meant the pathways for care, specifically for conditions such as epilepsy and asthma, were not clear. There were gaps in management and support arrangements for staff, such as appraisal, supervision and professional development in the `children's ward.

Care and treatment mostly reflected current evidence-based guidance, standards and best practice. Outcomes for children who used services were in line with expected ranges nationally, with the exception of diabetes care, which required improvement.

There was participation in relevant national audits but participation in local audits and benchmarking was limited. There had been no local audit activity between January 2014 and April 2015 due to a change in child health audit leads. There had not been any recent audit meetings due to a change in lead so information and learning was not always shared through all available routes.

Staff in the Dolphin children's ward and on the Neonatal Intensive Care Unit were qualified and had the skills they needed to carry out their roles effectively and in line with best practice. The learning needs of staff were identified

and training was provided to meet those learning needs. Nursing staff were supported to maintain and further develop their professional skills and experience in line with recommendations by the Royal College of Nursing.

Consent to care and treatment was obtained in line with legislation and guidance, including the Children Acts 1989 and 2004. Staff had a good understanding of Gillick competence and children were supported to make decisions where appropriate. Where needed, parents were provided with sufficient information to make decisions regarding the best interest of the child in respect of their treatment. The 'Gillick competence' is a test in medical law to decide whether a child of 16 or younger is competent to consent to medical examination or treatment without the need for parental permission or knowledge.

Evidence-based care and treatment

- Care was provided to children and young people in accordance with national guidance, including guidance from the National Institute for Health and Care Excellence (NICE) and the Royal College of Paediatrics and Child Health (RCPCH).
- Appropriate care pathways were in place for children with conditions including diabetes, epilepsy and asthma.
- Policies, procedures and guidelines were available to all staff, including bank, agency and locum staff, through the trust intranet. Staff we spoke to knew how to access the intranet and procedures and they could show us policies online that we asked to see.
- The trust took part in a range of local audit activity since April 2015. There had been only one local audit activity between January 2014 and April 2015 due to a change in child health audit leads.
- We viewed the audit tracker for audits being undertaken in the trust, which showed that the trust was working towards the completion of national audits for 2015 including NICE CG160, 'feverish illness in children: assessment and initial management in children younger than 5 years'; and NICE CG149, 'antibiotics for the prevention and treatment of early-onset neonatal infection'
- There was an ongoing national Ear Nose and Throat audit to explore the differences between a four and six hour stay for tonsil and adenoid patients that was ongoing in the Alexandra Day Surgery Unit at the time of inspection. Staff in the paediatric area were currently collecting data but were unsure of the expected finish date

Pain relief

- We examined the records of four children on Dolphin ward and observed that they used a child-specific pain monitoring score. Pain scores were recorded and monitored by staff during observations and care rounds and pain relief was offered where required.
- We examined the records of three babies on the Neonatal Intensive Care Unit and observed that a neonatal-specific pain monitoring tool was in use and that pain management of infants was appropriately monitored in all three records.
- We spoke with two children and three relatives and no one we spoke with had any concerns about pain relief or the monitoring of pain.

Nutrition and hydration

- On the Neonatal Intensive Care Unit staff regularly weighed the babies and provided assisted nutritional support and feeding to meet the needs of the baby. The neonatal assessment on feeding and malnutrition was undertaken appropriately and accurately in the three records we examined.
- Children on Dolphin ward were offered a choice of foods to meet their needs. The families were able to bring in additional items if approved by staff to encourage the children to eat.
- Weights of children on Dolphin ward were monitored where required. Nutritional monitoring was required in one record we examined and this was undertaken appropriately, with a clear plan of how the service would meet the needs of the child.

Patient outcomes

- The trust took part in all the required national audits for children, including babies admitted to the Neonatal Intensive Care Unit who required cooling, Urinary tract infection management in paediatrics and pathway tracking for type one diabetes in children occurred.
- The trust's rate for emergency readmission within two days of discharge for non-elective procedures for

children aged 1-17 was 1.5 as opposed to the national average of 2.7. There had been no emergency readmissions for elective children between December 2013 and November 2014.

- The Paediatrics Diabetes Audit showed that the Trust's median HbA1c, (mmol/mol) was slightly above the national average 77 as opposed to 69. HbA1C is a measure of the average blood sugar over the last 3 months and is a measure of longer term control of diabetes rather than a spot check of sugar level.
- The Paediatrics Diabetes Audit indicates that the Trust had only 5.4% of children with long term diabetes as measured by their HbA1c being less than7.5%. This is less than a third of the national average for trusts. The services rate of multiple emergency admissions within 12 months for children aged 1-17 with Asthma is slightly lower than the national average at 16.4% as opposed to 17.3%.
- CQC reviews the information provided by trusts to assess if the service has a higher mortality rate for patients with different conditions. These are called outliers if they are outside of the national rates. There are no open CQC outliers that relate to the service for children and younger people.
- The Neonatal intensive and special care (NNAP) audit identified that the trust needed to ensure that children who had been cared for in these environments were followed up after two years of their admission. Since this audit was published the trust is looking to introduce quarterly clinics in order to follow up two year olds who had been treated in NICU.
- The Royal College of Paediatrics and Child Health audit on epilepsy showed that the service was only able to submit 75% of the required cases to the national data set. The service was required to appoint a new consultant to improve the oversight and management of epilepsy, which was achieved with a new consultant starting in post just before our inspection.

Competent staff

- In the Neonatal Intensive Care Unit all staff had received an appraisal, supervision or one-to-one reviews within the last 12 months.
- The development opportunities available through the NICU service were in accordance with the RCN guidelines.
- In the Neonatal Intensive Care Unit staff were offered opportunities to obtain further qualifications. An example of this includes the development opportunities for the nursery nurses to increase their skills or go on to the registered nurse training.
- On Dolphin ward 77% of staff had received an appraisal within the last year. We spoke with the acting manager of the ward and there was a clear programme to ensure that all staff received appraisal. One-to-one meetings for supervision had also been established.
- Throughout the trust there was work commencing through the HR department to review nurses and midwives in line with Nursing and Midwifery Council revalidation requirements.
- Revalidation for all medical staff had been undertaken and completed by the trust.
- Medical staff appraisals within the children's service were at 88%, with valid reasons for delays in undertaking the other appraisals. The dates for those remaining appraisals had been scheduled.

Multidisciplinary working

- The Neonatal Intensive Care Unit service had excellent working relationships with both the maternity service and children's services. The teams were involved in communicating the progress of babies on the unit with the teams who were also involved in the future care of the child.
- The Dolphin children's ward staff were excellent at working with the local team as well as community children's services. Community nurses were invited in to the hospital to join the teams during the ward rounds to provide an integrated approach. We observed a ward round set up in this way, which was well organised and showed how all services worked well together.
- Staff told us that they had good working relationships with all specialties, although on occasion it could be a challenge to get a specialty service to attend to see a child.
- There was a lack of transition between children's and adults services. The service had a policy for the transition of children into adult services but this was currently out of date and due for review.
- The only pathway where there was integration to transition children into young adult and then into adult services was with diabetes care.

Services for children and young people

- Access to psychiatric and psychology services was available through child and adolescent mental health services in the area. We were provided with examples of when these services had been used and staff reported a good working relationship with the local teams.
- The children's service liaised with the health visitor, GPs and school nurse services to ensure that all information relevant to the child was shared appropriately.

Seven-day services

- There were consultant ward rounds seven days a week on the wards, and consultants were available outside normal working hours through on-call arrangements.
- The pharmacy department was open Monday to Friday, with on-call arrangements for weekends and outside normal hours on weekdays.
- Physiotherapy services were available Monday to Friday, with out-of-hours arrangements supported by an on-call system. The trust was planning to increase its provision to provide onsite support seven days a week.

Access to information

- Staff had access to all main computer systems, including test results, diagnostics and records systems.
- Procedures were all available through the intranet and there were sufficient computer points to support staff access.

Consent

- Staff we spoke with were aware of Gillick competence. This is a decision whether a child of 16 or younger is able to consent to his or her own medical treatment without the need for parental permission or knowledge.
- Staff we spoke with could clearly articulate the requirements of Gillick competence and informed us that where possible they would encourage the child to be part of the decision-making process regarding their care.
- Parents, where needed, were always involved in the decision-making processes regarding care and leaflets were available for parents who were making decisions with regards to providing consent to surgery for their child.

Are services for children and young people caring?

Good

Care within the children's service and the Neonatal Intensive Care Unit was good. Feedback from all family members and children we spoke with was positive about how the care was provided and the parents believed that staff could not do enough for their children. The children's survey, undertaken by CQC, also showed that the trust performed about the same as other trusts of a similar size for feedback from children.

We observed good interactions between staff and children during out inspection; it was observed that staff respected the child's dignity and privacy where possible. Staff were observed to engage well with children. We noted that the children appeared to have had a good rapport with the staff.

Children and their families were active partners in their care. We observed how families were actively engaged and encouraged to participate in the planning of care for the child. Children were encouraged, where able, to make decisions regarding their care, which was explained in a language and manner that they would understand. Staff were fully committed to working in partnership with people and making this a reality for each person.

Support from a range of specialist staff including nurse specialists, chaplaincy and counselling services was available, which meant that children and parents' emotional needs were recognised. We observed instances of these staff members providing support to those who needed it.

Compassionate care

- The CQC undertook a children's survey, with the outcomes being published in 2015. We asked children and young people, and their parents and carers, to answer questions about different aspects of their care and treatment.
- We received information on the care of 90 children and young people who received inpatient or day case care during July, August and September 2014. The trust is performing about the same as other trusts in the

majority of the questions asked. The only areas that the trust are performing worse than other trusts are on staff playing with children and new staff introducing themselves.

- Throughout the inspection we observed really good interactions between staff, children and families. We observed on Dolphin ward that one staff member's tone did not come across as friendly but this was one incident amongst many examples of positive interactions.
- Staff on the Neonatal Intensive Care Unit demonstrated outstanding examples of compassionate care to families. Their approach to difficult situations for families and how they were accommodated were outstanding. For example, we observed how they worked with the maternity service and intensive care service to obtain information for a relative to put them at ease whilst visiting their baby during a really difficult time.
- All parents we spoke with during the inspection told us they had been treated with respect and compassion by the staff and praised the staff for the care their child had been given.
- Staff on the Dolphin children's ward stood at the entrance of the bays and asked for permission to approach the child and demonstrated that they treated the child and the family with respect.
- We observed some of the teenagers on the wards interacting with staff and it was evident that they had built up a good relationship with the staff and were able to have a joke and a laugh with them.
- The rate of compliments received by the service demonstrated that children and their families thought that the care was good. The service had received 151 compliments compared to 18 complaints over the last 12 months.
- Children's stories about their experience of care were displayed on the walls of the Dolphin children's ward for other families and children to read, which was positive.

Understanding and involvement of patients and those close to them

- The play specialist in the children's service was outstanding and as an individual they went above and beyond the call of duty to accommodate the needs of children of varying ages. They provided us with examples of accommodating games, DVDs and films to meet the needs of children, as well as organising group activities to try to encourage the children to be more active.
- The play specialist recognised that the service needed more to entertain the children and actively sought to fundraise with other staff from the service to get more toys, books and other items for children or all ages to use during their stay in hospital. This was shown through the range of toys available and also the 'teenager zone', which was built on the secure roof outside the main ward.
- Staff communicated with children and parents to ensure they understood their care and treatment. Parents we spoke with told us they felt well informed and could ask any questions of the staff if they wished to do so.
- We observed nursing and medical staff on Dolphin ward explain procedures and what children were going to have done to them in a way they would understand. The tone used put the child at ease and this made the parents feel good about the care.
- Parents, children and community teams were all involved in children's care and children were encouraged to participate in their care and be a part of the decision- making process regarding care and treatment.

Emotional support

- Staff gave examples of how they were able to break bad news and what support and training they had had to do this. This also enabled them to recognise what support families would need emotionally during difficult times. This included the need to recognise what location or room would be best for breaking bad news, which staff should be there and even what time of the day would be better, depending on the family.
- The chaplaincy team were available to provide pastoral care to children, babies and families.
- There was a range of leaflets available on Dolphin ward, which explained a range of conditions to the children and also to families to provide them with information about their choices, what to expect and where to get further information.
- The service had access to counselling and support services for the children and the families to support their needs.

Services for children and young people

- Clinical nurse specialists for children, including nurses for oncology and learning disabilities, were available to provide support to staff, children and families where required.

Are services for children and young people responsive?

Requires improvement

The children and young people's service was not always responsive to the needs of children. The service was not meeting the needs of children's through outpatient services because there were delays in receiving an appointment in a timely way. The service was achieving 38.4% of patients being seen within 18 weeks of referral for treatment and there were notable backlogs and delays in ophthalmology services for children.

Inpatient services were planned and delivered in a way that met the needs of the local population and plans to improve the service to meet the growing demand were being developed. Care and treatment was coordinated with other services and other providers including other specialist children's services and hospitals, school nurses, health visitors and mental health services.

The facilities available to families enabled them to stay and met their needs in supporting their children. For the children in the children's area they had indoor and outdoor play areas and for teenagers the 'teenage zone' was an excellent idea to support the needs of younger adults.

Children can access care when needed. Whilst the admission rates were slightly higher than the national average for emergency admissions children could access this service as there was capacity within the service. It was easy for people to complain or raise a concern and they were treated compassionately when they did so. The service had received 18 complaints compared to 151 compliments in the last 12 months. There was openness and transparency in how complaints were dealt with and complaints and concerns were always taken seriously and where appropriate apologies were provided.

Service planning and delivery to meet the needs of local people

- The increase in demand for children's services meant that the service was drafting a proposal for the reconfiguration of children's services in the Princess Alexandra Hospital to make the flow more efficient for children. The director of nursing was also aware of this and recognised the need and was supportive of the team looking at possible ideas for the service.
- In the Neonatal Intensive Care Unit capacity was achieved through refurbishment and reconfiguration. The trust had 16 cots to meet demand.

Access and flow

- Twenty-one of the 24 elective admissions (88%) among children in the under one age group and 1,181 of the 1,301 elective admissions (91%) in the 1 to 17 age group had a length of stay of less than a day. This meant that the trust's median length of stay for children for non-elective stays was higher than the national average for children aged under one year and in line with the national average for children aged 1 to17.
- The multiple admission rate for children at 16.4% was less than the England average of 17.4%, which was a good outcome.
- Bed occupancy for the Dolphin children's ward was regularly above 80% for the 12 months before our inspection. We were informed that there had been an increase in activity that required more beds to be used. The service had added additional nursing staff to each shift to cover the increase in demand.
- The ambulatory care service for children was on the main ward and because the team had recognised that this was no longer the most appropriate place for the children and families to wait they were working to identify a new area within the trust for this service.
- The overall average occupancy level for the Neonatal Intensive Care Unit in the 12 months before our inspection was 63%. The optimum occupancy level was 70% according to the British Association of Perinatal Medicine guidelines. This meant the unit was managing to maintain the availability of emergency cots and providing optimum safe nursing levels.
- Children who attend the hospital in an emergency were seen in the emergency department. Where possible the child was admitted soon after arrival straight to the children's ward for the specialist care they required.
- Children's outpatient's services did not meet children's needs in a timely way. Paediatric services did not meet the referral to treatment time targets this at any time

over the previous twelve months. Whilst the trust was not formally submitting RTT data due to concerns with their internal IT system, the data provided demonstrated that RTT for Children's outpatients up to April 2015 was 100% for Paediatric Diabetic Medicine and 79.2% for children's services for non admitted care.

- The incomplete pathway performance figures for children's outpatient services was a concern. Incomplete pathways are waiting times for patients waiting to start treatment at the end of the month. Children's services had 1822 children on the 18 week pathway and of those 700 (38.4%) were seen within 18 weeks.
- We requested further information on this data and the trust provided us with evidence which showed that by 31st August 2015 there were 460 children on the waiting list for an appointment and of those 71% had been seen within 18 weeks.
- The trust provided us with assurances that they have a process for patients on the waiting lists where they are triaged and reviewed based on referral and clinical history and can be clinically prioritised with their appointment brought forward if required.
- We also heard how there was a long waiting list for children with eye conditions due to the lack of an ophthalmologist. The trust confirmed that ophthalmology was an area of concern for them for both paediatric and adult outpatient care. The chief executive informed us that the trust were prioritising ophthalmology patients for appointments and that these patients were currently being reviewed to assess clinical need and prioritise those in need of urgent appointments swiftly.
- Children's clinics started late throughout our inspection and staff told us that the services frequently ran late.

Meeting people's individual needs

- Where medicines were required for discharge the pharmacy team liaised with the ward staff to prioritise the urgent cases for discharge.
- Bottle feeding and expressing rooms enabled breast milk to be available for babies and young children where needed.
- Child and Adolescent Mental Health Services were available through the local mental health trust. We were informed that this service would also respond to the needs of the child and worked well with the hospital. However, they were always in demand and response times were not as short as they could be.
- Translation services were available through Language Line, which was accessible to staff 24 hours a day.
- The service's play specialist worked alongside nursing and medical staff to provide support to children and young people. Parents were very complimentary about the service available from the play specialist.
- Within Dolphin ward there were dedicated play areas for children both inside the ward and outside. Outside there was an area on the roof (secure) which had been converted into a playground for younger children to get fresh air and play with toys.
- The outside area also had a dedicated area for adolescents known as the 'teenager zone'. This was a 'Wendy house' that contained a sofa, a football table and a TV and games console for the teenagers to have time alone away from the ward. This area was outstanding and well thought out to meet the needs of teenagers.
- The service had access to a learning disabilities specialist nurse as well as mental health nurses if required to support the care of children on the ward.
- Parents of children were able to stay on the unit where the child had been admitted.
- At the time of the inspection there was a paediatric dental theatre list taking place. All children went into theatre in their own clothes, helping to relieve some anxiety for them.
- There were six curtained beds for children within the paediatric area of the Alexandra Day Surgery Unit. Children and parents were seen by the medical staff at the bedside. Patients and relatives we spoke to stated that they had not felt this to be a problem for their privacy and dignity. The ward sister's office could be utilised for private conversations if required.
- The paediatric waiting room in outpatients on corridor B5 although bright and pleasant was too small, and not very accessible for parents or carers with pushchairs. In general, few clinics had separate play areas for children.

Learning from complaints and concerns

- Between April 2014 and March 2015 the service received 18 complaints, the majority of which related to the care provided to children on Dolphin ward. Dolphin ward was an area of recognised concern for the trust. The trust

worked with the team to understand the root causes of the issues to learn from the complaints being raised. These complaints related in general to communication issues between families and staff.
- The reporting of complaints has reduced over the last three months but the service continues to receive at least one per month.
- The service received 151 compliments between April 2014 and March 2015.
- Learning and feedback from complaints was shared to all staff through the monthly newsletters. Learning was also shared at quarterly audit and mortality and morbidity meetings.

Are services for children and young people well-led?

Requires improvement

The service required improvement in leadership because the vision for the future of the service had not been developed. The staff of this service were not all aware of the trust's vision or strategy. The arrangements for governance and performance management did not always operate effectively because the risk registers used to monitor performance did not clearly identify what the key risks for the service were. Staff we spoke with at all levels provided us with different risks for the service, some of which were not on the risk register.

There was a good level of staff satisfaction within the service and staff felt engaged and encouraged to provide the best care possible. There had been changes at local leadership level, which had a positive impact on the culture of the service, which was still going through a period of change. The culture within the service was open and transparent and there was a willingness to improve from staff and a willingness to tackle poor practice by the local and senior leadership teams.

The local leadership teams within the services demonstrated good leadership and had a clear understanding of where improvements were needed and how they planned to make them.

Where possible, the services tried to encourage public engagement and feedback to help them improve the service. Staff engagement was encouraged through team meetings, feedback and staff surveys.

Vision and strategy for this service

- There was a vision and strategy for the trust but staff we spoke with were not familiar with the trust's vision for the future. Staff said the future of the trust was unclear and that this was sometimes unsettling.
- The neonatal intensive care service had a clear vision for how it would deliver care to babies over the coming years, including service growth, training and accreditation options.
- The vision for the Dolphin children's ward was being developed at the time of our inspection. There had been a recent change in leadership on the ward, which meant that the vision was still being developed to identify service needs in future.

Governance, risk management and quality measurement

- The service completes an 'Acute Child Healthcare Dashboard' for the trust board. We examined the dashboard prepared for the board for April 2014 to March 2015 and found that it was not fully completed.
- The dashboard contained gaps and in some cases no submission at all between December 2014 and March 2015.
- The service risk register contained items that were out of date or had been completed but had not been removed from the register. For example, the use of sharps was added in 2012 and was completed and displaying on the risk register as a 'green' risk yet had not been removed.
- The risk register contained 28 risks that were added between 2011 and 2015.
- The risk added in 2011 was for delays in availability of an assigned paediatrician to carry out baby checks before discharge from post-natal care. There were remedial actions added, including the introduction of a standard operating procedure (SOP), but the action to recruit additional staff for this was due to be completed in May 2015 and had not yet happened. We were therefore not assured that sufficient priority was given to governance and the reduction of risk.

- Local audit activity to measure the quality of children's health services had not taken place for over six months due to a change in clinical leadership. This meant that managers could not be sure that the best possible care was being provided.
- When we asked staff what the risks for the services were, we received one answer that was the same through all levels of management but the rest were different. All were clear that staffing levels were a risk but the other risks mentioned – such as audit, discharge, flow and ambulatory care – were all raised by different people and were not all consistent with what was listed on the risk register.

Leadership of service

- There had been changes in the management of Dolphin ward and the Neonatal Intensive Care Unit. On the Neonatal Intensive Care Unit there had been a change in senior management and this had had a positive impact on the service, which was now more stable and performing in line with the trust's expectations.
- On Dolphin ward the acting ward manager had taken on a challenging role to improve the service. They had made a significant impact on the ward in a short time and improvements in the service were already visible. The acting ward manager demonstrated excellent leadership to the team.
- Both services were actively supported by a senior managers and the director of nursing. Throughout the nursing line of management there was good leadership evident, though some areas were still being developed. The services were locally well led by nurses and this leadership linked to the trust board well.
- The clinical leadership was undergoing change and the trust was still working on what was required to develop and evolve the service. The lead clinician demonstrated good leadership skills and was working to improve the leadership of clinical staff to the service.

Culture within the service

- Before the inspection we were notified by a stakeholder of concerns regarding the culture of safety and management on the Neonatal Intensive Care Unit which were identified in 2013. When we inspected we found that there had been a change in leadership since those concerns were originally raised to the trust and there was a visibly open culture within the Neonatal Intensive Care Unit.
- Neonatal Intensive Care Unit staff were willing to report concerns and willing to recognise where changes were required to improve the service.
- There had been a poor culture on Dolphin ward, which had led to acceptance of poor practice. The culture was undergoing a change due to the change in leadership and was showing signs of improvement, with the acting manager providing examples of appropriate action to tackle the difficulties with staff culture.
- Throughout our inspection we found that staff were willing to speak openly about concerns and they were not afraid to raise concerns to the trust if they believed they needed to.
- Locally, the teams felt that the leadership teams, including the executive management teams, were accessible and were willing to listen to concerns.

Public engagement

- The public were engaged through a variety of routes, including meetings with staff, surveys, and the Friends and Family Test to provide the service with feedback.
- Comment cards were also available throughout the service for parents to use.
- Children were encouraged to tell the story of their experience when they had sessions with the play specialist. This included drawing pictures, and writing stories and poems, which were displayed on the walls around the ward.

Staff engagement

- There was limited evidence of how staff were engaged in the service, with the exception of completing the staff survey. Dolphin ward had not had a ward meeting for several years before our inspection and the first one had been arranged by the acting ward manager in July2015.

Innovation, improvement and sustainability

- The service was drafting a proposal for the reconfiguration of children's services in the Princess Alexandra Hospital to make flow more efficient for children and also to make the service more sustainable for the future. The plans were in the very early stages but the services were keen that it progressed.
- The Neonatal Intensive Care Unit team had plans to develop the unit further and obtain accreditations to be a family-friendly service that meets the needs of babies

End of life care

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

Information about the service

End of life care encompasses all care given to patients who are approaching the end of their life and following their death. Care was delivered on wards or from within any service in the trust. End of life care is not solely the responsibility of the specialist palliative care team as care includes; nursing care, specialist palliative care, bereavement support, chaplaincy services and mortuary services. There was no specialist palliative care ward at The Princess Alexandra Hospital.

The trust has a specialist palliative care team including two whole time equivalent nurses and two consultants providing 0.4 whole time equivalent between them. One of the consultants had other responsibilities within the trust and the other shared their hours between one of the local hospices and the trust. In addition there is a bereavement support team offering assistance after the death of a loved one and a chaplaincy team offering support where required and requested.

The specialist palliative care team were referred 478 patients between April 2014 and March 2015, 187 of whom died in within the hospital. Of this number 70% were diagnosed as having cancer and 30% had another diagnosis. 64% of the patients referred to the specialist palliative care team achieved their preferred place of death and most patients were seen within one day of a decision being made that they were in need of this service. Preferred place of death was achieved for 64% of 187 patients in palliative care in 2014/2015. The remaining patients preferred place was not achieved as a result of issues such as rapid deterioration or hospice bed availability.

During the inspection we observed the care given to patients who were at the end of their lives. We visited 12 wards, and spoke with 17 staff, including nurses, doctors, mortuary, chaplaincy, portering and support staff. We reviewed 15 sets of patient notes and spoke with five patient's relatives and friends. Unfortunately we were unable to speak to any patients who were currently receiving end of life care, as the patients were too unwell to speak with us.

End of life care

Summary of findings

Services for end of life care required improvement, with some improvements required in safety and leadership and significant improvement required in effectiveness.

There were environmental concerns that could potentially interrupt services and prevent a safe service from being delivered. Lessons were not consistently learnt or shared from incidents that occurred within end of life care, which meant that opportunities to improve the service were sometimes missed. We found that patient records were not always appropriately updated, which could result in inappropriate care being given.

The trust did not have a specific pathway for patients at the end of their life since the withdrawal of the Liverpool Care Pathway. There was a draft plan still in its infancy. This meant that we could not be assured that patients received the appropriate care at the end of their lives. We saw that Do Not Attempt Cardio Pulmonary Resuscitation forms did not always comply with The Mental Capacity Act 2005.

The results of the National Care of the Dying Audit showed some positive results in organisational key performance indicators, but improvements could be made in the clinical results when compared nationally.

Staff at The Princess Alexandra hospital were passionate about end of life care and displayed kindness and compassion when delivering care to patients at the end of their lives. Consideration was given to the needs of patients' relatives and loved ones, such as open visiting hours.

Local leadership in end of life care required improvement to implement the actions taken to address the concerns in safety and effectiveness. Staff spoke highly of the support they were offered by the specialist palliative care team. Relatives and friends were invited to share their experience, so that end of life care could be improved.

Are end of life care services safe?

Requires improvement

End of life services required improvements in order to protect patients from avoidable harm.

Incident reporting in end of life care was not robust enough to ensure that lessons could be learnt from incidents that occurred, as not all staff were aware of recent incidents in relation to end of life care. This meant that learning could not be gained and was not shared from previous incidents.

There were environmental issues related to the plumbing within the mortuary which resulted in the mortuary flooding with waste water and this presented a risk of cross contamination and placed a risk on the provision of the service.

Staffing levels for nurses and doctors within specialist palliative care team was not sufficient. There was 2.4 whole-time equivalents of staff employed by the trust. Patient records for end of life care were not always updated, which meant that inappropriate care may be given.

The provision of training for staff involved in any element of end of life care was good, with specialist palliative care staff, mortuary staff and chaplaincy staff all having received up to date training in safeguarding.

Incidents

- The trust used a recognised online incident reporting tool. We spoke with staff that were aware of what constituted an incident and how to report an incident in relation to end of life care.
- There have been nine identified incidents reported by wards and departments within the trust within end of life care between January 2015 and May 2015. We spoke with staff from the specialist palliative care team and Fleming ward that were unable to recall any incidents to us regarding end of life care. This meant that we could not be assured that the team were aware of these incidents and that learning had been implemented throughout the trust from these incidents to prevent them from re-occurring.

End of life care

- The specialist palliative care team were involved in trust wide mortality and morbidity meetings to discuss where care could have been improved or deaths could have been prevented.

Environment and equipment

- Syringe drivers were used in palliative care as they helped to deliver a continual flow of medication to alleviate symptoms such as pain or sickness.
- There were no incidents reported in relation to delayed pain relief as a result of different syringe drivers in use in the hospital and community and we spoke with two staff members who were confident that patients who were discharged with a hospital syringe driver did not suffer from any delay in pain control as the district nursing team were competent in the use of both types of syringe driver.
- In the mortuary there was visible rust on two of the fridge doors. The fridges were installed within the last twenty years and we were informed by mortuary staff that they do have incidents where the fridges break down on average once per month. This meant that there was a risk of the fridges compromising the care of people.
- The mortuary had an alarm system on the fridges which was monitored twenty four hours per day in the hospital switchboard room. In the event of a fridge temperature concern the switchboard staff would alert the on call member of the mortuary team who would attend and respond to any concern with the fridges.
- There were issues with the drainage within the post mortem room. At the time of our inspection, water was still visible in pooled areas on the floor. We asked when the floor was last cleaned and were told 90 minutes prior to our arrival. There were visible marks from lime scale which risks damaging the floor.
- The mortuary had concerns with regards to the drainage of the water from the hospital impacting on the mortuary environment. On the day of our inspection the mortuary flooded due to plumbing issues in the ward above the mortuary. This caused the toilets to overflow leaving waste water and sewage in the corridors. It was reported that this was not the first event of its kind with a similar incident occurring two weeks prior to our inspection.
- These events were reported as incidents and the issues were on the trust's risk register. However, upon investigation by the trust no resolution was found and the staff were informed that this would likely happen again. The flow of waste water and sewage into the mortuary compromises the safety of the mortuary service provision with risk of contamination and also the wellbeing of staff.

Medicines

- The trust had a policy in place to ensure that anticipatory prescribing was in place which ensured that appropriate medication was prescribed to ensure symptom management in end of life care. There was guidance available to staff on the intranet and advice was available through contact with the specialist palliative care team.
- Medications were prescribed for pain control, nausea, agitation and respiratory secretions, which are common symptoms experienced at end of life.
- Medications were prescribed for patients in an anticipatory form, so that should a patient's condition deteriorate, the nursing staff were able to provide the patient with appropriate medication without having to wait for medical staff to authorise the prescription.
- We looked at six patient medication charts and all anticipatory medications were prescribed for four patients. We saw that one medication chart on the stroke ward had no anticipatory medications prescribed.

Records

- We examined the records of fifteen patients receiving end of life care and also those patients with an advanced decision for end of life care in place.
- Staff were able to speak with us about a patient's preferred place of care or preferred place of death. When we looked at the corresponding notes for these patients and we found that the preferred place of care or preferred place of death was not documented in nine of the fifteen sets of patient's notes.
- The specialist palliative care lead reviewed patient notes to ensure that there had been appropriate discussions and decisions made about care and that appropriate medications had been prescribed. We saw that not all end of life patients were referred to the specialist palliative care team. We found two patients receiving end of life care on Winter ward and two on Henry Moore ward that had not been referred to the specialist palliative care team.

End of life care

- Records of discussions and decisions required improvement throughout end of life care. The exception to this was Harold ward where the standard of documentation around end of life care was noted to be very good.
- We found that consent arrangements were in place for managing tissue removal after death. The last Human Tissue Authority inspection concerns related to environment but found no concerns with the records maintained. The Human Tissue Authority regulate organisations that remove, store and use tissue for research, medical treatment, post-mortem examination, teaching and display in public.
- On Tye Green ward there were a total of sixteen printed policies that were out of date, the oldest of which was the do not attempt cardio pulmonary resuscitation decision for adults (DNACPR) which was dated 2005. The rationale given by the sister in charge was the difficulty in access them on the computer.

Safeguarding

- We examined the training records for the palliative care team, mortuary staff and chaplaincy staff, and found that 100% of staff were up to date with their training on both safeguarding adults and children.
- The specialist palliative care team and ward staff were aware of what constituted a safeguarding concern and how to report any concerns.
- We saw evidence of a safeguarding referral that had been made by nursing staff for an end of life care patient who had received poor care in the community.
- During a review of records in the hospital we found a Do Not Attempt Cardiopulmonary Resuscitation form that had not been counter-signed by a consultant and did not show evidence that a family member had been involved in the decision. We asked the consultant about this who told us that they would rectify this immediately

Mandatory training

- The specialist palliative care team had provided end of life care training to 96% of staff that work in areas that may see patients at the end of their lives.
- In order to ensure staff were trained in this specialty all new clinical staff joining the trust attended a mandatory training session on end of life care as part of their induction.
- One of the consultants provided training to first and second year foundation doctors, and covered subjects such as symptom control and opioid management.
- Since the implementation of foundation year doctor training there had been an increase in the number of junior doctors requesting advice from the specialist palliative care team.
- We reviewed the mandatory training records for the specialist palliative care team, mortuary staff and chaplaincy staff. We found that 100% of eligible staff had attended dementia training, 90% fire awareness and equality and diversity training and, 80% infection control and moving and handling training.

Assessing and responding to patient risk

- Meetings took place at the beginning of each day to discuss the patients being cared for on the wards. Patients approaching the end of their life were discussed at these meetings to ensure all staff were aware of patients' particular needs.
- Discharge facilitators also attended daily morning meetings to assist in the rapid discharge of patients to their preferred place of care.
- The specialist palliative care lead was part of the deteriorating patient committee and the palliative care lead discussed topics such as any inappropriate resuscitation of dying patients.

Nursing staffing

- There were two whole time equivalent nurses who worked in the specialist palliative care team. We were informed that there was a bid to Macmillan Cancer Support (MCS), in June 2015 to fund a 3rd clinical nurse specialist in palliative care for 2 years. We saw documentation that confirmed this.
- There were 478 referrals made to the specialist palliative care team between April 2014 and March 2015. This placed a strain on the number of nursing staff and we saw that the staffing cover was not always sufficient.

Medical staffing

- There was one palliative medicine consultant and one consultant in acute medicine who had a diploma in palliative medicine working in the specialist palliative care team. The whole time equivalent of medical staffing was 0.4 consultant hours.
- Both consultants gave two sessions per week of their time to specialist palliative care which equated to the

0.4 whole time equivalent hours. This meant that medical staffing is not sufficient to provide palliative care cover for the number of referrals seen by the team each year.

- The National Institute for Health and Care Excellence guidelines for end of life care for adults (QS13) recommends between 1.56 and 2.00 whole-time equivalent consultants in palliative care medicine per 250,000 population. The Princess Alexandra hospital provides care to a local population of approximately 350,000. This meant that there were not enough palliative care consultants to meet the guidelines.
- We reviewed minutes from a report to the board from the quality and safety committee on 5 March 2015, whereby there was a discussion indicating the trust were aware that they needed to increase their consultant cover to ten consultant led sessions per week in order to meet the National Institute for Health and Care Excellence guidelines.
- We were told by the specialist palliative care team that there were plans for an increase to six consultant led sessions per week from September 2015.

Major incident awareness and training

- The trust has a major incident plan and the majority of the end of life care team took part in the required major incident exercises scheduled throughout the year. The mortuary team had not been involved in the undertaking of the last two exercises.
- The mortuary team had been consulted and included in discussions, plans and arrangements for the hospital in relation to infectious disease outbreaks such as Ebola, and were prepared for the receipt of infectious patients.
- The Mortuary service was part of the wider working network of hospital mortuaries which would respond in the event of a multi fatal event and demonstrated to us how they would be prepared for such an event.

Are end of life care services effective?

Inadequate

The trust was rated inadequate in this area as there was no end of life care plan and outcome measures were poor. The trust-developed end of life care plan had not been rolled out for use trust-wide at the time of our inspection. This tool was a care plan developed by medical and nursing staff to replace the Liverpool Care Pathway. The trust planned to roll this out once staff had been piloted.

The trust participated in the National Care of the Dying Audit 2014 and performed worse than the England average on six out of ten of the clinical key performance indicators. The trust performed in line with the national average in five organisational key performance indicators and better than the national average in two organisational key performance indicators. Local audits around end of life care were limited and still being developed.

The completion of Do Not Attempt Cardio Pulmonary Resuscitation records were not always completed in line with best practice. Do Not Attempt Cardio Pulmonary Resuscitation forms examined did not always comply with the requirements of the Mental Capacity Act 2005. We saw that discussions around the decision with families were not always clear or written down.

Specialist palliative care services were available between 9am to 5pm, Monday to Friday and were not available over seven days.

The services undertook audits which showed that the majority of patients received care and passed away in their preferred place.

Evidence-based care and treatment

- The Department of Health asked all acute trusts in England to undertake a clinical review of all patients receiving end of life care following a national independent review, “More Care, Less Pathway: A review of the Liverpool Care Pathway”. All trusts were asked to replace the Liverpool Care Pathway with a trust and patient-specific individualised care plan. The trust had implemented a decision support tool for end of life care planning and was piloting individualised end of life care plans at the time of our inspection.
- We looked at fifteen sets of patient notes and we found no complete nursing care plans for the dying patient.
- On Lister ward we were told of a draft nursing care plan, “Delivering Compassionate Care for the dying patient and their family/carer”. The plan was still in draft form, staff on Henry Moore ward told us that there was no specific pathway for patients at end of life.

End of life care

- The draft nursing care plan was dated April 2015. There was no planned date for this document to be finalised for trust wide use which meant that the delivery of end of life care on the wards was not consistent.
- When looking at nursing notes we saw that some contained the acronym 'COMPASSION' which had been adapted for use within the end of life care plan that was being piloted in the trust. The acronym was an aide memoir for staff with “C” standing for communication, “O” for observations, “M” for medications, “P” for pain, “A” for activities of daily living, “S” for skin, “S” for spirituality, “I” for invasive devices, “O” for oral care, and “”N” for nutrition. This provided nursing staff some guidance towards caring for the dying patient.
- When we examined documents provided to us by the trust, we noted that the discharge policy in use by the trust (January 2012) made reference to the Liverpool Care Pathway. This policy was scheduled for review, in January 2014. This meant that the trust policy was not up to date and staff were not provided with up to date procedures relating to patient discharges at the end of their life.
- We reviewed the trust action plan which documented how the trust had considered the implications of the service it provided and agreed upon a timeframe to improve this service in response to the National Care of the Dying Audit.

Pain relief

- Anticipatory medications were being prescribed for patients and we saw that medicines recommended for use when a patient is reaching the end of their life were readily available on wards providing this care.
- We checked six patient drug charts for anticipatory medications and found that they had been prescribed for only four patients. There were no anticipatory medications prescribed for one patient receiving end of life care on the stroke ward.
- Where there were issues with a patient’s ability to communicate with staff, for example a patient living with dementia, the trust used the Abbey Pain Scale, a recognised observational tool to assist with pain assessment.
- We saw that pain was scored from zero to three. This is not a broad enough score to accurately document severity and range of pain. We saw no records of separate discussions should there be an issue around pain management.
- Staff told us that they could access syringe drivers in a timely manner and could confidently talk us through their use. We did not see any in use at the time of our inspection.

Nutrition and hydration

- We were told by staff on Henry Moore, Fleming, Winter and Lister ward that patients were allowed to eat and drink as they wished for as long as they were able. This was also written into the trust draft plan for caring for the dying patient.
- Staff were aware of the challenges patients faced with maintaining a good eating and drinking routine towards the end of their life and kept this process subject to review to meet the needs of the patient.
- We were told by staff on Henry Moore and Winter ward that the speech and language team were involved in discussions around nutrition and hydration with patients at the end of life as required. There were no patients on the ward that had been referred to the speech and language team, so we were unable to review this in practise.
- On Ray ward we saw that a patient responded better to family members at meal times and arrangements had been made for relatives to attend hospital at the protected meal times to support the patient.
- In the most recent National Care of the Dying Audit the trust had undertaken a review of the patient’s nutritional needs in 33% of cases and hydration needs in 45% of cases. The England average is 41% for nutrition and 50% for hydration. This meant that the trust was performing worse than the England average for both of these indicators.

Patient outcomes

- Records of discussion between doctors and patients or patient relatives were not always well documented, especially decisions around do not attempt cardio pulmonary resuscitation.
- On Ray ward we noted an incident whereby the staff were unsure if a patient had a do not attempt cardio pulmonary resuscitation form duly completed. There was no do not attempt cardio pulmonary resuscitation form for this patient. Staff were not confident which patients were or were not to be resuscitated.
- Records for patients were not detailed with regard to the care pathway each patient required. Staff spoke confidently about the patient’s preferred place of care

and preferred place of death. We saw that this was not always documented in the patient's notes. Within the fifteen sets of notes we looked at, we found that the preferred place of care or death was only noted in six sets of notes. This meant that patients could not be assured that their preferred place of death would be taken into consideration.

- The trust had taken part in the National Care of the Dying Audit 2014. A national audit looking at how hospitals provide care to those in the last hours, days and weeks of life.
- The Princess Alexandra Hospital achieved three of the seven organisational key performance indicators and performed worse than the England average in six out ten clinical key performance indicators.
- The trust scored above the England average within the National Care of the Dying Audit achieving 58% with regards to the question asking 'medication prescribed for the five key symptoms that may develop during the dying phase' the England average was 51%.
- The National Care of the Dying Audit results for 'Care of the dying: Continuing education, training and audit', the trust achieved the target. Only 51 other trusts nationally achieved this target.
- The specialist palliative care team submit data to the national minimum data set which allowed the trust to benchmark their service nationally.
- The trust undertook regular audits of patient care during their clinical Fridays. With the exception of do not attempt cardio pulmonary resuscitation audits, none were specific to end of life care patients.
- Preferred place of death was achieved for 64% of 187 patients in palliative care in 2014/2015. The remaining patients preferred place was not achieved as a result of issues such as rapid deterioration or hospice bed availability.

Competent staff

- The specialist palliative care team provided training sessions to ensure end of life care was included in staff education and during induction into the trust.
- 96% of trust staff had attended face to face training sessions on end of life care provided by the specialist palliative care nurses.
- Training sessions included induction for all clinical staff, preceptorship for nurses in end of life care, monthly simulation of scenarios around end of life care.
- There were also workshops for topics such as 'breaking bad news.' Sessions using trained actors to allow staff the opportunity to practice discussions around sensitive topics such as do not attempt cardio pulmonary resuscitation and reflective practice sessions.
- We examined the training records for the specialist palliative care team, mortuary staff and chaplaincy staff, and found that 100% of staff were up to date with their training, including safeguarding adults and children.

Multidisciplinary working

- Specialist palliative care team attend weekly specialist palliative care multidisciplinary meetings.
- With one consultant providing hours to the trust and also working at the local hospice, this facilitated established links that worked well with the hospice.
- Staff on the wards spoke very highly of the specialist palliative care team and we witnessed good working relationships between the ward staff and palliative care lead.
- Meetings were held on the wards each morning to discuss the patients that were being cared for. If there were any end of life care patients on the wards, professionals from relevant specialties were invited to attend to input into the patient's care plan.
- Staff from the specialist palliative care team were part of the East of England end of life care facilitators' network. This group championed education, networking and, shared learning.
- Palliative care staff attended and had input with regards to community based meetings on end of life care.

Seven-day services

- The specialist palliative care team operated between 9am to 5pm, Monday to Friday, with out of hour's advice cover being provided by the two local hospices.
- The trust was working to increase this to three nurses through support from a local nursing group to help provide a seven day service. The Trust had submitted a bid to Macmillan Cancer Support for a third clinical nurse specialist, to enable six day working. The current team of two clinical nurse specialists worked Monday to Friday, with specialist telephone advice available from two local hospices out of hours. This had not been agreed at the time of our inspection.
- Palliative consultant cover at 0.4 whole time equivalent meant that cover was not available seven days a week.

End of life care

However, one of the consultants was sometimes able to make themselves available outside contracted as was also working as an acute medicine consultant in the trust.

- There was a plan to increase both palliative care nursing and palliative care medical staff. These plans had not been formally agreed or funded. Whilst the provisional plan was for this to commence from September 2015, we were not assured that this would be the case.

Access to information

- Staff had access to information, such as policies and guidance via the trust's intranet site. Staff demonstrated to us how they located the information they needed.
- Palliative care referral forms were available for staff on the intranet.
- There was a 24/7 advice line provided by local hospices for staff or relatives to access should they need help or advice.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- As part of our inspection we looked at thirteen sets of patient notes with active do not attempt cardio pulmonary resuscitation decisions. Out of the thirteen sets of notes, nine had the do not attempt cardio pulmonary resuscitation decision made because it was noted that the patient did not have the mental capacity to make this decision. One of those nine patients had a mental capacity assessment undertaken. Therefore, medical staff were not always following The Mental Capacity Act 2005 in relation to making best interest decisions in end of life care.
- Audits of do not attempt cardio pulmonary resuscitation forms had been undertaken on eight occasions between July 2014 and March 2015.
- The audits had shown improvement in the documentation around do not attempt cardio pulmonary resuscitation decisions since the implementation of 'Clinical Fridays' with 17% of documentation being completed fully in the audit in July 2014 and 77% completed fully in the audit in March 2015.
- We looked at thirteen do not attempt cardio pulmonary resuscitation forms. Five of the thirteen patient notes had no documented discussion around a do not attempt cardio pulmonary resuscitation decision.

Are end of life care services caring?

Good

Staff at The Princess Alexandra Hospital provided good compassionate care to patients. We spoke with five relatives but unfortunately we were unable to speak to any patients, who were currently receiving end of life care, as the patients were too unwell to speak to us.

Feedback from the relatives we spoke with was positive. Relatives spoke highly about the relationships which had been built with staff and they told us how the hospital staff recognised their needs and provided them with emotional support.

The care we observed of those patients receiving end of life care was compassionate and understanding and staff went the extra mile to make the experience as comfortable as possible. We saw examples of outstanding care by staff. For example, how they placed slippers on the feet of one patient who had died at the wish of the family so their relative's feet would not get cold.

Feedback received from relatives and the staff about the care provided by the specialist palliative care team was entirely positive. The bereavement and chaplaincy teams were available to provide emotional and wellbeing support where required to relatives, patients and staff.

During our inspection we saw the mortuary staff demonstrate empathy and understanding of dignity and respect when continuing the care of people that had passed away.

Compassionate care

- We spoke with five relatives about the end of life care. All were very positive about how caring the staff had been. One patient had been coming to the hospital over a period of ten months and had been admitted to three different wards in this time. The family told us that "everyone is so kind and they think of us as individuals" and "they can't do enough to help".
- Another relative told us that staff had discussed the patient's preferred place of care with the patient and with the relative and they had decided for care to be carried out in the hospital because the care had been "so good".

End of life care

- The national bereavement survey results report that, of 218 responses, 38.9% of people rated the care that their loved one was given in the last three months of life as "outstanding" or "excellent". The England average for these ratings was 43.2%. This meant that the trust was not performing as well as the England average in this survey.
- Patient rounds by the specialist palliative care team were conducted in a sensitive, caring, and professional manner throughout with staff engaging well with the patient. For example, a discussion was needed with a patient regarding their care and the staff member spoke in a tone which comforted the patient despite being faced with bad news. The staff member recognised the patient's needs and respected their wishes when they requested to rest. We witnessed caring staff who understood the needs of their patients for example the palliative care lead nurse stroking a patient's hair and to gently attract their attention and holding patient's hands when they were spoken to.
- We were told of a patient who had passed away. The patient's family were visibly upset and asked staff to bring the patient's body to the mortuary with the patient's slippers on their feet as the patient always complained of cold feet. The staff prepared the body for the mortuary and ensured the patient had their slippers on.
- We were told of another patient whose family had requested that a family blanket remained with the patient and again this patient was brought to the mortuary wrapped in the blanket. This was very compassionate toward the grieving relatives.
- We were told of families being offered keepsakes such as a lock of hair or a handprint of the patient in the intensive therapy unit.

Understanding and involvement of patients and those close to them

- The National Care of the Dying Audit 2014 identified that the health professional's discussions with both the patient and their relatives/friends regarding their recognition that the patient is dying was slightly above the England average of 74% with the trust at 76%.
- The National Care of the Dying Audit showed that an assessment of the spiritual needs of the patient and their nominated relatives or friends was scored at 38, which is slightly higher than the England average of 37.
- There are no visiting restrictions for friends and family of patients who are at the end of their life. Family members or those close to the patient were allowed to stay overnight on the wards.
- During our inspection we saw the relatives of a patient rush into Henry Moore ward in a distressed state. They had been called because their relative had deteriorated. Staff calmed the relatives and brought them to the patient, offering them refreshments and support. Staff explained that they would give them privacy but were available if needed.
- The wishes of the patient's relatives after death were considered. For example, we were told of a patient whose family wished for a family keepsake to remain with the patient at all times. When preparing the body for the mortuary the staff ensured this remained with the patient. The family were comforted by this.

Emotional support

- Chaplaincy support was available 24 hours a day using an on-call system.
- The chaplain was supported by one full time member of staff and two volunteers, there were six further volunteers undergoing induction training. Chaplaincy staff offered to accompany relatives when viewing the body of a relative.
- Staff felt confident in their abilities to support the patient and their relatives at the end of life. They gave examples of how they had given support and were happy that they knew who to contact if further support was required. We were told of an incident involving a distressed relative, a staff member and the relative spoke in a quiet room and the staff member was able to calm the relative and provide advice.
- We witnessed a distressed relative arrive on Henry Moore ward. A nurse approached the relative, reassured them and walked with them to their relative once they were calm.
- The trust had a bereavement support team who were available to speak to relatives, co-ordinate services and offer practical advice.
- The team had access to a quiet room that they used to facilitate discussions around support offered and the practicalities of dealing with a relatives death.
- The hospital had a range of clinical nurse specialists to support patients with identified illnesses, such as cancer care.

End of life care

Are end of life care services responsive?

Good

We rated responsive within end of life care services as good because the trust provided services to patients, relatives, and friends which responded to individual needs.

One ward had a discharge box that was given to the families of patients going home to die to ensure that any necessary equipment was available to the family when they needed it.

The family and friends of any patient deemed to be at the end of their life had the hospital parking charges waived and open visiting hours.

Relatives were allowed to stay overnight. However, there was no specific room provided for them but a mattress was provided so a relative staying could be in the same room.

There was limited multi-faith provision in the chapel, although people of all religious denominations were welcomed into the chapel.

We saw that lessons were being learnt from concerns raised through complaints. Relatives and friends were invited to share their experience, so that end of life care could be improved.

Staff worked collaboratively to ensure patient's wishes were achieved where possible.

Service planning and delivery to meet the needs of local people

- There were 478 referrals to the specialist palliative care team between April 2014 and March 2015, 70% of these referrals were cancer patients.
- Within the period of April 2014 and March 2015 there were 187 deaths recorded which had been referred to the specialist palliative care team.

Meeting people's individual needs

- The trust has 84 side rooms and for those patients approaching the end of their life were offered the opportunity to be nursed in a side room if one was available.
- If a side room was not available every effort was made to respect the patient's privacy. We were told of examples of beds being moved around to allow the patient extra space around their bed and beds being moved so that patients could look out of a window.
- The relatives' room in the accident and emergency department was not an appropriate space for breaking bad news or for those recently bereaved. The furnishings were in need of replacement. There was no refreshment provision but we were told staff offered refreshments to those using the room. The matron for accident and emergency had recognised this and staff had arranged for a fund raising event to raise money to improve this room.
- There was a lack of facilities for relatives on the stroke ward where relatives had to use the ward sister's office if they were receiving bad news or needed some quiet time. We spoke with one relative on the stroke ward and in order to speak to them in private, we had to use the rehabilitation room as the only available space.
- There were no overnight rooms provided for families due to lack of space, but we saw that mattresses could be placed on the floor should a relative wish to stay overnight. Relatives were also allowed to sleep on the chairs provided.
- Friends and family were provided with refreshments and snacks when they were present on the wards.
- On Harvey ward we were told of a scheme to ensure that whereby families who were going to nurse a relative through end of life at home had all the necessary equipment given to them on discharge. There was a box on the ward that contained equipment to be given out to the family including; wipes, paperwork, mouth care equipment, pads, emesis bowls, contact numbers and, appropriate paperwork. This was in addition to medications provided. This meant that should an emergency happen at home, all of the necessary equipment was available.
- There was a quiet room provided within the mortuary area for families who were waiting to view their deceased relative. This had been designed to take into consideration the lighting and appropriate decoration.
- The hospital had a multi-denominational Christian chapel. We saw that the chapel provided the Bible for the Christian faith, but could find no other sacred texts, such as the Quran. The Chaplain told us that sacred texts for other religions were on order and that people from any religion were welcome to use the chapel.

End of life care

- There were no restrictions on visiting hours for the relatives and friends of those patients at the end of life.
- Car parking fees were waived for relatives visiting end of life patients.
- We were told of a patient on Harvey ward who had been successfully discharged home within three hours after deciding that they wished to die at home. The staff worked collaboratively to ensure that transport was arranged and a care package in place at home so that this could be achieved.

Access and flow

- In June 2015 there were 54 referrals to the specialist palliative care team. 54% of these patients were seen on the day of referral and 89% of these patients were seen within 24 hours. 93% of patients were seen within 48 hours. However, one patient waited 5 days, to be seen by a member of the SPCT, although the referrer had been contacted within 24 hours. The clinical nurse specialist had established that the referral was non-urgent.
- There is an end of life discharge facilitator who ensured that patients and relatives had all the required information on discharge.
- 64% of patients referred to the specialist palliative care team with an identified preferred place of death achieved this. Some patients were unable to choose their preferred place of death due to being too unwell to have this discussion or being too poorly to move.
- On Ray ward we saw that a patient had waited nine days for rapid discharge as a result of issues with obtaining appropriate equipment in the community for this patient.
- We noted that problems within delays with rapid discharge were as a result of rapid deterioration of the patient, availability of care facility and delays in obtaining equipment in the community.
- The mortuary had 80 fridges, with an ability for a further 20 fridges available against demand as required.
- The mortuary was consistently at 80-90% occupancy so capacity to meet demand was challenged. There were contingency plans in place with local undertakers to cope with increased demand. Further work to plan for capacity was required.

Learning from complaints and concerns

- There have been nine complaints received regarding end of life care between January 2015 and June 2015.
- Meetings have been held with families of four of the patients concerned. Changes had been made to the trust processes as a result of one of these complaints with new discharge leaflets being produced.
- The trust invited patients and relatives that had provided feedback to the trust, both good and bad, to attend sessions to pass on their experiences.
- Staff involved in the patient's care were present at feedback and learning meetings and this was supported by the board. This meant that learning could be gained from previous care given.

Are end of life care services well-led?

Requires improvement

We have rated well led as requires improvement. The lack of implementation of the alternative to the Liverpool Care pathway and the inconsistencies in do not attempt cardio pulmonary resuscitation documentation should have been driven by the specialist palliative care team leaders. There was no clear vision or strategy for the service despite staff being caring towards those at the end of their lives. There was no non-executive director with responsibility for end of life care**.** The director of nursing was the executive director for end of life care and was visible on the wards, promoting end of life care.

The local leadership of the specialist palliative care team worked in collaboration with colleagues in all teams. All staff within the specialist palliative care team demonstrated a passion about the delivery of patient care at the end of life. The specialist palliative care team were recognisable on the wards and staff felt happy to approach them for help and advice. Staff at all grades felt able to challenge decisions, promoting an open and transparent care environment.

Vision and strategy for this service

- There was no clear vision or strategy for the provision of end of life care. Staff providing end of life care were aware that there were plans being developed to improve the trusts end of life care plan but were unclear when it would be launched.

End of life care

- Locally staff understood what their contribution was to providing care to a person at the end of their life. In the mortuary there were clear procedures for end of life care.
- At the time of the inspection there was no non-executive director with responsibility for end of life care**.** This was a recommendation following publication of the review of the Liverpool Care Pathway to NHS Trust Chairs and Chief Executives in July 2013.

Governance, risk management and quality measurement

- There was an end of life strategy group, that was chaired by the lead for specialist palliative care, that met to discuss issues relating to end of life care.
- We reviewed an action plan in response to the results of the National Care of the Dying Audit 2014. The action plan set out the key areas the trust would improve around the delivery of end of life care.
- Following the review of the Liverpool Care Pathway in 2013 all trusts were asked to replace the Liverpool Care Pathway with a trust and patient specific plan. The Princess Alexandra Hospital's end of life care plan was still being piloted.
- There was a lack of audits which focused on end of life care so the trust could not measure how well this service was performing or take steps to improve care.
- Do not attempt cardio pulmonary resuscitation forms were not consistently completed and preferred place of death was not always recorded in patients' notes. This meant that patients could not be assured that they would receive the appropriate care at the end of their lives.

Leadership of service

- The chief nurse was the executive director responsible for end of life care and chaired the end of life strategy group, which met monthly. Ward and specialist palliative care staff were very positive about this and commented on the visibility of the director of nursing on the wards.
- Locally, the specialist palliative care team was well led and demonstrated good leadership in clinical areas. For example the palliative care lead was observed leading discussions with medical staff regarding the appropriate care of the dying patient. Staff felt that the team were approachable and recognisable within the wards.
- The mortuary team were well organised and the leadership lines were well established and had good links with senior management in the trust and the trust board.
- We were told by a member of staff on Lister ward that the "Director of Nursing is very supportive and approachable and comes to the ward" but that they "do not see any other leaders."

Culture within the service

- Staff on the wards felt that they could contact the specialist palliative care team, chaplaincy or bereavement support team at any time for advice or to visit patients.
- There were very good relationships evident between staff groups. For example, we witnessed staff from all grades work together to discuss the care of the dying patient. The input from all grades of staff was given equal weight in the discussions.
- All staff we spoke with demonstrated a positive and proactive approach to caring for the dying patient. They spoke of how important their role was in maintaining the dignity of patients at the end of their life.
- We spoke with a health care assistant who stated that they felt they would be able to challenge a more senior member of staff if they had concerns over the care of a patient and they were able to provide an example of where they had done this. This showed that leaders were open to challenge.
- We witnessed staff approach their managers for advice or help on Ray ward and Lister ward.
- A member of nursing staff on Lister ward told us that their ward manager "is very supportive and does more than they should."
- A Health Care Assistant on Henry Moore ward told us that they felt "100% supported."

Public and staff engagement

- The service promoted the completion of the national bereavement survey and was aiming to improve their response rates from the public.
- Patient's relatives were invited into the trust to give feedback and share their experiences relating to the care that their relative had received in the last days, weeks or months of their life.

End of life care

- Staff from the specialist palliative care team were involved in a recent community event during National "Dying Matters Week". Over 90 members of the public attended sessions in the community based around care of the dying.

Innovation, improvement and sustainability

- We saw that the mortuary staff had patented a bariatric system they had designed that had a capacity of 70 stone (445kg).
- The bariatric system allowed full access to bariatric patients for post mortem as it allowed for the lowering or rising of the table as required. There was space for two bariatric tables in a separate fridge.

Outpatients and diagnostic imaging

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

Information about the service

Outpatients' services at Princess Alexandra Hospitals Trust are based at Princess Alexandra Hospital, St Margaret's Hospital and Herts and Essex Hospital with 70%, 18% and 11% of attendances respectively. There are approximately 600 clinics held per week across all sites. Between January and December 2014, there were 279,511 new and follow up appointments, an average of 5,375 per week.

We visited the B5 outpatient's corridor, the eye clinic, and the Wych Elm building, and Bevan buildings at Princess Alexandra Hospital. We also visited St. Margaret's Hospital which runs breast care, rheumatology, orthopaedics, audiology, urology, gastroenterology, ear nose and throat (ENT)

The new Clinical Support Service Health group, set up in 2015 as the result of a restructure, combined outpatients and diagnostics under the same management team.

We spoke with 19 patients in the locations listed above. We spoke with seven nurses, three health care assistants' four administrative staff and four senior managers and consultants.

Summary of findings

Overall we rated the outpatient and diagnostic services as inadequate. The outpatients department had issues with medical records not always being available for the clinic which had resulted in a number of serious incidents. Whilst the trust had taken action to address these issues, this area requires further improvement as monitoring of clinic records availability was not undertaken. We also noted a safety issue within the clinical procedure room at St Margaret's hospital which, once highlighted to the trust was investigated and remedial action was taken. The significant patient back log of patients waiting for appointments was being addressed by the hospital but this work had only commenced in January 2015 and was only reviewing those patients waiting more than a year for an appointment. The lack of clinical prioritisation of the waiting list has led to the safety domain as being rated as inadequate. The departments had sufficient staff and implemented good systems to ensure that incidents were not repeated.

The diagnostic services, by contrast, did not have a waiting list and took part in local and national audits and took steps to address any areas highlighted through audit. Auditing processes were less well developed in the outpatients department. Staff were competent and sufficiently skilled for their own area of work. There were good examples of staff working collaboratively to meet patients' needs, for example in cancer multidisciplinary teams.

Outpatients and diagnostic imaging

Patients were treated with kindness, dignity, respect and compassion when receiving care and treatment. Patients spoke positively about how they were treated by staff. Consultants gave patients helpful information so that they could make their own decisions about care.

The responsiveness of the outpatients' service was inadequate. Patients were not consistently offered timely access to services. The trust was not currently reporting referral to treatment times due to information technology issues. However, there was a significant backlog of patients waiting for appointments. Shortages of administration staff and lengthy waiting times made clinics crowded and often delays occurred. Short notice cancellations and problems with letters for appointments meant that patients either did not turn up to appointments or were waiting a long time to see consultants as appointments were double or triple booked.

The managers of this area were aware of the issues and had plans in place to address them. However, at the time of our inspection these had not been addressed. Staff were well supported and there was a culture of learning and driving improvement. Staff were well supported and trained to undertake their roles within the departments.

Are outpatient and diagnostic imaging services safe?

Inadequate

Safety in outpatients was rated as inadequate. Some facilities such as the procedure room at St Margaret's hospital were not fit for purpose. Once highlighted to the trust a full investigation was carried out and the procedure room made safe for the procedures carried out there. The lack of medical records caused delays to some appointments and there were problems with medical record storage. Outpatient's track record on safety was inconsistent. Safety for patients on the waiting lists was not maintained as clinical prioritisation had only commenced in January 2015 for those waiting above 52 weeks.

The service had good incident reporting and learning. Arrangements for staffing, safeguarding and risk assessment were sound. Clinical and diagnostic areas were clean. By contrast there were good arrangements for safety in diagnostics. The issues found in the outpatient service were not replicated in the diagnostics department.

Incidents

- Staff understood their responsibility for raising concerns. Staff told us that managers asked them to record everything of concern on the electronic incident recording system. However, staff did not always receive feedback from senior nurses about what had happened as a result of their reporting. The trust acknowledged that it could get better at explaining what action had been taken as a result of staff raising concerns.
- The outpatients department had one never event in dermatology clinic. This related to the wrong skin lesion being removed. The trust reviewed this incident and is now using photography to ensure that the correct site is operated on.
- The number of incidents at St Margaret's Hospital was increasing before our visit. This could indicate a raising awareness of reporting incidents. Some incidents had the potential to compromise safety. For example, a doctor diagnosed a patiently incorrectly because he had the wrong patient's details in front of him. On another occasion, a patient with skin cancer waited eight months for their procedure because of the difficulty getting a follow up appointment.

Outpatients and diagnostic imaging

- Diagnostics staff described how they had learnt lessons and made improvements when things went wrong. Two years ago, the wrong patient received a CT scan. Since then the service has used bar codes on records and wristbands to identify patients. There were processes in place to ensure that the right person got the right scan at the right time. The Radiation Protection policy outlined procedures for establishing a patient's identity in circumstances were a patient could and could not respond.
- Outpatients and diagnostic imaging services carried out robust reviews when things went wrong. Managers analysed any 'red incidents' or complaints to share any learning across the group and decide on any changes needed.
- We were informed how a wrong site lung biopsy in April 2015 led to learning about improving communication between consultants. A large cross service team analysed the incident and found that it was only nurses who used the World Health Organisation checklist and not the doctors. As a result the service introduced a new standard operating procedure to ensure that the consultants used the checklist. This was audited in June and showed 97% compliance and that the required changes in practice were being complied with. The findings of the audit were shared at the health group quality and safety meeting and the quality and safety committee of the board.
- In line with the duty of candour, outpatients and diagnostics imaging nurses and consultants admitted their mistakes to patients and apologised. For example, as a result of the incident detailed above the service arranged a meeting with the patient to explain, apologise and offer redress. The respiratory consultant and the nurse specialist attended. This was followed up by a letter to the patient and a report of the incident.

Cleanliness, infection control and hygiene

- Standards of hygiene and cleanliness were evident. We observed a range of outpatient clinics including the Eye Clinic, B5 corridor, Wych Elm and Bevan buildings and we found clinical and waiting areas to be visibly clean.
- Outpatients and diagnostics had reliable systems and procedures in place to ensure cleanliness and infection control. Each clinical area conducted a hand hygiene audit once a week. A different person each week led the audit and reported the results to the matron. The latest audit in B5 showed 98% compliance. Outpatient's nurses told us that they conducted a variety of audits including hand hygiene audits, environmental audits, and cleaning audits which included equipment checking. Managers also carried out unannounced infection and prevention and control visits to the Williams Day Unit, St Margaret's Hospital, outpatients and diagnostics. This led to a comprehensive action plan to clean, de-clutter, fix soap dispensers and taps.
- Staff complied with 'bare below elbow' policy. Alcohol hand gel dispensers were accessible and fully stocked. We saw nursing and care staff using hand gel regularly. We did not see a poster explaining how to wash hands thoroughly.
- We checked toilets including the toilet for disabled people. They were visibly clean and there was a signed sheet to show that the cleanliness was regularly monitored.
- There were arrangements for treating infectious patients while minimising the risk to others. Infection control measures included seeing the patient at the end of the list, removing excess furniture and ensuring that staff wear personal protective equipment. The equipment would then be cleaned afterwards. If the patient had an infectious disease, then diagnostics team would inform the infection control team. They would trace all contacts and alert the ward that the patient arrived from.
- Some sinks in outpatients did not conform to HBN 00 09 which stipulate that there should be no plug or overflow trap, as this can cause a build-up of bacteria.
- We observed a cleaning log checklist in diagnostics which was up to date. The service had its own cleaner so any room or piece of equipment could be cleaned promptly. For example, we noticed that the x-ray machine was cleaned without delay between patients
- Arrangements for managing clinical waste and samples in diagnostics kept people safe. Radio isotopes are kept in a locked room on site following use. Radioactive waste was checked and logged with Geiger counter readings. If it had decayed in storage it was then disposed of in clinical waste. It was then kept behind locked doors.

Environment and equipment

- The minor operations room at St Margaret's Hospital was not fit for purpose. The room was used for the removal of lesions, skin flaps and warts. It was clean but two open windows near the couch were covered with stick-on plastic which was peeling off. The paint work

was chipped and there was no specialist ventilation. During our inspection we noticed that a patient had received a skin graft procedure in this room. The trust confirmed that this procedure should be carried out in an appropriate day surgery environment. The trust immediately decommissioned the room until such time as they could be assured that an appropriate environment could be provided.

- Staff checked resuscitation trolleys and other equipment regularly at Princess Alexandra Hospital and St. Margaret's Hospital, reviewing loose items daily and sealed items weekly. Trolleys in outpatients also had a signed sheet to show they were checked on a daily basis. Sharps bins (bins for used needles and syringes) were kept in separate lockable areas and labelled with an expiration date. All items we saw were within their date. Posters were on the wall reminding people what to do in the event of a sharps injury.
- At all Princess Alexandra Hospital clinics there were safe arrangements for transporting blood samples. All blood samples were sent to the laboratory in approved containers.
- The diagnostic imaging service ensured that it was up to date with technological developments. As a reference site for major equipment manufacturers, it tried out new equipment and passed on learning to other sites. This led to upgrading of the scanners. .
- The diagnostic imaging department took into account the risk to staff as well as patients from imaging, and ensured that specialised personal protective equipment was available. For example, one consultant wanted to stay with a patient during isotope treatment and had reached the limit for safe exposure. The department ordered a made to measure radiation suit for them.
- Effective controls were in place to control the risk of radiation. Staff had radiation dose badges with their own initials on and management kept a regular audit. One radiologist had excessively high doses due to biopsies in the room and the service organised a made to measure protective suit for them.
- Nuclear medicine had a separate waiting area and a separate toilet to avoid any radiation risk.

Medicines

- The outpatients department had safe arrangements for medicines. Doctors and clinical nurse specialists issued prescriptions which were dispensed from the in-house pharmacy. FP10s (prescriptions so that medicines could be obtained externally) were issued only out of hours of if the product was not available in-house and rarely used.
- In-house prescription forms and FP10s were stored securely in a locked cupboard within a locked room. The prescription pad was signed out to a doctor for a clinic, and then checked back into cupboard at night. There was a minor discrepancy in the doctor's recording of prescriptions in one book when we inspected. When we raised this with the team it was investigated.
- Medicines were stored in a locked cupboard in a locked room.

Records

- The system for ensuring that medical records were available for clinics was unreliable. The trust's own incident recording system showed that in the last year, there were twenty five reports of notes missing, incorrect or incomplete for outpatients in the Princess Alexandra Hospital, seven for Herts and Essex Hospital and nine for St Margaret's Hospital. There were also incidences of clinicians using the wrong set of notes and of a member of the public finding medical records on the floor. Sometimes, the absence of correct records meant that patients had to wait while the issue was resolved or return another day for another clinic time.
- Delays in delivering medical notes had the potential to put some patients at risk. Although medical records aimed to deliver notes to clinics during the evening before the appointments, this did not always happen with clinics in other locations such as St. Margaret's Hospital. When this occurred, we heard that some consultants took a history or basic details from the patients. Some patients were seen on this basis and others were asked to come back as soon as possible. This meant that for some patients a definite diagnosis would be delayed. The trust could not supply us with audits on the number of medical records which did not arrive to clinics.
- Staff at Wych Elm told us that on a daily basis there were appointments with no patient notes available. Therefore patients were delayed in their appointments as clinicians did not always have a GP referral letter for new patients. The receptionist rang other departments to find notes which sometimes made the clinic run late. Staff suggested that the solution was to scan in the GP

letter so at least there would be some information electronically on the system. However, at Wych Elm, even if the notes were not present, the patient usually had their appointment with the consultant.

- Managers told us that there was a tracking system for patient notes. However, administration staff told us that there were problems with the flow and storage of notes and filing notes again after the clinic. This was due to lack of time or lack of storage boxes, especially in satellite locations such as St. Margaret's Hospital. In Princess Alexandra Hospital, one patient told us that they had gone in search of their own notes in another part of the hospital when staff were unaware of their appointment for a scan.
- Staff tried to ensure that records were kept in lockable rooms. Boxes of notes were left in a public area in St Margaret's Hospital in February 2015 until a nurse reported a concern.
- During our unannounced inspection of St Margaret's Hospital we reviewed the record of minor procedures undertaken in dermatology outpatients. We found that these were incomplete. For many patients the nature of the procedure was not well documented and consisted only of "mid back" or "right ear." One patient did not have any operation recorded but only had the fact that they had four sutures undertaken. We raised our concerns with the trust who took action to address these deficits in record keeping. A review of the notes of the patients we highlighted was undertaken to ensure that record keeping in the patients notes was of an acceptable standard.
- The trust recognised there were problems with patient records. They recruited a project manager in post from 1 July 2015, to troubleshoot the problems. These included ensuring that the logistics were in place to transport the records, analysing capacity and flow and addressing staff sickness in medical records. Ultimately, the trust aimed to scan the records and then transfer them to the electronic patient record system (Cosmic).

Safeguarding

- Staff understood safeguarding arrangements and received training to Level 2 or level 3. Outpatients improved their safeguarding training compliance rates which was 76%. This was below the trust target of 90%. In diagnostics, 98% of staff were trained on safeguarding level 2.
- Nurses and health care assistants understood what to do to protect patients from avoidable harm. They logged any areas of concern on the incident reporting system and took action to alert the safeguarding lead about adults or children who were at risk of harm.

Mandatory training

- Compliance with mandatory training was at 80% in outpatients. This comprised of the three outpatient areas with outpatient staff at The Princess Alexandra Hospital achieving 95% compliance, St Margaret's Hospital achieving 75% and Herts and Essex Hospital achieving 85%. However, some clinics were well below this standard. These included ophthalmology (50%) where 38% of medical staff had completed training and in oral surgery 50% of medical staff had completed mandatory training. 56% of staff had completed equality and diversity training.
- Staff had protected learning time so that they could do their training. Staff told us that this was because the training module was three hours long so it was difficult to attend in one session.

Assessing and responding to patient risk

- During the period of non-reporting of referral time to treatment the trust the trust put in place a manual system to review the numbers of patients waiting for appointments. In January 2015 they began to risk assess patients waiting over 52 weeks to ensure that there was no harm coming to these patients. At the time of this inspection the trust had completed nearly 80% of this work. This meant that patients who were waiting were clinically assessed to maintain their safety.
- Outpatient's staff carried out a regular check on patients in the waiting room so that they could respond to any change in a patient's condition, or offer medical help if needed.
- Staff knew what to do if a patient became unwell. Outpatients and diagnostics had had processes in place for medical emergencies. Named members of staff were trained on cardiac procedures.
- Risk registers did not necessary lead to appropriate action to mitigate risks. The services identified some risks to patients but the registers were not comprehensive .For example, they did not include the risk in the minor operations room at St Margaret's Hospital.

Outpatients and diagnostic imaging

- Diagnostics had clear processes in place to minimise patient risk. We observed nurses working through a handover sheet when a patient went to diagnostics from outpatients. The service had a standard procedure for each type of diagnostic. Nurses also observed patients after their diagnostic procedure and completed after care sheets. They had a standard operating procedure to follow if there was a problem post procedure. With a procedure such as angioplasty, staff rang patients at home the day following the procedure to check patient's welfare.
- There were comprehensive arrangements for managing risk in diagnostics. The service had access to a radiation protection advisor located at another NHS Trust but also had an on-site representative and radiation protection supervisors in each service. The service learnt to improve its communication with women patients who could be pregnant after x-raying a female patient in the early stages of pregnancy who gave her consent to the procedure. As a result it developed a more rigorous system of using a calendar to check the patient's last period date and the likelihood of pregnancy.
- Requests for x-rays could be either electronic or by paper. Specialist nurses could order x-rays but only if they had the appropriate training certificate.

Nursing staffing

- Clinics assessed their nurse staffing needs. Nurses told us that they planned their rotas around clinics some weeks ahead and the number of patients with planned appointments. In most cases there were two nurses per clinic.
- Nursing and care assistant staff were rotated between clinics on all three sites. The service currently had no vacancies for nurses.
- Staffing was reviewed against the needs of individual clinics. Some clinics required more staff than others. For example the gynaecological clinic required extra staff available to chaperone patients.
- Sickness was not significant and there was limited use of agency or bank nurses. However, the ophthalmology service used around 15% bank and agency staff.
- Most nurses were experienced and there was a range of skills within the departments. The service had recruited a registered children's nurse and this nurse was due to start in August 2015.

Medical staffing

- Clinicians and managers in outpatients assessed the medical staffing needs for clinics and flexed these to meet needs of individual clinics.
- The trust was recruiting a third consultant to the haematology service as referrals had increased. At the present time they were using a locum to ensure that these patients received treatment.
- In diagnostic and imaging services there were no vacancies for medical staff. After 9 pm radiology is outsourced to a private provider to ensure cover. There were systems in place to ensure appropriate cover over the holiday periods.

Major incident awareness and training

- Radiology had clear policies for major incidents. This included a command and control approach and a major incident control pack in the department at all times.
- Arrangements were in place in case of a radiation or radioactive incident. This procedure was in the radiation incidents reports section of the radiation protection folder, with a list of notifiable occurrences and specified taking equipment out of service immediately.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

Diagnostics had protocols and organisational arrangements in place to ensure that imaging procedures were effective. They used national and local audits in order to keep up with best practice. Work on this was less developed in outpatients. All services had appropriate arrangements for consent and knew when they had to involve others due to mental capacity issues.

Staff were suitably qualified and skilled to carry out their roles effectively. Staff received relevant training and appraisals. There were good examples of staff working collaboratively to meet patients' needs, for example in cancer multidisciplinary teams.

Evidence-based care and treatment

- Outpatients were behind schedule with clinical audits, according to the six monthly management review report. Attendees at the June 2015 outpatient's board

were asked to make suggestions for possible clinical audits. The trust carried out audits of pathology in 2014 (sentinel lymph node sampling in carcinoma and squamous cell carcinoma) which resulted in action plans for improvement. The trust had not audited the improvements.

- The eye unit kept up to date with protocols and compares its processes with Moorfields Eye Hospital. This did not provide any resulting action plans.
- Diagnostics and imaging services based their processes on best practice. They carried out Radiology Royal College Audits. They held monthly discrepancy meetings to discuss any scans which might have missed something. There was an anonymous box for staff and clinicians to report this. Following a peer review process any decisions on actions are made in the group.
- Diagnostic imaging used clinical audits as a way to ensure that its practices were based on NICE/Royal College guidelines. For example, there is a designated audit lead that chaired and managed the departmental database of pre and completed audits and they used Royal College Audit Templates.
- In diagnostics we saw a range of protocols including a procedure for patients who were unable to complete the safety questionnaire.
- There was a standard operating procedure for staff to follow for each type of diagnostic imaging. There were also aftercare sheets and a clear process to follow if patients had a problem after their procedure.

Nutrition and Hydration

- In the main outpatient's corridor, nurses conducted an hourly clinic round to ask whether patients were comfortable and if they needed refreshments.

Patient outcomes

- Cancer services took part in the NHS England National Peer Review Programme based on the National Institute for Health and Care Excellence guidance. This resulted in recommendations for the trust to act on, such as the need to provide a second bronchoscopy list. The trust was analysing capacity and demand with a view to meeting this need.
- Diagnostics managers and clinicians analysed care pathways to improve outcomes for cancer patients. They were successfully implementing timed stages of treatment which reduced cancer wait times, particularly for prostate cancer.
- From January 2015 the service gave patients an MRI scan before moving to biopsy which has saved time and provided more complete information. This had considerable impact as cancer was comparatively significant in the local male population. The service still had work to do around colorectal cancers which were also above the England average locally.
- Cancer service staff regularly carried out audits to ensure that patients were seen within 62 days. This led to individual problem solving on behalf of the patients.

Competent staff

- Staff had the skills, knowledge and experience to deliver effective care and treatment.
- Outpatient services had processes in place to improve individual and team performance. We heard how nursing staff would have a mentor assigned to them if they had made a mistake. They would not be allowed to work autonomously.
- Health care assistants and nurses told us that there were audit days to inform staff of performance and highlight further action. These were also used for training, especially if staff needed training on new equipment. Staff considered them to be very useful.
- Staff had an annual appraisal meeting with their line manager. We saw that 80% of staff had received a recent appraisal. However, the opportunity for a regular one-to-one meeting offering supervision and support between appraisals was limited. Staff felt this was because of their rota arrangements which meant that they had to work across the three sites of St Margaret's Hospital, Princess Alexandra Hospital and Herts and Essex Hospital.
- Senior management told us they planned to launch a band six development programme to acknowledge the leadership skills of this grade and make the most of their potential.
- Staff administering radiation were appropriately trained to do so and sub specialities and satellite locations conformed to the radiation protection policy. The register of trained staff included staff at other locations such as dental staff at the Bevan building. All staff working in the controlled area received radiation safety training.

Multidisciplinary working

- Multidisciplinary teams worked well. This approach enabled improvement work, particularly in the chest

and urology specialities. New consultants joined with new ideas. The NHS England national peer review programme (May 2015) described the multidisciplinary teams as well organised and enthusiastic. All core members were in place apart from a member of the specialist palliative care team and there were good cover arrangements agreed for all other disciplines. .

- All diagnostic procedures were monitored within multidisciplinary teams to monitor progress. This included monitoring of outcomes performed by doctors. Consultants also had a monthly audit meeting to ensure the service was continually learning.

Seven-day services

- Senior managers told us that they were undertaking a seven day working pilot for therapies to start this process in outpatients.
- Diagnostic Imaging provided a seven day service, with new staffing arrangements. Managers and staff recognised that it was more efficient to utilise scanners as much as possible.

Access to information

- Access to information between services was variable. The trust's own incident reporting log for the last year showed that sometimes patients were not collected for their MRI scan, two- week wait patients were coded wrongly, patients were sent to the wrong location and that test results were sometimes not communicated to other clinicians. Managers told us that there was scope to standardise procedures across clinics in outpatients.
- Clinical coding of outpatient's notes was sometimes incorrect as some clinicians were unfamiliar with the coding system. This meant that extra work was created as administrative staff had to correctly code notes which had previously been mis-coded.
- The trust had a system for auditing patient records. Every week the patient quality and safety audit team chose five sets of notes at random, and reviewed any omissions with staff, reminding them of hospital policy. In addition, clinicians conduct a medical records audit which is random check of 10 sets of notes from each speciality. We reviewed three sets of notes at the Bevan building (dental and dermatological) and found that they were fully completed, easy to read and included consent forms
- Diagnostic test results were available electronically, which facilitated communication throughout the hospital**.** Outpatients communicated results to GPs by letter, and patients told us there was sometimes a delay of up to a month, as there was a typing backlog.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff we asked in outpatients and diagnostic and imaging services were aware of their duties and responsibilities in relation to patients who lacked mental capacity to make decisions. They knew the procedures to follow, including involving champions and other professionals, so that a decision could be made in the patient's best interests.
- Outpatients had forms for consent and we heard from patients that consultants explained the options and risks clearly, before signature.
- Diagnostic and imaging services had clear arrangements for consent. There was a departmental policy document to guide decisions. They tracked consent on forms and if a patient did not have the capacity, team clinicians and radiologists worked together to complete a best interests form.
- We saw that in diagnostics, female patients from the age of 12 to 55 had risks explained to them and were asked to sign a pro-forma to confirm their understanding. Consultants also used the WHO checklists for interventional radiology to ensure that patients knew what they were consenting to.

Are outpatient and diagnostic imaging services caring?

Good

Patients were treated with kindness, dignity, respect and compassion when receiving care and treatment.

Patients spoke positively about how they were treated by staff. Consultants gave patients helpful information so that they could make their own decisions about care. Outpatient feedback was mixed, but diagnostics patient feedback was good.

Compassionate care

Outpatients and diagnostic imaging

- Staff and clinicians in outpatients delivered compassionate care. We heard from patients that their dignity was maintained and that staff and clinicians were kind, respectful and caring. We observed care assistants and nurses interacting with patients and speaking to them appropriately. For example, supporting elderly patients to walk to their clinics and using appropriate humour.
- Friends and family test results varied. Between April and June 2015, over 80% of patients were extremely likely or likely to recommend the hospital if they attended the main outpatient's area, Herts and Essex hospital, Alexandra Day Unit or the Williams Day Unit. Only 48% of eye unit patients were extremely likely or likely to recommend the hospital because of long in-clinic wait times. Wych Elm also saw a decline in satisfaction in June but the service has not analysed this. In June 2015, the trust had not started Friends and Family surveys at St Margaret's' hospital.
- At all sites the trust has a token system to obtain immediate patient feedback. These tokens were completed by patients and posted into the appropriate box labelled extremely likely, likely, unlikely so that the service could see how well they were doing.
- In all areas, nurses and doctors routinely offered patients a chaperone. A poster advertising the chaperone policy was displayed on consulting room doors.
- Radiology feedback on the Trust's own token cards indicated that 100% of patients would recommend the unit. We observed diagnostics staff interacting with patients in a gentle and polite way. There was no formal Friends and Family assessment in diagnostics.

Understanding and involvement of patients and those close to them

- People we spoke to within outpatients told us that consultants gave them information so that they could make their own decisions about care. For example, a patient told us that her consultant explained the risks and benefits of different sorts of arthritis medication, and made sure the next step was the patient's own choice .
- We spoke with patients who told us that consultants and nurses made sure that they understood when their next appointment would be. They received a copy of any correspondence sent between the hospital and their GP. They could also contact a named person if they were worried about their condition or treatment after they left hospital.
- Staff and consultants ensured that diagnostic and imaging services patients had appropriate post procedure plans and received relevant information, and encouraged them to ask questions about their condition.

Emotional support

- Patients we spoke to in outpatients thought staff were helpful, caring and supportive. Other patients told us that consultants rang them at home between appointments, and encouraged them to ring them at the hospital is they were anxious.
- Survey findings indicate that the service did not help patients deal with bad news. Feedback from the National Cancer Patient Survey in May 2015 placed the trust in the bottom 20% with regards to the question 'patient felt they were told sensitively that they had cancer' and 'patient told they could bring a friend when first told they had cancer.'

Are outpatient and diagnostic imaging services responsive?

Inadequate

The outpatients department was inadequate as it did not ensure that patients were consistently offered timely access to care. The trust was not currently reporting the referral to treatment times due to information technology issues. There was a significant backlog of patients waiting for appointments across the three trust sites. There were administrative problems and a high proportion of patients who did not attend appointments. Patients were often double or triple booked into appointment slots which caused excessive waits within the department. Cancer and diagnostics had improved their response times but all services needed to improve so that patients can expect a good performance consistently. The services adapted their approach to some patient groups but more could be done to tailor services to children and older people. Systems for learning from complaints were effective.

Outpatients and diagnostic imaging

Within the diagnostics department we found that waiting times were responsive and staff ensured that an individualised service that was responsive to the needs of patients was provided.

Service planning and delivery to meet the needs of local people

- Patients could choose which outpatients department they would like to attend at GP referral stage. This could be at Princess Alexandra Hospital, St Margaret's Hospital or Herts and Essex Hospital. Those with urgent needs, such as two-week cancer wait patients were given the first available slot, regardless of location.
- Outpatients departments included comfortable seating, toilets and magazines and had a water dispenser and access to a vending machine for drinks and snacks. They also included a notice board with contact details and 'you said, we did' feedback.
- Physical access to the Wych Elm building needed improving. There was no dropped curb for wheelchair access. Patients told us that the signposting was 'awful' and that sometimes it was not obvious which building they had to attend.
- Staff updated the white board with clinic delay times so that patients knew how late the clinic was running. A notice also informed patients that they could give their car registration details to a nurse to avoid any problems is they exceeded their parking time.
- Demand for eye clinic services was high. Staff told us that the service was overbooked, and the building was too small, especially as it was shared with audiology and the ear nose and throat clinic. There was no plan to adapt this to future needs.
- The eye clinic building did not offer a patient friendly environment. Although it was bright enough for patients with sight difficulties, and used black on yellow signage, it was cramped and too small for the number of patients. This meant that patients had little privacy when discussing their details at reception.
- Some outpatient locations and equipment were unsuitable or outdated. Although many of these issues were on the department's risk register, they were not resolved. For example, at Princess Alexandra Hospital the eye clinic, although bright and clean, was too small for the number of patients. At St. Margaret's Hospital, there was a lack of bariatric couches. There were also specific issues with the Wych Elm building, which was across the road from the main site. This location lacked wheelchair access.
- The x-ray department had an air conditioned environment with a waiting room and a patient screen to relay information including waiting times. The CT scan preparation area was also patient friendly and promoted patient dignity. It had a private, calm area where patients could change into gowns and sit separately. The ultrasound rooms included good segregation of patients (male/female and inpatient/outpatient). It had coded doors to control areas and restrict access.
- The service had clear service level agreement arrangements in place for outsourcing services. The agreement for dexa scanning specified a five week turnaround and seven day arrangements for reporting.
- The Princess Alexandra Hospital site had insufficient car parking and public transport in place for outpatients and diagnostic imaging patients. For those patients who could find a space, nursing staff tried to help reduce anxiety caused by outpatient clinics overrunning by taking a note of patient car registrations so that patients didn't have to pay extra.

Access and flow

- The introduction of the cosmic system, a new electronic patient management system, meant that the trust was unable to calculate accurately the waiting times for patients attending the outpatients department. The trust was not currently reporting referral to treatment times but some local information was available. The trust aimed to return to national reporting by the end of September 2015.
- According to trust's figures (invalidated and not reported nationally), In June 2015, no speciality achieved the non-admitted target of 95% patients receiving definitive treatment before 18 weeks. Overall the trust treated approximately 84% of patients within 18 weeks (invalidated). Certain specialities with high demand such as general surgery, ophthalmology, oral surgery, trauma and orthopaedics and urology, fell short of achieving the standard. However, in April 2015 and May 2015, the hospital achieved the 95% non-admitted target for breast surgery, the only speciality which achieved the standard.

Outpatients and diagnostic imaging

- Some patients waited a long time before their first definitive treatment. The trust confirmed that 333 patients had waited over fifty two weeks. Some of these patients had waited in excess of seventy weeks. They were waiting for cardiology, ear nose and throat, orthopaedic or ophthalmology. The chief executive informed us that the trust were prioritising ophthalmology patients for appointments but that cardiology had reported a backlog of 2,125 patients which were being held on a waiting list that the system was unaware of. These patients were currently being reviewed to assess clinical need.
- The trust was setting up tracking arrangements and treatment plans for individual patients and made it a priority to see patients who had been waiting over a year. The trust anticipated that all patients waiting over a year would have been reviewed by September 2015.
- The trust had a systematic approach to assessing the risk to these outpatients who waited a long time. As of January 2015 they validated the patient's details, and then contacted the GP or patient if they needed further details, and then assessed the patients at a clinical harm review meeting, with consultants. These reviews were continuing until the end of August 2015, but at the time of our visit there was no evidence that any patient had been harmed.
- Outpatients had out-of-hours clinics, mostly in the evening and on Saturday mornings, in cardiology, orthopaedics, rheumatology and ophthalmology. The eye clinic had a backlog of more than 3000 patients and was validating and prioritising these cases. Evening clinics were available at the eye clinic from November 2014. However, lack of staff and rooms to run the clinics were a constraint. Patients for other specialities also had long waits. Rheumatology patients told us they had to wait eight months for an appointment.
- After introducing Cosmic, there were a number of initial problems. These included patients not receiving appointment letters or not getting follow up appointment letters. Short notice re-booking of patients led to an increase in patients not attending, commonly known as did not attend (DNA).
- During October 2014 did not attends reached a peak of 14.5% at Herts and Essex Community Hospital, 12.5% at St. Margaret's Hospital and 10% at Princess Alexandra Hospital. Although improving slightly, this problem persisted throughout the first half of 2015, with overall did not attend figures for April, May and June 2015 at 7.98%, 8.23% and 8.58% respectively. Within these statistics, did not attend figures for some specialities were in excess of 10% such as ear nose and throat, gastroenterology, colorectal surgery, neurology, paediatrics, and urology. The trust had analysed the reasons for this and had developed actions to address which were being monitored as part of a weekly meeting.
- The trust had vacancies within the booking department which impacted upon the flow of the department. Some clinic appointments were double or treble booked, so two or three patients arriving for the same appointment time. This led to clinics running late. We observed during our inspection that the ophthalmology, rheumatology and orthopaedic clinics were running between thirty minutes to an hour late. Staff marked up the waiting times on a notice board so that patients would know. Senior management acknowledged that waiting times in-clinic were a problem.
- Many patients were unhappy with the waiting times for an appointment. In some specialities, they told us that it was difficult to get an appointment in the first place. For example, some patients awaiting ophthalmology appointments were so anxious to know when their appointment would be, that they dropped in to the eye clinic regularly to enquire about where they were on the list.
- Patient experience was adversely affected by short notice hospital cancellations. Staff told us about short notice cancellations, notably in cardio-angiography where some of the equipment was old and prone to break down, and at St Margaret's where clinics had had to be cancelled due to the lack of a consultant. However, the chief executive had worked with clinician's leaders to reduce short notice cancellations. This led to better teamwork by clinicians to ensure that clinics were fully staffed and short notice cancellations reduced.
- Overall, outpatient's services held around two follow ups for every new appointment. The ratio of new appointments to follow ups in April, May and June 2015 was 1.98, 1.9 and 1.76 respectively, indicating a slight focus on new appointments, and a lower rate of follow up than the national average. However, in certain specialities there were three to six follow ups for every new appointment, for example, nephrology, general medicine, obstetrics, oncology, optometry and rheumatology.

Outpatients and diagnostic imaging

- Projects were under way to resolve performance problems and to improve outpatient access. The trust had a programme of improvement initiatives which included assessing capacity against demand, gauging new to follow up ratios, re-thinking the access policy and improving data quality. It was continuing to validate patient details and needed external resources to do this. Patient did not attend rates were reducing in some specialities because of better communication.
- Cancer services improved their performance over the last year. In the third quarter of 2014/2015, the percentage of people seen by a specialist within two weeks (urgent GP referral) improved to England average levels. The percentage of people waiting less than thirty one days from diagnosis to first definitive treatment improved to better than the national average over the same time. More recently, the trust improved its performance on people waiting less than sixty two days from urgent GP referral to first definitive treatment.
- The waiting time for a cancer scan has reduced from ten to seven days. This was achieved by introducing seven day working, having dedicated scanning lists over a weekend to improve patient attendance rate for people with work commitments, introducing new standard operating procedures for booking staff and weekly monitoring of lists. Scans were also prioritised for two week wait patients.
- Diagnostic imaging performance from April 2014 to June 2015 consistently met the six week standard and was aiming for four weeks for some types of scan. However, outsourced performance on dexa scanning in June 2015 only met the six week standard in 70% of cases.

Meeting people's individual needs

- Staff were trained on domestic violence issues and could respond sensitively as required. The Daisy project within the trust provided all outpatient staff with domestic violence awareness training.
- The eye clinic adapted its information to the needs of partially sighted people. The clinic routinely sent letters in large print to patients. Receptionists also helped patients through the clinic on arrival and read any relevant leaflets to them.
- There were learning disability and mental health champions within outpatient services. It was part of their role to look after these patients and minimise their anxiety. The aim was to provide the appointment early in the day, so that the patient could be home as soon as possible. They also ensured a chaperone was present.
- The outpatients service co-ordinated its activities effectively to meet the needs of patients with dementia. As with all vulnerable patients, the service arranged to see vulnerable patients early in the day and return home as soon as possible, to minimise waiting in an unfamiliar place. Staff told us that patients living with dementia were always chaperoned. The department had a dementia champion to represent the interests of this patient group and advise the wider team.
- The outpatient's service had a limited approach to meeting the needs of some groups. For example, the service recognised that it had no couches for bariatric patients and entered this on the risk register. The service had some bariatric seating in place but there were very few extra wide seats available at any site. In diagnostics, there was a special trolley for bariatric patients and the hospital could order in special scales and bariatric beds if needed. Scanners were suitable for patients up to 32 stone.
- Patients told us that they could choose to have a phone call or text reminder of a clinic appointment butt letters could take a good couple of weeks to arrive. Some patients felt that the outpatient's service was 'trying to squeeze too many appointments into one day' and that there was a need to 'sort the workload out. '
- Very elderly patients had the same wait times in clinics as other patients. In the eye clinic we spoke with a lady in her 90's who explained that she was at the eye clinic for two hours every time she visited.
- The quality of information given to outpatients was variable. For example, at St. Margaret's skin services clinic, this information was on a poorly photocopied leaflet. In other clinics the leaflets were more attractive.

Learning from complaints and concerns

- Outpatients and diagnostic imaging had clear processes for patients to complain. How to complain information was openly displayed. For example, on a noticeboard in Bevan building, a priority was to resolve a complaint informally. If someone wanted to complain officially, staff understood the system and could explain it to patients. The radiology manager would also set up a meeting with the complainant and the Patient Liaison and Advisory service to sort out any resolution locally.

The matter would then be recorded on the electronic incident recording system so that the learning could be shared. The aim was to resolve any official complaint within 24 hours.

- Outpatient's clinics learnt from feedback. For example, in the eye clinic they invested in new seating as a result of patient feedback. However, most complaints in the eye clinic are about clinic wait times
- The diagnostic department learnt from feedback. Patients were unhappy with wait times after arrival. Diagnostic staff adjusted appointment times so that patients could come in just before their procedure instead of all patients attending at the same time. The most common complaint in diagnostics had been the waiting time to have a scan which has now reduced and the average wait was three weeks at the time of our inspection.

Are outpatient and diagnostic imaging services well-led?

Requires improvement

Outpatient services require improvement to ensure that leaders address the known issues within the department. The management team which oversaw outpatients and diagnostics was new. Whilst plans were in place and managers were aware of these the implementation and resolution of the issues the implementation of these plans was slow and only addressed those patients waiting over 52 weeks for an appointment The department had yet to resolve the issue of patients being double or triple booked for an appointment thereby incurring excessive waiting times in the department. This impacted on the experience of the patient. The outpatients' team were still developing governance arrangements, but the meetings and reporting structure reflected a focus on safety, quality and staff involvement. The need to improve patient access and outcomes had led to some innovations, for example, timed pathways.

Vision and strategy for this service

- The management team recently restructured and this led to closer working within outpatients and diagnostic services. The trust had a clearer vision within the Cancer and Clinical Support Services group. The restructure within the service provided an overview, better clinical leadership and teamwork.
- Senior managers were also working on improving staff engagement and recognition.
- Staff received training on the trust's values and these were clearly communicated by the team.

Governance, risk management and quality measurement

- Since the restructure in the clinical support health group, managers had implemented a clear meeting structure and governance arrangements. Managers felt that the new arrangements promoted nursing and clinical leadership. However, these were yet to be embedded.
- Monthly business meetings were held to review a clinical dashboard which was being developed, which included data on patient experience, staff training, progress with medical record management. Heads of the teams met weekly, and there was also a monthly budget review meeting.
- Outpatients and diagnostic imaging held risk registers, and used these to take action to mitigate risks. However, the outpatient's register concentrated on risks relating to the tired fabric of some of the buildings, and did not include some of the operational risks, such as not meeting demand for outpatient's eye appointments, or a replacement x-ray machine for the Bevan building.
- Staff were clear about their roles and what they were accountable for. At the same time they felt that managers were helpful, visible and approachable. There were weekly visits to satellite clinics, for example a weekly matron's visit to St Margaret's Hospital.
- An outpatient's management group met to address problems within outpatients' access and performance. Although in the early stages, this aimed to resolve issues around capacity, did not attend appointments and short notice cancellations. At a corporate level, the trust initiated daily meetings to try to resolve issues around the long waiting patient clinic times, patient access and achieving the referral to treatment 18 week standards. However, work had been slow and only addressed the risk to those patients waiting over 52 weeks for an appointment. This meant that there were significant

numbers of patients who were not being clinically prioritised for appointments and the department and the trust were not aware of the potential risks to these patients.
- A monthly patient safety and quality forum analysed quality issues, such as a delay in turnaround of a CT report and a skin tear on mammogram. This aimed to avoid similar incidents in future. This information was transferred to the clinical and cancers support services group management meetings and the trust Board monthly health group board.
- Diagnostic imaging had its own governance arrangements including a mortality and morbidity monthly meeting.

Leadership of service

- Staff within the outpatient's service told us they had good leadership support and that local leaders were capable and demonstrated good teamwork. They understood the challenges to good quality care and could identify the range of actions needed to address them. For example, the need for diagnostics and outpatients to work more closely to achieve better outcomes for patients.
- Managers were in touch with day to day issues. We heard how they would support bids for training and business cases for better equipment and increased staffing. The extent to which individual managers met with staff varied this could be every month or every quarter.
- Diagnostics was proactive in ensuring that it generated income for the hospital and met the local population's imaging needs. We heard how managers developed business cases to ensure the strategic future of the service.

Culture within the service

- There was a positive culture within the diagnostic and imaging service. Consultants and staff we spoke with were pleased to be part of a clinically led organisation. Many had training in organisational values and felt that the corporate leadership team were approachable.
- Managers within the service reported that they attended the chief executive's monthly brief and found it very helpful.
- Clinicians in the outpatient's service thought it was a good place to work and compared well with other hospitals of a similar size. They also felt there were good opportunities for staff to progress within diagnostics.
- Many of the staff we spoke with had worked for the trust for five years or more. Some staff were even longer serving and were proud to work for the trust.

Public engagement

- Staff within outpatient and diagnostic imaging services encouraged patients to give their views. In all outpatient waiting areas we saw the feedback from token cards. These were customer satisfaction cards which patients or relatives could post into a box in the department. They also included open questions so that patients could give their views rather than tick boxes.
- The service put 'You said we did' information on noticeboards so that patients could see what action the department had taken. For example, it had taken action on car parking tickets for patients delayed in clinics.

Staff engagement

- Two months prior to our visit, managers commenced a staff experience group which had met twice. This led to work, putting some staff ideas into practice. For example, parking for phlebotomists dropping off urgent bloods, photo boards for children in children's phlebotomy, and staff recognition awards.

Innovation, improvement and sustainability

- Local leaders were working towards improvement and innovation. They analysed and changed lung pathways so that patients went straight to diagnostic testing from the GP. As a result, the consultant already had test results by the time the patient arrived for the first clinic appointment. The process is shorter and more efficient, and the patient could start treatment sooner.
- Managers analysed pathways to improve quality and timeliness of care. This analysis had resulted in time targets for sections of the patient pathway in order to ensure that care was more efficient.
- Diagnostic imaging provided one stop arrangements where possible. They had a state of the art interventional suite which enabled patients to have several procedures. The diagnostic service invested in equipment to improve efficiency and patient flow. The

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new interventional unit provided a number of diagnostics and so provided patients with the opportunity for a one-stop shop approach to their tests. It was also an income generator.

Outstanding practice and areas for improvement

Outstanding practice

- The acting ward manager for the Dolphin Children's ward had made a significant improvement in a short time to the ward and showed outstanding leadership and determination.
- The play specialist providing dedicated time to fundraise to purchase toys and set up playgroups for the children was outstanding.
- The teenage zone within the children's ward was outstanding and was very responsive to the needs of teenagers.
- The gynaecology outpatient and emergency service as a function, including the termination of pregnancy service was outstanding and provided a very responsive service which met the needs of women.
- The outcomes for women in the maternity service were outstanding and comparable with units in the top quartile of all England trusts.
- The permanent staff who worked within women's services were passionate dedicated and determined to deliver the best care possible for women and were outstanding individuals.

Areas for improvement

Action the hospital MUST take to improve

- Ensure that there is a system in place to protect patients from avoidable harm whilst awaiting an outpatient appointment.
- Ensure that an end of life care pathway is in place so that patients receive appropriate care and treatment.
- Ensure that disposable items of equipment are not reused on patients.
- Ensure that the maternity unit is secure and that there is an effective system in place to ensure the safety of babies from abduction from the unit.
- Ensure that the child abduction policy is updated, reflective of current practice and tested.
- Ensure that the escalation policy is reviewed to prevent medical outliers being placed on the birthing unit at times of high capacity.
- Ensure that medicines administered to patients take into account the patient's allergy status and that the policy for the administration of medicines is adhered to. That medicines are stored appropriately and that appropriate checks are maintained to ensure the safety of medicines.
- Ensure that all staff are appropriately trained, appraised and inducted for their roles, including agency and temporary staff.
- Ensure that equipment is checked in accordance with trusts policies including resuscitation equipment.
- Ensure that all guidelines and policies within the children's accident and emergency high dependency room are up to date with current practice.

Action the hospital SHOULD take to improve

- The trust should continue to work towards improving the levels of all disciplines of staff in order to provide appropriate staffing levels and in order to provide a seven day a week service.
- Review the provision of maternity services at the trust to ensure that the service provision can be sustained beyond the next twelve months.
- The trust should review the level of understanding of the major incident policy amongst all staff.
- The trust should review the level of understanding of safeguarding processes in the children's and young people's services.
- Review the information flows within the directorates to ensure that all staff are aware of audit information and learning from incidents and complaints to improve services.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The hospital did not ensure that care and treatment was provided in a safe way for patients in that: Patients awaiting outpatient appointments were not clinically prioritised. Disposable equipment was not always disposed of after single use. The security of both children's ward and maternity departments was not maintained. The guidance on abduction of children was out of date. There were medical outliers on the birthing unit. Allergy status was not recorded on patients charts. Medicines were not always administered or stored correctly. Agency and temporary staff did not receive an induction to the ward areas. Equipment was not always being checked in line with the trusts policy.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The hospital was not delivering person centred care as : The end of life care pathways was not consistently implemented or used to ensure that patients at the end of their lives received appropriate treatment in line with their wishes.

This section is primarily information for the provider

Requirement notices

Guidelines for children in the urgent and emergency care services were not up to date nor in line with current guidance.