Care Quality Commission

Mid Cheshire Hospitals NHS Foundation Trust

Leighton Hospital

Quality Report

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

Ratings

Overall rating for this hospital	Good
Urgent and emergency services	Good
Medical care	Requires improvement
Surgery	Good
Critical care	Good
Maternity and gynaecology	Good
Services for children and young people	Good
End of life care	Good
Outpatients and diagnostic imaging	Good

Summary of findings

Letter from the Chief Inspector of Hospitals

Leighton Hospital is one of three locations providing care as part of Mid Cheshire Hospitals NHS Foundation Trust. It provides a full range of hospital services including emergency care critical care, coronary care, general medicine including elderly care, general surgery, orthopaedics, anaesthetics, stroke rehabilitation, paediatrics and midwifery-led maternity care. The trust also provides outpatient services and a minor injuries unit at Victoria Infirmary and intermediate care services at Elmhurst Intermediate Care Centre.

Mid Cheshire Hospitals NHS Foundation Trust provides services to a population of approximately 300,000 living in and around Alsager, Crewe, Congleton, Knutsford, Middlewich, Nantwich, Northwich, Sandbach and Winsford.

We carried out this inspection as part of our comprehensive inspection programme.

We carried out an announced inspection of Leighton Hospital between 8 and 10 October 2014. We also carried out an announced inspection of the Victoria Infirmary. In addition an unannounced inspection was carried out between 5pm and 8.30pm on 24 October 2014 at Leighton Hospital only. As part of the unannounced visit we looked at the management of medical admissions out of hours.

Due to the size and nature of services provided at the Victoria Infirmary we have included our findings for this service within the core service reports for outpatients and emergency & urgent care services.

Overall we rated Leighton Hospital as 'good'. We have judged the service as 'good' for safe, caring, effective and well-led care and noted some outstanding practice and innovation. However improvements were needed to ensure that services were responsive to people's needs.

Our key findings were as follows:

Access and patient flow

- Due to the numbers of emergency admissions there was continual pressure on the availability of beds at the hospital. This meant that some patients were not placed in the area best suited to their needs. As a result the management of patient access and flow across the hospital was of concern and remained a significant challenge for managers. The hospital had made sound arrangements to ensure the timely medical review of patients. However, some of the areas used for escalation beds, especially the primary assessment area, did not provide an appropriate environment for the care of patients overnight. The trust had implemented the Golden Patient initiative to ensure that patients did not spend more than 23 hours in this area and were moved to a setting more suited to their needs at the earliest opportunity.
- There were occasions when patients were moved from ward to ward, sometimes at night due to pressures on bed availability.
- There were also pressures placed on bed capacity by the number of delayed discharges.
- Patient discharge letters were not always issued to GPs in a timely way. In addition the quality of information included in the letters varied considerably. This was of concern as poor communication with GPs and others can lead to delays and confusion in managing patients' care going forward.

Cleanliness and infection prevention and control

- Patients received care in a clean, hygienic and suitably maintained environment.
- Appropriate equipment was in good supply and was clean and well maintained.
- Staff were aware of and applied infection prevention and control guidelines.
- We observed good practices in relation to hand hygiene, 'bare below the elbow' guidance and the appropriate use of personal protective equipment, such as gloves and aprons, while delivering care.

Medical staffing

Summary of findings

- Medical treatment was delivered by skilled and committed medical staff.
- However, there were not always enough medical staff to provide timely treatment and review of patients, particularly during out of hours.
- Shortages of medical staff also meant that some patients waited for long periods in outpatients as medical staff were sometimes called to the wards or emergency department to see patients whose condition had deteriorated.
- The trust was working hard to recruit and retain consultants. It had a number of initiatives in place including cross working with neighbouring trusts and recruiting medical staff from overseas. These initiatives were helping to address medical shortfalls. Nevertheless, the shortage of medical staff meant that patients sometimes waited for extended periods of time to be seen by a consultant.
- There was also a shortage of trainee doctors. This was being taken forward by the Medical Director with the regional training schools, with a view to the trust being allocated a full complement of trainee doctors. This would alleviate pressures on the existing team and free up more senior colleagues so they could see patients quickly.
- The pressures on the medical workforce had also led to delays in discharge letters to GPs. There were also concerns about the quality and content of the discharge letters as they were of variable quality and clarity. The lack of clarity had the potential to lead to confusion about who was responsible for the ongoing care of patients. The trust had recognised this as an issue and had begun to pay medical staff overtime to reduce the backlog. However, there were a number of wards and departments that were still struggling to send out this important information in a timely way.

Nursing staff

- Care and treatment was delivered by committed and caring staff who worked hard to provide patients with good services. However nurse staffing levels, although improved, remained a challenge. The trust was actively recruiting nursing staff from overseas to try and improve staffing levels.
- Although we found staffing levels were adequate at the time of our inspection, there was no flexibility in numbers to cope with increased capacity and demand, or short notice sickness and absence.
- Nurse staffing on the critical care unit did not always meet best practice requirements.

Mortality rates

- Our intelligent monitoring report highlighted the trust as being an elevated risk for mortality rates. The medical director took the lead for addressing this and implemented an action plan that appears to be effective. The plan included partnership working with community providers and commissioners and is reducing HSMR and SHMI rates.
- The trust showed insight in understanding the mortality data and identifying any potential improvement areas for patient safety or the patient pathway. In addition, work had been undertaken with the coding team and the medical staff to improve the coding information. Changes in coding practice had been made and the trust was confident that its mortality data quality had improved and would continue to do so.
- Mortality and morbidity meetings were held weekly and were attended by representatives from all teams within the relevant divisions. As part of these meetings, attendees reviewed the notes for every patient who had died in the hospital within the previous week. Any learning identified was shared and applied.
- While we were carrying out our inspection the latest SHMI data became available. This indicated that the trust was moving nearer to expected levels at 104, continuing the positive downward trend. The trust stated its intention to remain proactive and vigilant in understanding and improving its mortality rates.

Nutrition and hydration

- Patients had a choice of nutritious food and an ample supply of drinks during their stay in hospital. Patients with specialist needs in relation to eating and drinking were supported by dieticians and the speech and language therapy team.

Summary of findings

- There was a period over mealtimes when all activities on the wards stopped, if it was safe for them to do so. This meant that staff were available to help serve food and assist those patients who needed help. There was a coloured tray system in place so that patients who needed assistance with eating and drinking could be easily identified and offered appropriate and discreet support.

Medicines management

- Medicines were provided, stored and administered in a safe and timely way.
- Anticipatory end of life care medication was appropriately prescribed. Patients who had moved into the community on an end of life pathway were sent home with prescriptions including a signed prescription chart. This was good practice as it enabled community nurses to give symptomatic relief without delay from the time the patient arrived home.

We saw several areas of outstanding practice including:

- In medical care, the trust had introduced an electronic handover tool (e-handover) for which they had received a Health Service Journal Award. Medical staff at the trust had developed documentation for the care of patients on an alcohol detox pathway.
- The new critical care unit had been designed in accordance with the latest best practice guidance with the aim of reducing delirium and the problems associated with sensory deprivation. For example the rooms on one side of the unit benefitted from full length windows incorporating an electronic blind so that natural light was visible. In addition the unit made use of sky ceiling photo panels above patient beds, which displayed realistic images of blue skies, white clouds and blossom trees.
- The end of life care service had direct access to electronic information held by community services, including GPs. This meant that hospital staff could access up-to-date information about patients, for example, details of their current medication.
- The hospital had a rapid discharge pathway to enable patients to be discharged from the acute hospital to home in the last hours /days of their lives. An audit in March 2014 showed that the preferred place of care (PPC) was achieved for 84% of patients seen by the specialist palliative care team (SPCT) and PPC wishes were met for 96% of the patients seen by the team.

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

Importantly, the trust must:

- Ensure that medical staffing is sufficient to provide appropriate and timely treatment and review of patients at all times including out of hours.
- Ensure that medical staffing is appropriate at all times including medical trainees, long-term locums, middle-grade doctors and consultants.
- Improve patient flow throughout the hospital to reduce the number of patient bed moves and patients' length of stay – particularly in the medical division.
- Take action to clear the backlog of discharge letters, and implement an effective system for managing discharge letters so that GPs receive accurate and robust information about their patients in a timely way
- Ensure that escalation areas are appropriate environments for the care of patients and provide them with ready access to bathing and toilet facilities.

In addition the trust should:

- Consider improving arrangements for clinical supervision to ensure they are appropriate and support staff to effectively carry out their responsibilities, offer relevant development opportunities and enable staff to deliver care safely and to an appropriate standard.

Summary of findings

- Ensure that, where patients are deemed not to have capacity to consent, staff are establishing and acting in accordance with the best interests of the patient and that this is appropriately documented.

In emergency & urgent care services:

- Ensure that all staff complete their mandatory training in a timely manner.
- Consider updating the sudden death checklist for paediatrics to include a "do not leave child alone with parents" step.
- Ensure they have a list of appropriate staff that have been trained with the required scene safety and awareness training.

In medical care services:

- Ensure timely access to treatment for upper gastrointestinal bleeds and stroke thrombolysis, including out of hours.
- Ensure action is taken to improve outcomes for patients with diabetes or who have had a stroke.

In surgery services:

- Ensure that appropriate action is taken to reduce the number of elective surgical patients that are readmitted to hospital following discharge.
- Continue to monitor and fully implement the proposed actions in order to reduce the number of cancelled operations and improve theatre utilisation.

In maternity & gynaecology services:

- Review and improve the provision of consultant anaesthetic sessions for elective caesarean sections to provide a more responsive service for women.

In services for children & young people:

- Consider reviewing safeguarding children training to ensure that the format, content and duration is in line with best practice guidance, in particular the provision of inter-agency training, and that the time allowed for level 3 training is appropriate to support the learning needs of staff
- Ensure that safeguarding concerns are reported via the incident reporting systems to make sure that incidents are fully investigated, and provide assurance that all relevant staff are aware of lessons learned.

In outpatients and diagnostic imaging services:

- The trust should take action to ensure that waiting times for outpatient clinics are improved and that clinics do not over run leading to cancellation of appointments.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	Good	There were good systems in place for reporting and managing incidents. There was a risk-aware culture in the department and a willingness to learn from incidents. Patients received care in a clean, hygienic and suitably maintained environment. Appropriate equipment was in good supply and was clean and well maintained. Medicines and records were managed effectively and safely within the department. The staffing levels were sufficient to meet patients' needs and processes were in place to ensure resource and capacity risks were managed and mitigated. There were efficient and well managed processes in place for the handover of patient information to ensure continuity of appropriate care and treatment. The trust had an up-to-date major incident plan that listed key risks and actions to maintain the provision of care during a major emergency. Patients received care and treatment that was based on evidence-based practice and a national guidance. Multi-disciplinary team working was well established and used effectively to manage patients' individual care and treatment needs. Staff treated patients with dignity, compassion and respect. Staff provided patients and their families with emotional support and comforted patients who were anxious or concerned about their condition and treatment options. The emergency department faced a number of challenges, including the management of increasing emergency admissions and changes in the needs of the local population. The trust had carried out a significant amount of work to tackle the capacity and patient flow challenges that had affected their A&E performance. Performance was improving and staff were engaged, enthusiastic and proud of the improvements achieved. The organisation's vision and strategy had been cascaded to all staff. There was clearly defined and visible leadership within the department and staff felt there was an open and supportive culture.

Summary of findings

Medical care

Requires improvement



Medical services at Leighton Hospital were well-led, and delivered by caring and compassionate staff. We observed staff treating patients with dignity and respect and patients we spoke with were positive about their interactions with staff.

However, clinical outcomes for patients in some areas required improvement. Our analysis of data showed that particular improvements were needed in the management of patients with diabetes and those who had had a stroke. There also gaps in the provision of some out-of-hours services for patients with upper Gastrointestinal (GI) bleeds and in providing thrombolysis for patients that had suffered a stroke. In addition, some specialist nursing posts had not been filled at the time of our inspection.

Patients were regularly at Leighton Hospital longer than they needed to be, usually as a result of delays in providing, or the availability of, care home placements or care at home packages.

Discharge letters were not prepared and issued promptly, leading to possible delays in follow-up care and treatment for patients. There was continual pressure on the availability of beds which meant that some patients could not be placed in an area best suited to their needs. Some of the areas used for escalation beds, especially the primary assessment area, did not provide an appropriate environment for the care of patients overnight.

Surgery

Good



Surgical services provided good care and treatment for patients. Patient safety was monitored and incidents were investigated to assist learning and improve care. Patients received care in clean, hygienic and suitably maintained premises. The staffing levels and skills mix was sufficient to meet patients' needs and staff assessed and responded to patient risks appropriately

Surgical services provided effective care and treatment based on evidence-based national clinical guidelines and staff used care pathways appropriately. The services participated in national and local clinical audits to benchmark and improve care and treatment for patients. Surgical outcomes were, in the main, positive. However, the number of patients that had elective surgery and were readmitted to hospital following discharge was

Summary of findings

worse than the England average. There were plans in place to improve areas where national clinical and performance standards had not been achieved, such as compliance with the national hip fracture audit.

Patients received care and treatment by trained, competent staff that worked well as part of a multidisciplinary team. Patients spoke positively about their care and treatment. Patients were treated with dignity and received their care in a compassionate way. Surgical services were planned and delivered to meet the needs of local people. There was sufficient capacity to ensure patients admitted to the surgical services could be seen promptly and receive the right level of care. There was effective teamwork and clearly visible leadership within the surgical services. There was a positive culture within the service that was focused on patient safety and learning. There was routine public and staff engagement and actions were taken to improve the services in response to patient feedback. The management team understood the key risks and challenges to the service and how to resolve them.

Critical care

Good

The trust was providing a good critical care service overall. However, to maintain safe care, some improvements were required relating to medical and nursing staff numbers.

There was evidence of strong medical and nursing leadership in the critical care unit that led to positive outcomes for patients. The service submitted regular Intensive Care National Audit and Research (ICNARC) data so was able to benchmark its performance and effectiveness alongside other units nationally.

There was a clear understanding of incident reporting and an embedded culture of audit, learning and development. However, the unit's risk register contained risks had been there for a number of years and it was not clear whether these had been reviewed as planned or what the actions were.

The unit employed two nurses specifically in practice educator roles, which enabled them to support both new staff and those requiring additional support or performance management.

Summary of findings

Based in critical care, there was also a well-developed outreach service staffed on a daily basis by experienced band 7 nurses from the critical care unit. On the days of our inspection the unit had five to six empty beds at the start of the morning shift. It was safely staffed with the appropriate number of trained nurses per patient plus a senior co-ordinating nurse, clinical services manager and both junior and consultant medical staff.

Maternity and gynaecology

Good

Maternity and gynaecology services provided good and effective care in accordance with both local and national guidance. We found midwifery staffing levels were calculated using a recognised dependency tool.

A triage service introduced by the service enabled women to be directed to the most appropriate support in a timely manner. However there was no dedicated list for elective caesarean sections. As a result we found that patients may have their surgery delayed if an emergency arose. In addition, anaesthetic support was provided on a second on call basis from the main critical care service. This could also lead to delays for women.

There were systems in place for reporting actual and near miss incidents across the maternity and gynaecology services. The service monitored all its risks and had local risk registers. Action plans were in place and regularly monitored to ensure that risks had been addressed. Staff had a good knowledge and understanding of the need to ensure that vulnerable people were safeguarded. Staff understood and followed best practice infection control guidance. Services were delivered by committed, caring and compassionate staff. We observed that staff treated mothers and their partners with dignity and respect and planned and delivered care in a way that took their wishes into account. Emotional support was available for both mothers and their partners.

Services for children and young people

Good

Care provided by services for children and young people was supportive to children, young people and their families. People told us that the staff were “lovely” and “very kind”. There were processes in place for safeguarding and such concerns were identified and referred to the relevant authorities. There were robust arrangements in place to report

and monitor incidents and near misses. Staff were clear about their responsibilities in this regard. However the process for reporting safeguarding concerns via the incident reporting system was not as robust. This meant that incident reporting systems may not accurately reflect the safeguarding concerns identified.
There were clear governance arrangements in place that monitored the outcome of audits, complaints, incidents and lessons learned throughout the service. Staff were positive about the culture in children's and young people's services and felt supported by their senior managers. Staff were able to be innovative and introduce new practices to improve the quality of the service provided. Children's and young people's services were forward thinking in how services could to be adapted to provide flexibility and sustainability in the future. There was a strong commitment to developing relationships across health networks.

End of life care

Good

Patients received a good standard of end of life care that involved relatives and carers. Care was provided by supportive and compassionate staff who respected patients' need for privacy and dignity. Nursing and care staff were appropriately trained and they were encouraged to learn from incidents. Relatives of patients, nurses and doctors spoke positively about the service provided from the Specialist Palliative Care Team (SPCT). End of life care services worked collaboratively with both primary and tertiary care services to best meet patients' individual needs.
Patients and those close to them spoke positively about the rapid discharge pathway that enabled patients to be discharged from hospital to home in the last hours/days of their lives. Staff gave examples of how this policy worked in practice and where this had happened for patients. There were also several examples of how the service met the spiritual, religious, psychological and social needs of patients. Future plans for the service included the introduction of the AMBER care bundle, a system that would provide a systematic approach to manage the care of hospital patients facing an uncertain recovery and who are were at risk of dying in the next one to two months.

Summary of findings

The trust had policies and a number of monitoring systems in place to ensure that it delivered good end of life care. However there was limited medical input to the SPCT. General medical cover was provided on the wards for patients with end of life care needs. There was only one part-time consultant (two sessions per week) in palliative medicine.

Outpatients and diagnostic imaging

Good

Patients attending the outpatient and diagnostic imaging departments were treated in a dignified and respectful way by caring and committed staff. Staffing numbers and skills mix met the needs of the patients in the department. However, consultants were sometimes called away to deal with emergency situations in other parts of the hospital or clinic's over ran the times allocated. This meant that, at times, patients waited a long time to see their doctor.

There was a clear process for reporting and investigating incidents. Learning from incidents was shared and there were examples of changes in practice in response to incidents. Staff received training in safeguarding adults and children, the mental capacity act, health and safety, patient confidentiality and infection control.

The outpatient and diagnostic imaging departments were clean and well-maintained although the outpatient departments were sometimes quite cramped in terms of space and seating arrangements. Patient records generally were available for clinics and were secured and stored securely. There were occasions in the dermatology clinics at Leighton Hospital when patient records were not available for an appointment. In such cases staff prepared a temporary file for patients that included the most recent diagnostic and test results coupled with essential patient information so that the patient's appointment could go ahead. Staff acknowledged that this was not ideal; however it meant the patient did not have to reschedule their appointment.

There was good local leadership and a positive culture within the service. Staff worked well as a team and supported each other.

Good

Leighton 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

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Detailed findings

Background to Leighton Hospital

Leighton Hospital provides a full range of hospital services, including emergency care, critical care, coronary care, general medicine including elderly care, general surgery, orthopaedics, anaesthetics, stroke rehabilitation, paediatrics and midwifery-led maternity care. The trust also provides outpatient services and a minor injuries unit at Victoria Infirmary and intermediate care services at Elmhurst Intermediate Care services.

Mid Cheshire Hospitals NHS Foundation Trust provides services to a population of approximately 300,000 living in and around Alsager, Crewe, Congleton, Knutsford, Middlewich, Nantwich, Northwich, Sandbach and Winsford. In total the trust has 582 hospital beds.

We carried out this inspection as part of our comprehensive inspection programme. This report also includes our findings for the Victoria Infirmary.

Our inspection team

Our inspection team was led by:

Chair: Dr. Nick Bishop MB BS MRCS FRCR FRCP, Senior Medical Advisor, Care Quality Commission

Head of Hospital Inspections: Ann Ford, Care Quality Commission

The team included a CQC inspection manager, eight CQC inspectors and a variety of specialists including: Director of Improvement, Quality and Nursing, Trust Secretary, Quality Governance and Risk Management Specialist, Designated Lead Nurse for Safeguarding Children, Renal Physician, Consultant in Clinical Oncology, Surgeon (general surgery), Consultant Obstetrician and Gynaecologist, Consultant Anaesthetist, Junior Doctor (general medicine/care of the elderly), Registered General Nurse, Paediatric Palliative Care Consultant Nurse, Nurse Clinician (surgical care services), Accident and Emergency Nurse, Head of Midwifery and Supervisor of Midwives, Critical Care Nurse, Nurse Practitioner, third year Student Nurse (general medicine).

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?

Before visiting, we reviewed a range of information we held about Mid Cheshire Hospitals NHS Foundation Trust and asked other organisations to share what they knew about the hospital. These included the Clinical Commissioning Groups, NHS England, Health Education England, the General Medical Council, the Nursing and Midwifery Council, the Royal Colleges and the local Healthwatch.

We held a listening event in Crewe on 6 October 2014 when people shared their views and experiences of Leighton Hospital and the Victoria Infirmary. Some people also shared their experiences by email or telephone.

The announced inspection of Leighton Hospital took place on 8, 9 and 10 October 2014. We also carried out an announced inspection at the Victoria Infirmary on 9 October 2014. We held focus groups and drop-in sessions with a range of staff in the hospital, including nurses, trainee doctors, consultants, midwives, student nurses, administrative and clerical staff, physiotherapists, occupational therapists, pharmacists, domestic staff and porters. We also spoke with staff individually as requested.

Detailed findings

We talked with patients and staff from all the ward areas and outpatients 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 undertook an unannounced inspection between 5pm and 8.30pm on 24 October 2014 at Leighton Hospital only. During the unannounced inspection we looked at the management of medical admissions out of hours.

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 Leighton Hospital.

Facts and data about Leighton Hospital

Leighton Hospital is one of three sites providing services as part of Mid Cheshire Hospitals NHS Foundation Trust. There are 582 beds in total. In 2013/14 there were 29,404 admissions; 255,834 outpatients and 82,140 emergency department attendances. The trust employs 3,200 members of staff. In 2013/14 the trust had a total income of £183.3m

The trust serves a local population of approximately 300,000 living in and around Alsager, Crewe, Congleton, Knutsford, Middlewich, Nantwich, Northwich, Sandbach and Winsford. The health of people across Cheshire East, Cheshire West and Chester varies. Life expectancy for both men and women is better than the England average.

However the local health profiles show Cheshire East has three indicators for children and young people that are worse than expected: for smoking in pregnancy, starting breast feeding and alcohol specific hospital stays for those under18 years old.

Cheshire West and Chester also has two indicators for children and young people that are worse than expected: for starting breast feeding and alcohol specific hospital stays for those under 18 years old. In addition instances of malignant melanoma and hospital stays for alcohol related harm (adults) are worse than the England average. Road injuries and deaths are also worse than expected across both East and West areas.

Detailed findings

Our ratings for this hospital

Our ratings for this hospital are:

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

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

Information about the service

Urgent & emergency services are provided across two sites that form part of Mid Cheshire Hospitals NHS Foundation Trust. The Accident and Emergency department (A&E) at Leighton Hospital is open 24 hours a day, seven days a week, providing emergency care and treatment to people across Mid Cheshire. The Minor Injuries Unit at Victoria Infirmary in Northwich is a nurse-led unit seeing a variety of patients with various illnesses and minor injuries. It is open from 9am to 10pm seven days a week.

The urgent & emergency services saw 80,000 adult patients and 20,000 children during a year. The A&E department was originally built for 200 attendances daily but was seeing in excess of 230 attendees and the minor injuries unit was seeing around 55 patients daily.

There are 21 bays in the A&E department at Leighton Hospital, five bays in the resuscitation area (one designated for children). There are six bays in the minor injuries area and 10 in the major injuries area with one bay in each area designated to be a paediatric bay. There are waiting rooms including a dedicated waiting area for children. The Minor Injuries Unit at Victoria Infirmary consisted of four cubicles, with one designated for children and one with ophthalmic equipment.

Patients who require diagnosis, observation, treatment and rehabilitation, but are not expected to need an overnight stay, attend the clinical decisions unit (CDU). The unit accepts patients who are mobile and who do not have an early warning score of more than three. There are exclusion criteria, including patients under 16 years and patients with mental health issues. These patients are referred to a more appropriate setting. Patients can be discharged home from the unit and booked an appointment to return for further assessment.

We spoke with six patients and relatives. We observed care and treatment and looked at care records. We also spoke with a range of staff at different grades including the divisional associate medical director, the divisional general manager, lead consultant, the matron for emergency department, the service manager, medical and nursing staff, staff from the alcohol and drug liaison team, staff from the mental health liaison team, paramedics, healthcare assistants, domestic staff, stores people as well as the reception staff. We received comments from our listening events and from people who contacted us to tell us about their experiences, and we reviewed performance information about the trust.

Urgent and emergency services

Summary of findings

Systems were in place for reporting and managing incidents. There was a risk-aware culture in the department and a willingness to learn from incidents. Patients received care in a clean and suitably maintained environment with the appropriate equipment. Medicines and records were managed effectively and safely across the areas we inspected. The staffing levels were sufficient to meet patients' needs and processes were in place to ensure resource and capacity risks were managed. There were efficient and well managed processes in place for handovers. The trust had an up-to-date major incident plan which listed key risks that could affect the provision of care and treatment.

Patients received care and treatment that was based on evidence-based practice and adhered to national guidance. We saw effective collaboration and communication among all members of the multidisciplinary team. Staff treated patients with dignity, compassion and respect. Staff provided patients and their families with emotional support and comforted patients who were anxious.

The emergency department faced challenges such as patient flow and changes in the needs of the local population. The trust had done a significant amount of work to tackle the capacity and patient flow challenges that had affected their A&E performance. Performance was improving and staff were engaged, enthusiastic and proud of the improvements they had achieved. The organisation's vision and strategy had been cascaded to all staff. There was clearly defined and visible leadership and staff felt there was an open and supportive culture.

Are urgent and emergency services safe?

Good

Systems were in place for reporting and managing incidents. There was a risk-aware culture in the department and a willingness to learn from mistakes. Patients received care in a clean and suitably maintained environment with the appropriate equipment. Medicines and records were managed effectively and safely across the areas we inspected. Staff were aware of the safeguarding policy and obtained consent from patients appropriately. The staffing levels were sufficient to meet patients' needs and processes were in place to ensure resource and capacity risks were managed. There were efficient and well managed processes in place for handovers. The trust had an up-to-date major incident plan that listed key risks that potentially could affect the provision of care and treatment.

Incidents

- Staff were confident about reporting incidents, near misses and poor practice.
- Incidents were raised via the electronic incident reporting system for issues such as abuse from patients, patients who had absconded and medication errors.
- Staff were able to describe recent incidents and clearly outlined actions that had been taken as a result of incident investigations to prevent reoccurrence. We saw that all members of the multidisciplinary team were involved in these investigations.
- Trust data showed there were 2169 incidents reported in the medicine and emergency division from April 2014 to October 2014 of which the majority (1484) were rated as low risk. A total of 460 incidents were reported by the emergency department at Leighton Hospital and only three were reported at the minor injuries unit at the Victoria Infirmary.
- We reviewed a number of incidents from the electronic reporting system and found the majority of incidents that had been reported within the emergency department were related to violence and aggression from patients towards staff. This risk had been added to the divisional risk register which was regularly reviewed. A policy was in place for managing abusive and aggressive patients that was consistently applied.

Urgent and emergency services

- A recent incident at Leighton Hospital had involved a patient who had been given a request card with the wrong patient information sticker on it. This had resulted in the patient having the wrong body part X-rayed. As a result, staff ensured the correct patient information sticker was placed on request cards and that two staff members checked the information where possible.
- Learning from incidents was shared across the emergency department via noticeboards, newsletters and "Board Huddles".

Cleanliness, infection control and hygiene

- The emergency department at Leighton Hospital and the minor injuries unit at the Victoria Infirmary were clean, well-maintained and in a good state of repair. Staff were aware of current infection prevention and control guidelines and we observed good practices such as hand washing facilities and hand gel available throughout the departments. Staff followed hand hygiene and 'bare below the elbow' guidance and staff wore personal protective equipment, such as gloves and aprons, while delivering care,
- Suitable arrangements were in place for the handling, storage and disposal of clinical waste, including sharps,
- Cleaning schedules were in place and displayed throughout the ward areas. There were clearly defined roles and responsibilities for cleaning the environment and suitable cleaning and decontaminating equipment was available.
- Data showed that healthcare associated infections for MRSA and Clostridium difficile (C.diff) rates for the trust were within expected limits.

Environment and equipment

- Both the emergency department at Leighton Hospital and the minor injuries unit at the Victoria Infirmary were well maintained and secure. The emergency department at Leighton Hospital was built to treat around 200 patients daily and was mostly able to accommodate the number of patients who attended.
- The areas we inspected were compliant with same-sex accommodation guidelines. We saw that patients' bed curtains were drawn and staff spoke with patients in private to maintain confidentiality.
- The admission route for patients was streamlined and well laid out. The emergency department was set up so ambulatory patients could always be seen by staff and high risk patients were visible from the nursing stations for observation and quick intervention.
- There was a specific x-ray service situated within the department for easy access.
- There was a secure room that was used to assess patients with mental health problems. This wasn't a Section 136 room (a designated place of safety) under the Mental Health Act (1983). Patients who required a designated Section 136 room would be conveyed to a nearby hospital with suitable facilities to provide good care.
- The resuscitation room had five cubicles designated for trauma that were all well-equipped for adult and paediatric patients.
- We saw equipment in place for specific procedures that may only be carried out several times a year. Staff confirmed all items of equipment were readily available and any faulty equipment was either repaired or replaced efficiently.
- Adequate equipment was available in all areas including appropriate equipment for children. The equipment was appropriately checked and decontaminated regularly with checklists in use for daily, weekly and monthly checks of equipment in the resuscitation trolleys and within the cubicles.
- Staff were aware of alerts that had been issued by the Central Alerting System and warnings had been shared with staff such as potential equipment sabotage.

Medicines

- Policies were available for the management of medication and posters were displayed reminding staff to check protocols if changes were made to patients regular medication.
- The emergency department was equipped with an electronic dispensing module that could dispense in single doses or complete packs. Medication was safely stored with a comprehensive audit trail of who had accessed the medication.
- When issuing medication, the system adjusted stock levels automatically and when minimum or critical stock levels were reached the module automatically transmitted orders for top up to the pharmacy department who were responsible for maintaining stock.

- Medicines throughout the emergency department were stored correctly and safety in locked cupboards or fridges and temperatures were recorded where necessary.
- We checked the storage and balance of controlled drugs at Leighton Hospital and at the Minor Injuries Unit in the Victoria Infirmary and found the stock balances were correct.
- When controlled drugs were dispensed the controlled drugs registers had been signed by two staff members and the volume of any wasted drugs was accurately recorded.

Records

- The emergency department had developed its own patient clinical assessment record that included the patient's personal details, previous admissions, alerts for allergies, patient's weight, observations charts, social information, falls and bone assessments as well as early warning scores (EWS) and triggers for sepsis with a flowchart for easy understanding.
- We looked at eight patient records and were able to follow and track patient care and treatment easily. Observations were well recorded; the timing of such was dependent on the acuity of the patient.
- Patient records were kept securely in trolleys, easy to locate and we could easily obtain any notes we required when conducting our patient record reviews.

Safeguarding

- Policies were in place that outlined the trust's processes for safeguarding vulnerable adults and children. Safeguarding formed part of the mandatory training programme for all staff.
- A safeguarding link nurse and a health visitor for children worked with specific teams to ensure patients were not at increased risk of neglect or abuse.
- Staff confirmed they knew who to contact and were aware of the services being offered.
- The health visitor told us they felt the process for safeguarding children was robust.

Mandatory training

- Staff received mandatory training in areas such as infection prevention and control, moving and handling, and safeguarding children and vulnerable adults including dementia awareness training.
- Staff within the emergency department also received mandatory training in medicines management, resuscitation training, **Advanced Paediatric Life Support** (APLS), Trauma Nursing Core Course (TNCC), Major Incident Medical Management and Support (MIMMS), Advanced and Immediate Life Support and Paediatric Life Support (ALS, ILS and PLS).
- All staff had been trained to deal with paediatric trauma.
- The lead consultant explained how a simulation was conducted on a monthly basis which involved a trauma, such as a car accident, where staff had to determine the route and the actions they would take. This enabled them to prepare for unforeseen circumstances and helped to keep practice up to date.
- Senior staff told us they had been supported to attend management courses to enable them to progress in their careers. The trust board had invested in a clinical leadership programme to develop senior doctor's leadership and management skills.
- Trust data showed that as of March 2014 the majority of staff groups in the emergency department had completed their mandatory training with the medical staff being the lowest performing group at 91% against a trust target of 95%. All non-compliant staff had been identified and lists had been sent to their line management for remedial action to be taken.
- Training records for nursing staff showed that during July to August 2014 70% of mandatory training had been delivered to staff but due to the senior nurse, who managed the training retiring, the delivery of the training had been delayed and the department had fallen slightly behind. However, at the time of our inspection they were on target to achieve 95% by March 2015.
- Mandatory training was delivered on a rolling programme and the matron and clinical lead told us they were confident the trust mandatory training compliance target would be achieved by year end (March 2015).
- Staff confirmed there were mechanisms in place for staff to receive clinical supervision and staff confirmed they received clinical supervision.

Assessing and responding to patient risk

Urgent and emergency services

- All patients who presented to the emergency department were either booked in via the receptionist, who asked routine questions to determine the nature of the ailment, or were conveyed by an ambulance direct to the major injuries area and as such took priority.
- The nurse performed screening of patients depending on the severity of their ailment and streamed patients to the appropriate route. This could be the minor injuries area or walk in urgent care centre that was only open 8am to 6pm Monday to Friday. The walk in centre treated patients who weren't registered with a GP such as students and then signposted them to register with a local GP.
- Triage systems were in place at Leighton Hospital for minor and major injuries and were manned by a senior sister or an experienced band 5 nurse who performed triage assessments. All minor injuries (self-referral) patients were streamed and assessed immediately to check the severity of their ailment.
- The "See and Treat" area was not in use at the time of inspection. Staff told us this was used mostly during the winter period and was managed by a GP and a nurse practitioner. They felt this made the department run smoothly and felt it should be more a permanent feature within the department
- On admission, patients at high risk were placed on care pathways to ensure they received the right level of care. An early warning score (EWS) tool was part of the patient record with clear directions for escalation printed on the reverse of the observation charts. Staff were aware of the appropriate actions to take if a patient's condition deteriorated. (An EWS is a system that scores vital signs and is used as a tool for identifying patients who are deteriorating clinically).
- We reviewed completed charts and saw that staff had escalated correctly, and repeated observations within the necessary time frames.
- All patients who presented at Victoria Infirmary were booked in via the receptionist, who asked routine questions to determine the nature of the ailment. If any patients had any ailments which were serious or needed further treatment they would be conveyed by an ambulance to Leighton Hospital. The emergency nurse practitioner performed screening of patients depending on the severity of their ailment and streamed patients to the appropriate route.
- Staff knew how to escalate key risks that could impact on patient safety, such as staffing and bed capacity issues. There was an escalation policy in place and daily involvement by ward managers and the divisional matrons to address these risks.

Nursing staffing

- The matron for the emergency department told us nursing staffing had historically been low in the department. An acuity tool was used in 2012 to assess patient dependency levels which identified shortfalls in nursing staffing.
- A proposed plan to recruit additional staff was submitted to the trust board in 2012 and was approved with staff being filtered into the department.
- The matron confirmed five band 5 nurses were recently recruited and were due to begin work. They were also looking to recruit three band 7 nurses to support junior staff in order to teach and enhance clinical leadership.
- In May 2014, the emergency department leadership team had looked at the peak attendances and as a result had introduced an additional 3pm to 3am shift. The matron told us they were cultivating and supporting junior nursing staff as well as increasing the numbers of healthcare assistants to support this approach.
- There were issues with the low number of applicants for these nursing roles that meant the trust were looking to recruit staff from abroad. This initiative had proved successful in the past.
- Nursing staff of differing grades were assigned to each of the patient areas within the department and the nurse allocations were the same for day and night shifts. One nurse was assigned to the resuscitation area, three nurses in the major injuries area, one nurse in the clinical decision unit (CDU) and one nurse performed the triage. An additional two nurses worked from 10am to assist during the busy periods.
- The numbers were adequate for the flow of patients we observed. However, if the department had a surge of patients, particularly in the resuscitation area, then these numbers did not have the flexibility to manage the increased demand and so were not always appropriate.
- Cover for staff leave or sickness was provided by bank staff made up of the existing nursing team. The matron told us they occasionally used agency nurses to provide cover at short notice. Where agency staff were used, they carried out checks to ensure they had the right level of training in delivering emergency care.

- Staffing at the Victoria Infirmary minor injuries unit consisted of an emergency nurse practitioner and a nurse who rotated between both sides and had a varied experience. They confirmed there were no issues and they could cope with the number of patients that presented.

Medical staffing

- The emergency department had sufficient numbers of medical staff with an appropriate skills mix to ensure that patients were safe and received the right level of care.
- The ratio of consultants at 19% and trainee doctors at 17% was worse than the England average of 23% and 25% respectively. The ratio of middle grade doctors was 25% which was better than the England average of 13%. The ratio of registrars (40%) was comparable to the England average (39%).
- The skills mix of the medical staffing although generally positive meant that there were times when patients waited for longer periods to see more senior clinicians. However, time to treatment rates were better than the national average.
- All staff worked various shifts over a 24-hour period to cover rotas and to be on call during out-of-hours and weekends. The department was funded for six registrars but only four full-time and one part-time registrar was employed. There were five middle grade doctors and eight trainee doctors.
- The service had access to 24 hour on-call paediatric consultant support.
- It was proving difficult to recruit senior house officer level medical staff so existing vacancies were covered by locum, bank or agency staff when required. Currently the night shifts at the weekends were covered by locum medical staff.
- The minor injuries unit was nurse led and therefore there was no routine medical cover at the unit. An A&E consultant held a clinic at the site once a week.

Handovers

- A consultant led "Board Huddle" took place three times daily and more frequently if required. This included all professionals such as nursing staff, medical staff, the mental health liaison team, the children's health visitor and the hospital alcohol liaison service. This took place around the patient white board and topics discussed included staffing levels, complaints, incidents as well as patient handover related issues such as clinical acuity and medication needs.
- Senior and junior staff attended to make sure they were all aware of any tasks that were allocated such as blood samples to be taken from patients.
- All the information was then logged in a communication file to ensure those staff not present could also be made aware.
- A system was in use for tracking patients before handover to the ward areas based on clinical prioritisation by the early warning scores (EWS) traffic light system.
- On admission to the emergency department, all patients were identified as being "needed to be seen" and were assigned a "red" marker. This prompted junior staff to see the patient and assign an "amber" marker which then went to "green" when seen by a consultant.
- We observed handovers of patients from the ambulance staff to the hospital staff. These were discreet, dignified and efficient. All patients conveyed by ambulance were weighed as they entered the department on a weighbridge and the BMI was estimated to allow the given dosages of drugs to be more accurate.

Major incident awareness and training

- There was a documented major incident and business continuity plan within the medicine and emergency division which listed key risks that could affect the provision of care and treatment.
- Guidance for staff in the event of a major incident was available within the trust's major incident plan which was also located in the department.
- The department had decontamination facilities and equipment to deal with patients who may be contaminated with chemicals and other hazardous substances.
- North West Ambulance Service (NWAS) had a Medical Emergency Response Incident Team (MERIT) in place to provide advanced medical care on scene at a range of emergency incidents, up to and including major and mass casualty incidents.
- Equipment to attend such scenarios was situated within the emergency department for staff to use.

Urgent and emergency services

- The lead consultant told us they rarely attended the scene of an emergency incident and there was no list of appropriate staff that had been trained with the required scene safety and awareness training.
- Staff told us they had been trained in Major Incident Medical Management and Support (MIMMS) which enabled staff to deliver medical support to major incidents.

Are urgent and emergency services effective?

(for example, treatment is effective)

Good

There was evidence of adherence to national guidance to provide evidence-based care and treatment for patients. Patients were assessed for pain relief as they entered the emergency department. The department participated in national College of Emergency Medicine audits and there were clear action plans indicating what improvements were needed as a result. Departmental records showed that all staff had received appraisals. We saw effective collaboration and communication among all members of the multidisciplinary team and services were geared to run seven days a week.

Evidence-based care and treatment

- The emergency department used a combination of National Institute for Health and Clinical Excellence (NICE) and College of Emergency Medicine (CEM) guidelines to determine the treatment they provided.
- A range of clinical care pathways had been developed in accordance with recognised guidance for example, stroke, pneumonia, and fractured neck of femur. The department audited compliance with these pathways regularly.
- The patient clinical assessment record reflected evidence-based guidance for effective risk assessment and included tools for risk assessing patient risks such as sepsis so that if the patient's condition deteriorated then medical staff could be alerted quickly.
- These pathways were put into action as soon the patient entered the departments. These meant patients were seen and treated effectively by the appropriate staff and that diagnostic tests were carried out and results were reviewed promptly.
- An audit of the treatment of fractured neck of femur had resulted in the introduction of a one page protocol for staff to follow to ensure the guidance was followed. An audit in line with CEM guidance had resulted in a sepsis pathway being included in the patient clinical assessment record.
- Guidance was regularly discussed at governance meetings, disseminated and the impact that it would have on staff practice was discussed. Staff were encouraged to undertake a clinical audit to assess how well NICE and other guidelines were adhered to. All of these audits resulted in staff education and changes in practice to improve patient care.

Pain relief

- Patients were assessed for pain relief as they entered the emergency department. A streaming process identified any patients who may need pain relief that was given immediately. We observed three patients who received appropriate pain relief immediately.
- Patient records indicated and patients we spoke with reported that they had been offered appropriate pain relief in a timely way.
- The department had participated in the national College of Emergency Medicine audit for renal colic which assessed the expedience of pain relief. The audits showed areas for improvement and actions had been taken in response including further training for staff to improve performance in this area.

Nutrition and hydration

- A healthcare assistant (HCA) was the designated staff member on each shift responsible for offering drinks and small snacks, such as yoghurts and fruit, on a two hourly basis to patients waiting within the department.
- We saw patients being offered refreshments during our visit. The HCA checked with nursing staff if patients (due to the nature of their medical conditions) could have refreshments before offering them.

Patient outcomes

- There was a consultant lead for audit in the emergency department. The department participated in national

College of Emergency Medicine audits so they could benchmark their practice and performance against best practice and other emergency departments. Audits included severe sepsis and septic shock, renal colic, pain relief, vital signs in majors and fractured neck of femur.

- There were clear action plans indicating what improvements were needed as a result which included adding information to be collected to the clinical assessment record such as observation charts, early warning scores and a sepsis detection flow chart. There was a long term plan to have a clinical assessment record specifically for paediatrics.
- Actions in response to external audits included a trauma audit in relation to The Trauma Audit Research Network (TARN). As a result a comprehensive fax referral form had been introduced to ensure the correct information was passed into the receiving centre.
- A safe prescribing audit was conducted and resulted in the prescription section of the record being been altered to ensure clearer and safer documentation was maintained in relation to prescribing.
- Re-admittance rates to the emergency department within seven days were better than the 5% target set by the Department of Health between April 2014 and September 2014.
- From January 2013 to May 2014 the unplanned re-attendance rate to A&E within 7 days was lower than the England average.

Competent staff

- Records showed that all staff had received appraisals for the year 2013 to 2014. Staff we spoke with reported they had received an appraisal within the last year. An appraisal gives staff an opportunity to discuss their work progress and future aspirations with their manager.
- Information provided by the trust identified that the process for 2014 to 2015 had started in July 2014 and was still ongoing. We saw there was a schedule in place for staff to see their managers.
- Staff under subject to peer appraisals using an electronic appraisal system and were overseen by their managers.
- The nursing and medical staff we spoke with were positive about 'on-the-job' learning and development opportunities.
- Medical staff told us clinical supervision was in place and was non-hierarchical whereby staff could choose their own supervisors.

Multidisciplinary working

- While care delivery was predominantly consultant led, we saw effective collaboration and communication among all members of the multidisciplinary team (MDT) to support the planning and delivery of patient centred care. Daily MDT meetings, involving the nursing staff, therapists and medical staff as well as social workers and safeguarding leads (where required), ensured the patients' needs were fully explored. This included identification of patients' existing care needs, relevant social / family issues, mental capacity as well as any support needed from other providers on discharge, such as home care support or alcohol rehabilitation.
- The hospital alcohol liaison service (HALS) was staffed externally by a team of project workers and a nurse. Support was available in the emergency department via a link nurse and a consultant who worked closely with the team. They were available from 8am to 4pm Monday to Friday and worked with the emergency department during the board huddles and linked in with the discharge process.
- The HALS team had a specific pathway for people with alcohol withdrawal symptoms and also had a route for people to be referred appropriately out of hours.
- Therapies provided included linking potential patients with other professionals, educating staff and patients about alcohol misuse and also providing drop in sessions for patients so they could avoid re-admittance to the emergency department.
- The mental health liaison team provided support to patients with psychiatric issues and worked with staff in the emergency department 24 hours a day, seven days a week. A consultant liaison psychiatrist was available for 2.5 days and nurse practitioners were available during other times. The team aimed to see patients within an hour and had their own pathways, management plans and confidential systems in place to support timely care and treatment.
- There was evidence of good partnership working with the local ambulance service. Regular meetings took place with the matron and the liaison staff from the ambulance service to ensure they worked cooperatively to ensure delays were kept to minimum.

Urgent and emergency services

Seven-day services

- Staff rotas showed that medical and nursing staff levels were sufficiently maintained during out-of-hours and at weekends. Due to peaks, especially on Sundays, the rotas made allowance for middle grade medical staff but sometimes there weren't enough senior doctors to provide cover at weekends. The trust was implementing plans to address this.
- The emergency department only performed thrombolysis on patients during 9am to 9pm, after these hours the patient would be transferred to another local hospital by ambulance.
- The X-ray department at Leighton Hospital was open 24 hours a day, seven days a week. There was limited access to specialist investigations such as MRI and CT scans and to a radiologist to interpret scans. Although an on-call radiologist was available. A local agreement existed whereby senior staff were able to interpret certain scans out of hours so that treatment/admission was not delayed.
- X-Ray services at Victoria Infirmary were available from 9am until 5pm Monday to Friday only. If patients presented at the weekend they would have to wait until Monday morning which caused delays and patients were reluctant to go to Leighton Hospital.
- Pharmacy services were not available seven days a week but a pharmacist was available on call out of hours. During working hours, patients attending the emergency department who required medication were directed to the hospital pharmacy. The departments held a stock of frequently used medicines such as antibiotics and painkillers which staff could access out of hours. Stock levels were appropriate and were regularly checked to ensure the supply was adequate for peak times such as weekends and public holidays.
- There was a nights, evenings and weekends (NEW) service provided by East Cheshire NHS Trust at the Victoria Infirmary to provide emergency medical cover for those people who couldn't wait to see their own GP. It wasn't a walk in centre but a service for people who had been redirected from their own GP out of hours.

Access to information

- Patients confirmed they had received information in relation to their care and treatment in a manner they understood.
- Information relating to patient safety was displayed on notice boards throughout the department. This provided up-to-date information on performance in areas such as hand hygiene, environment and equipment cleanliness, falls, pressure ulcers and other incidents.
- Staff could access information such as audit results, lessons learned from incidents, performance indicators and updates to policies via the staff room and we saw clinical pathways, policies and procedures were accessible on the intranet site.
- The department used an electronic system to track when patients were admitted to the department but found the system to be cumbersome. This system didn't link with the other departments or ward areas that meant it didn't show real time patient movement. We saw staff were still using a manual whiteboard for patient movement.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff had the appropriate skills and knowledge to seek consent from patients or their representatives. Staff were clear on how they sought verbal and implied informed consent due to the nature of the patients attending the departments. Written consent was sought before providing care or treatment such as anaesthetics or at the major injuries unit.
- Arrangements were in place to ensure staff understood the requirements of the Mental Capacity Act 2005 and applied these requirements when delivering care. All staff received mandatory training in consent, safeguarding vulnerable adults and children, the Mental Capacity Act 2005 and Deprivation of Liberties Safeguards (DoLS).
- Staff understood the legal requirements of the Mental Capacity Act 2005 and had access to link workers such as the safeguarding lead.
- When a patient lacked capacity, staff sought the support of appropriate professionals so that decisions could be made in the best interests of the patient. Patient records showed that verbal or written consent had been obtained from patients or their representatives.
- We observed positive interactions between staff, patients and their relatives when seeking verbal consent. The patients we spoke with confirmed their consent had been sought prior to care and treatment being delivered.

Urgent and emergency services

Are urgent and emergency services caring?

Good

Staff treated patients with dignity, compassion and respect, even while working under pressure. Patients spoke positively about the care and treatment they had received and we observed many positive interactions. Staff provided patients and their families with emotional support and comforted patients who were anxious. The department had worked hard to increase the friend and family test response rate and the resultant scores were positive.

Compassionate care

- All the patients, relatives and representatives we spoke with were positive about the care and treatment provided.
- We observed many examples of compassionate care including one within the clinical decisions unit; a confused and stressed elderly patient couldn't cope on their own so staff had interacted with the social services to get them a place in respite care. We also saw staff moving the trolley closer to the nurse call button for vulnerable patients and we observed staff hoisting a bariatric patient with due care and attention to ensure their privacy and dignity was maintained.(Bariatric care is the branch of medicine that deals with the causes, prevention, and treatment of obesity)
- The NHS Friends and Family Test (FFT) had a low response rate between April 2014 and July 2014 which meant the results weren't fully reliable. However, data showed that the department scored better than the England average indicating patients would recommend the department to friends and family.
- The computer touchscreen used to capture FFT was made available in multi languages (Bengali, English, Polish and Slovakian) to enable the response rate to increase.
- A review of the data from the CQC's adult inpatient survey 2013 showed that 7.7 of patients felt they were given information relating to their condition and 8.6 felt they were afforded sufficient privacy and dignity.

Understanding and involvement of patients and those close to them

- Staff in the department included patients in the decision making process regarding their care and treatment. Benefits and risks were shared in a language that patients could understand.
- Patients felt included and informed. Those people who were close to patients were also kept informed and were included in the decision making where appropriate.
- Patients and those close to them were also involved in the planning for discharge from the department.

Emotional support

- Staff were clear about the importance of providing patients with emotional support. We observed positive interactions between staff and patients and saw staff providing reassurance and comfort to people who were anxious or worried.
- There were two relative's rooms close to the ambulatory entrance for relatives or representatives who had witnessed trauma such as road traffic accidents. The rooms provided a tranquil environment for anxious or worried relatives and friends.
- One of the relative's rooms could be used as a viewing room for parents and guardians of babies that had passed away. This allowed families extra time to spend with their child in very difficult circumstances.
- A noticeboard and information leaflets outlined the various multi-faith services available, with timings for prayers and services.
- There was a sudden death checklist for paediatric staff that included information for staff and criteria for a debriefing session to be held after all child deaths. However, the list didn't include a "do not leave child alone with parents" step which was recommended. The clinical lead told us that debriefing sessions were held after all traumatic events.
- Staff confirmed they could access counselling services after they had assisted with a patient who had been involved in a traumatic or distressing event, such as fatal road traffic accidents, or if they had been subject to a negative experience.
- Staff told us a senior manager could be made available for emotional support to them and they could also take some downtime following very traumatic experiences.

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

Urgent and emergency services

(for example, to feedback?)

Requires improvement

Patient flow was a challenge within the department at Leighton. During routine operating hours the department could cope with the flow. However, when patients could not be moved out of the emergency department this impacted negatively on the flow.The service had carried out a significant amount of work to tackle the capacity and patient flow challenges that had affected its performance. Performance was improving and staff were engaged, enthusiastic and proud of the improvements they had achieved. However, there were times when the national 4 hourly target for patients being seen, admitted or discharged was not met.

Patients were regularly transferred to Leighton Hospital as they couldn't be treated at the Minor Injuries Unit at the Victoria Infirmary. A majority of these were for patients needing to be X-rayed after 6pm and at the weekends when the X-Ray department at the infirmary was closed.

Translation services were available for patients where English was not their first language. A new dementia care bundle had been implemented; that was monitored and evaluated by the dementia service. Staff also completed a "me to you" passport document for patients admitted to the hospital with dementia or learning disabilities. This was completed by the patient or their representatives and included key information such as the patient's medical history and likes and dislikes. The service sought feedback from patients through complaints and patient engagement. Improvements to the service had been made in response to feedback and complaints.

Service planning and delivery to meet the needs of local people

- The departmental escalation policy described how the department would deal with a range of foreseen and unforeseen circumstances where there was significant demand for services.
- There was a responsive coordination of senior staff who arranged beds, investigations and scans for patients to ensure the service could better manage patients at busy times.
- Daily bed management and safe staffing meetings were taking place so that capacity was constantly monitored so that patients could be managed and treated in a timely way.
- There was adequate seating and space in reception and waiting areas.
- There were designated bays to treat children in both the minor and major injuries areas. There was also a dedicated paediatric resuscitation bay. However we were told that children would be transferred to the local specialist children's hospital where possible.

Meeting people's individual needs

- A variety of information leaflets were available in all areas of the emergency department at Leighton Hospital and at the minor injuries unit at the Victoria Infirmary. These were available in other languages and were also accessible via the trust internet site. All leaflets were approved by the reader's panel (clear English campaign approved).
- Interpreter services were available in all departments, either via a telephone service or face-to-face.
- All staff told us they wouldn't use any relatives or family members to assist patients with consenting procedures during treatment and only used professional interpreters for this purpose. This is deemed good practice.
- A new dementia care bundle had been implemented; that was monitored and evaluated by the dementia service. A dementia link nurse in the department confirmed she attended workshops and shared good practice with colleagues in the department.
- Staff also completed a "me to you" passport document for patients admitted to the hospital with dementia or learning disabilities. This was completed by the patient or their representatives and included key information such as the patient's medical history and likes and dislikes.
- Where a patient was identified with dementia or learning disabilities, staff could contact a trust-wide specialist dignity matron for advice and support.
- We observed the process to manage bariatric patients. When a bariatric patient was being conveyed, the ambulance staff would usually make this known in advance. Additional staff and appropriate equipment, such as a bariatric trolley, bed or chair could be provided to support the moving and handling of bariatric patients as required.

- On admission we saw ambulance staff work with the hospital staff to ensure continuity of care by making sure all the information about the patient was handed over appropriately. Following admission, patients were allocated a named nurse who was responsible for their care and safe onward transfer or discharge,
- The patient records we reviewed contained appropriate signatures, and where the patient was under 16, we saw appropriate signatures from their parents or guardians.
- Care plans were in place in the A&E for children with direct access to the emergency department for reoccurring and ongoing conditions such as asthma who attended frequently. The file was conveniently located and all staff were aware of the actions to take if someone known to them attended.

Access and flow

- Data provided showed that around 50 to 60 patients were transferred to Leighton Hospital on a monthly basis by ambulance as they couldn't be treated at the Minor Injuries Unit at the Victoria Infirmary. A majority of these was for patients needing to be X-rayed after 6pm and at the weekends when the X-Ray department at the infirmary was closed. Patient flow was a challenge within the department at Leighton. During routine operating hours the department could cope with the flow. However, when patients could not be moved out of the emergency department this impacted negatively on the flow.
- The Department of Health target for emergency departments is to admit, transfer or discharge patients within four hours of arrival. Over the previous 12 months the department's performance against this target had been inconsistent.
- For 2014/15 the trust had met the target for quarter one (achieving 96% in April, 96% in May and 95% in June 2014). However, the trust had performed slightly worse than the target by the end of quarter two as the department didn't meet the target in September 2014 (achieving 94%).
- The trust had done extensive work to investigate the reasons when the four-hour waiting target was not met. All individual breaches were investigated and categorised into why they occurred. We looked at the data for week 15 to 21 September which showed there were a total of 147 breaches with 83 patients being delayed due to not being assessed in the department and 15 patients not being able to be discharged due to their clinical needs. In other weeks we saw patients couldn't be discharged due to needing assessment from a mental health specialist or beds not being available in the ward areas.
- Bed capacity within the trust averaged 90% for the year 2013/14 compared with the England average of 86%. It is generally accepted that the quality of patient care and how well hospitals perform begins to be affected when bed occupancy rates rise above 85%. In addition a shortage of services outside the hospital's control meant patients couldn't always leave the department as they were awaiting further input such as a care home assessment. For example, we saw one instance where an elderly patient spent the night in the CDU as social services couldn't perform an assessment and it wasn't safe to discharge the patient into their own home.
- Another contributing factor was the Patient Assessment Area (PAA) which consisted of 16 beds and was initially set up for patients who were awaiting referrals to medical wards. However, this area was often used to accommodate patients for long periods while they were waiting to be discharged or admitted to a ward. This meant that patients from the emergency department couldn't be moved out of the department and this led to further delays. During our unannounced inspection we found the trust had implemented the Golden Patient initiative to ensure that patients did not spend more than 24 hours in this area and were moved to a setting more suited to their needs at the earliest opportunity.
- The hospital had a clear escalation policy which described the steps it would take when demand caused pressure on capacity. Staff were familiar with this policy and were very clear about the importance of the whole hospital, and other agencies working together to address this matter.
- Data showed that the department was regularly seeing more than 200 patients daily with some days where the department was seeing more than 250 patients. This also impacted negatively on the four hour target.
- Data was collated around patients leaving the department without being seen. Staff told us this was mainly during busy times and patients wouldn't inform the reception which meant the four hours wait for them would also breach. However, data showed that the rate of patients leaving without being seen was consistently better than the national target of 5% (from 2% in April 2014 to 4% in September 2014).

Urgent and emergency services

- The target to achieve 85% of ambulance handovers within 15 minutes was mostly achieved by the department. From January 2014 to July 2014 there had been 12 breaches where the ambulance waiting times had exceeded 60 minutes. The clinical lead for the emergency department told us any ambulance waits over 60 minutes were automatically raised as an incident and a full investigation was undertaken.
- The percentage of emergency admissions via the emergency department who waited between four to12 hours from the decision to admit until being admitted was better than the England average.
- 'Referral to treatment' times were better than the England average for similar trusts.
- At the Victoria Infirmary, the minor injuries unit could cope with the patient flow during routine operating hours. However, patient flow was a challenge when they opened at 9am in the morning and during Monday mornings when patients had waited to attend.
- Data showed patients were seen very quickly and there were no breaches of the four hour target at the Victoria Infirmary. Many patients were seen, triaged and discharged within a matter of minutes. The data from this site was combined with the overall trust data which made the overall waiting times lower.

Learning from complaints and concerns

- Information was displayed in the department for patients and their representatives on how to raise complaints. This included information around the Patient Advice and Liaison Service (PALS) service.
- Complaints were recorded on a centralised trust-wide system. The centralised PALS team managed formal complaints. A complaints review panel was held six times per year to discuss more serious complaints.
- Staff understood the process for receiving and handling complaints and told us information about complaints was discussed during routine team meetings to raise staff awareness and aid future learning.
- Noticeboards included information such as the number of complaints and compliments received during the current month. For September 2014 four complaints and nine compliments had been received.
- The emergency department had received 33 complaints over the previous year. We looked at three complaints that had been raised and found staff had followed the correct process and timescales.

Are urgent and emergency services well-led?

Good

The service had strategies in place to address capacity and flow challenges and they were being implemented at the time of our inspection .The organisational vision and values had been cascaded to all staff. Staff were positive about the department and they were proud of the work they did. There was clearly defined and visible leadership within the department and staff felt confident to challenge and raise issues of concern. There was a positive culture within the department and a willingness to learn and improve. The management of risk was well developed and governance arrangements were robust.

Vision and strategy for this service

- The organisational vision, "To deliver excellence in healthcare through innovations and collaboration'' was visible across the emergency department. The core objectives for the service reflected the trusts and were focused on patient safety, clinical effectiveness and patient centred care.
- Staff were provided with a corporate induction that included the trusts and the services core values and objectives. Staff had a clear understanding and could articulate what the vision and values meant for their practice.
- The trust's priorities, outlined in the trust quality strategy 2014–2016, included a specific strategic objective that was applicable to the emergency department "to monitor the use of electronic handover in emergency care and share the lessons learned". The board update from September 2014 stated that the electronic nursing handover had been standardised in emergency care and was now being implemented throughout the trust.

Governance, risk management and quality measurement

- Senior staff were aware of the departmental risks, performance activity, recent serious untoward incidents and other quality indicators.

- The divisional risk register included risks and ratings identified for the medicine and emergency department; progress and improvements were monitored through a regular quality committee meeting and fed back at divisional, departmental and executive level.
- Risks were rated from low to high with the lower risks being managed at ward level and the higher risks being escalated corporately.
- The clinical lead and matron felt the local risks were the numbers of staff employed and the skill mix with the main risk being patient flow during busy times. We looked at the divisional risk register and saw these and other key risks had been identified and assessed. The risk register was maintained by a divisional risk manager and was reviewed at routine divisional board meetings.
- Day-to-day issues, information around complaints, incidents and audit results were shared on notice boards around the department and also via meetings and the board huddles.
- Routine audit and monitoring of key processes took place across the department to monitor performance against objectives.

Leadership of service

- There were clearly defined and visible leadership roles within the medicine and emergency care division. The division was divided into clinical departments each with a clinical lead and a service manager.
- Senior staff in the emergency department provided visible leadership particularly at times when the department was stretched. The teams were motivated and worked well together with good communication between all grades of staff.
- Staff felt their efforts were acknowledged and felt managers listened and responded to their needs.
- Staff we spoke with felt free to challenge any staff members who were seen to be unsupportive or inappropriate in supporting the effective running of the service.
- The matron told us they were looking to employ three additional band 7 nurses to improve clinical leadership within the department.

Culture within the service

- The clinical lead told us the overall ethos in the emergency department was that care came before targets and if the quality of care was good then the targets would follow. Staff confirmed this and told us they focused on providing the right treatment at the correct time.
- Staff spoke of an open culture where they could raise concerns that would be acted on. They were dedicated and compassionate and felt proud to work at the hospital.
- Staff told us the morale within the department was good and the teams worked well together. However, at times, when the department reached high patient capacity staff felt that the morale dropped.
- Staff were encouraged and supported to report any issues in relation to patient care or any adverse incidents that occurred.
- We observed that staff from all specialities worked well together and had mutual respect for each other's contribution to the holistic care of their patients.

Public and staff engagement

- Information about how the public could provide feedback was displayed in the departmental areas and feedback mechanisms for the public to engage with the trust were also on the internet site.
- Staff told us they routinely engaged with patients and their relatives to secure feedback. Information on the number of compliments and complaints was displayed on notice boards in the major injuries area.
- Staff received communications in a variety of ways such as newsletters, emails and briefing documents and meetings. Staff told us they were made aware when new policies were issued and felt included in the development of the service and of the trust.
- A Division of Medicine and Emergency Care newsletter included feedback from the public, staff and relayed information about events and strategies.
- The 2013 NHS staff survey results for the trust were positive and showed that 61% of staff from the division had taken part. Following the 2012 survey the trust had improved the quality of appraisals and improved the health and wellbeing of staff but hadn't reduced the number of incidents of violence, bullying and harassment towards staff. The trust had identified this as a risk and had an action plan in place to try and address this issue.
- The department included 'you said, we did' information on notice boards which listed improvements made by the trust to queries raised by staff.

Urgent and emergency services

Innovation, improvement and sustainability

- The lead consultant told us the main challenge was the flow of patients out of the emergency department and the changing needs of the local population, such as an increased elderly population.
- We found a number of initiatives in place to reduce patient flow into the emergency department such as the streaming from A&E to the walk in centre to manage patients' admission and discharge from the emergency department. The winter plan was to extend the opening times to include the service at weekends from 1 December 2014 to March 2015.
- A review was being initiated to look at other issues that affected flow that may include a whole redesign of how people entered the department and how they would be discharged.
- The department was looking to work with other wards in a more proactive manner and to rotate staff from other wards into the emergency department to allow them to appreciate pressures of working in the emergency department.
- Other areas and projects that were being considered included looking at the conversion rate of patients that were admitted but could have been discharged, managing bariatric patients and using data to predict bed management forecasts.

Medical care (including older people's care)

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

Information about the service

The division of medicine and emergency care at Leighton Hospital provides a range of general and speciality medical services including: cardiology, care of the elderly, diabetes and endocrinology, gastroenterology, respiratory medicine, rheumatology, acute medicine, general medicine and stroke care.

During 2013/14 there were 22,168 inpatient admissions to 538 medical and acute beds at Leighton Hospital and Elmhurst Intermediate Care Centre.

As part of our inspection we visited the following wards: ward 3 (acute medical unit), ward 14 (care of the elderly), ward 5 (respiratory), and ward 18 (endocrinology), ward 1 (cardiac), ward 2/19 (general medicine / cardiac), and ward 6 (stroke), ward 4 (gastroenterology), ward 7 (gastroenterology), ward 21b (non-acute rehabilitation) and the Primary Assessment Area. As part of our unannounced inspection we returned to the Primary Assessment Area, ward 7 (gastroenterology) and ward 4 (gastroenterology).

We spoke with 30 patients and eight relatives/people who were close to them, received information from our listening events and from people who contacted us to tell us about their experiences. We spoke with 53 members of staff at all levels including nurses, matrons, allied health professionals, consultants, trainee doctors, sisters and ward managers. In addition, we also held focus groups for nurses, matrons, allied health professionals, healthcare assistants and medical staff. We observed how care and treatment was provided and reviewed 27 patients' records. Prior to our inspection, we reviewed performance information about the trust and information received from the trust.

Medical care (including older people's care)

Summary of findings

Medical services at Leighton Hospital were well-led, and delivered by caring and compassionate staff. We observed staff treating patients with dignity and respect and patients we spoke with were positive about their interactions with staff.

However, clinical outcomes for patients in some areas required improvement. Our analysis of data showed that particular improvements were needed in the management of patients with diabetes and those who had had a stroke. There were gaps in the provision of some out-of-hours services for patients with upper gastrointestinal (GI) bleeds and in providing thrombolysis for patients that had suffered a stroke. In addition, there was no diabetes nurse specialist based on site at the time of our inspection nor did the hospital offer a nurse specialist service in rheumatology (although mitigating plans were in place).

Patients were regularly at Leighton Hospital longer than they needed to be, usually as a result of delays in providing, or the availability of, care home placements or care at home packages.

Discharge letters were not prepared and issued promptly, leading to possible delays in follow-up care and treatment for patients. There was continual pressure on the availability of beds, which meant that some patients could not be placed in an area best suited to their needs. Some of the areas used for escalation beds, especially the primary assessment area, did not provide an appropriate environment for the care of patients overnight.

Are medical care services safe?

Good

There were effective arrangements in place for reporting safety incidents and allegations of abuse. Staff at all levels could describe their role in the reporting process and were encouraged to report incidents and concerns promptly. Staff were provided with feedback and learning from incidents was applied to prevent reoccurrence. Risks to patients were assessed, managed and monitored at all times and plans were in place to respond to emergencies and major incidents.

Ward environments were clean and well maintained and staff followed infection control procedures. MRSA and C. Diff infection rates were better than the England average. Staff consistently followed hand hygiene practice and 'bare below the elbow' guidance.

Staffing levels were planned, implemented and reviewed to keep the wards appropriately staffed to meet patients' needs. However there were some pressures in medical staffing numbers, particularly out of hours, that the service and the trust were working to address. As a result of staff shortages there were times when medical staff found it difficult to respond to patients needs in a timely way.

Incidents

- There were systems for reporting actual and near miss incidents across the medicine and emergency care division. Learning from incidents was discussed during team meetings, shared via email and lessons learned information was displayed on notice boards in staff areas.
- There had been one never event reported in the division. (Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented). This related to a drug incident that had been investigated and action had been taken to prevent reoccurrence. Staff we spoke with were aware of the incident and the lessons learned from it.
- The 2013/14 data showed there had been seven serious incidents reported in relation to the medicine and

emergency care division, the majority of these were in relation to grade 3 pressure ulcers. All serious incidents had been investigated and action had been taken to prevent reoccurrence.
- Mortality and morbidity meetings were held weekly and were attended by representatives from all teams within the division. During those meetings attendees reviewed the notes for every patient who had died in the hospital within the previous week.

Safety thermometer

- For the period July 2013 to July 2014 the number of pressure ulcers reported had remained low, patients suffering from falls had been consistently low, as had reported catheter acquired urinary tract infections (CUTIs).
- Results of the safety thermometer were displayed on every ward and area we visited. The results related to that individual ward or area and showed comparison with results for the previous month. Where there had been a reduction in performance against previous months, ward managers had action plans in place for improvement.

Cleanliness, infection control and hygiene

- The wards we inspected were clean and well maintained. All staff were aware of current infection prevention and control guidelines. Infection rates were, in the main, better than the England average.
- There were sufficient hand wash sinks and hand gels. Hand towel and soap dispensers were adequately stocked.
- Staff consistently followed hand hygiene practice and 'bare below the elbow' guidance. Personal Protective Equipment (PPE) such as aprons and gloves were readily available and in use in all areas.
- Side rooms were used where possible as isolation rooms for patients identified as an increased infection control risk (for example patients with MRSA). There was clear signage outside the rooms so that staff were aware of the increased precautions they must take when entering and leaving the room. These rooms were also used to protect patients with low immunity.
- There were signed cleaning schedules and labels on equipment showing when cleaning had last taken place.
- There were systems in place to screen patients for infection where they had been transferred from other hospitals. On admission, swabs were taken and results received before patients could be moved into bays with other patients.
- We looked at the storage areas where bags of infected linens and laundry were stored. While infected linen was stored in water soluble bags, on most wards these bags were placed directly onto the floor. This was not in line with best practice guidance as linen in this category should then be placed in an outer polyester/nylon carriage bag to avoid risk of cross contamination in the event the water soluble bag becomes damaged or starts to degrade. During the inspection we saw staff had to manually move the infected linen in water soluble bags out of the ward onto trolleys risking cross contamination from contact with uniforms.

Environment and equipment

- Resuscitation equipment on all of the wards was checked regularly appropriately packaged and ready for use.
- The service had access to a central equipment bank for pressure relieving equipment and an effective process for issuing, returning and cleaning the equipment.
- The wards and areas we visited were well maintained. However, some wards and areas had insufficient storage areas which led to equipment being stored inappropriately in offices and bathrooms that were rarely used.

Medicines

- All wards had appropriate storage facilities for medicines, and had safe systems for the handling and disposal of medicines. All ward based staff reported a good service from the pharmacy team. Pharmacy audits had been completed in line with policy and any required remedial actions had been taken.
- There were suitable arrangements in place to store and administer controlled drugs. Stock balances of controlled drugs were correct and two nurses checked the dosages and identification of the patient before medicines were given to the patient. Regular check of controlled drugs balances were recorded.
- Patient records were checked by pharmacists at least once per week.
- All medicines were appropriately stored including patient medications in specific patient locked drawers.

Fridge temperatures were regularly checked, recorded and adjusted as appropriate. However, we found no evidence that temperatures within medication storage rooms were checked.

- Each ward had a stock list of drugs which was reviewed annually to assess if this was meeting the demands of the wards.
- All medications on wards were in date indicating there were good stock management systems in place.
- Some medicines in drugs fridges were out of their original packaging. This meant that it could not be established where stocks originated from, the date they were dispensed, or how they had been obtained. One item we saw out of original packaging was not part of the stock list of drugs and staff could not tell us how long it had been there or where the medicine had come from.
- There was no specimen signature list available of staff who administered medicines. Bank and agency nurses worked some shifts, without a list it may prove difficult to ascertain which staff member had dispensed medicines.
- Suitable cupboards and cabinets were in place to store medicines. This included a treatment room on each ward and secure lockers at patient bedsides.

Records

- Patient records included a range of risk assessments and care plans that were completed on admission and reviewed throughout a patient's stay. Patients had an individualised care plan that was regularly reviewed and updated.
- We saw comprehensive and well documented wound management plans. These showed wounds were dressed regularly and progress of healing was well documented.
- In most areas records were stored securely. However, there were instances where patient records were stored in unlocked trolleys at nurse's stations. This increased the potential for patient confidentiality to be breached.

Safeguarding

- There was a system for raising safeguarding concerns. Staff were aware of the process and information to support staff was displayed on wards. Staff received training at induction and subsequently annually at staff meetings. Staff also told us that safeguarding training was included in their bi annual mandatory training updates.
- Staff knew the name of the safeguarding lead for the trust and knew how to seek advice if they had safeguarding concerns.

Mandatory training

- The service provided by bi-annual mandatory training updates for all staff. Information supplied by managers for the period April 2013 to March 2014 showed an 88% completion rate against a target of 90% for staff in the division with individual ward figures ranging between 74% and 100%.

Assessing and responding to patient risk

- An early warning score system was used throughout the trust to alert staff if a patient's condition was deteriorating.
- Early warning indicators were regularly checked and assessed. Where the scores indicated that medical reviews were required staff had escalated their concerns. Medical reviews and repeated checks of the early warning scores were documented accurately.
- The trust was participating in a scheme where each patient was invited to undertake an assessment of their alcohol intake to indicate if there were potential dependency concerns.
- Patient wristbands had a colour coded system to alert staff if the patient had known allergies or there was a risk of the spread of infection.
- Where patients required naso-gastric tubes we saw that x-rays were used to ensure the tubes were correctly inserted into the stomach, reducing the risk of aspiration. Aspiration means breathing in a foreign object (such as sucking food into the airway).

Nursing staffing

- Nurse staffing levels had improved with a number of vacancies now filled. Matrons and ward managers met three times per week to discuss nursing staffing levels and there was good allocation of staff to ensure that skills were appropriately deployed and shared across all wards.

Medical care (including older people's care)

- Staffing levels were well monitored. Staffing meetings attended by the Matrons were held three times weekly. Bed managers knew where there were staffing shortfalls and where there were surplus staff that could be called on if needed.
- Each ward or area undertook a staffing analysis twice per year using a recognised acuity tool. Ward managers told us that they could escalate to matrons at any time if they had concerns about staffing levels or a patient needed one to one support.
- Every ward we visited displayed planned and actual staffing levels and at the time of our visit and all wards had a full complement of nurse staffing. Some ward managers raised concerns regarding nurse staffing levels at night. A member of the nursing staff team told us: "winter pressures are a concern. The workload gets excessive and gaps in nursing due to illness can undermine quality".
- Staffing levels were being maintained by staff working extra shifts, or by the use of bank/agency staff. Some 'block booking' of bank staff was being used. This meant that the same staff committed to working shifts and helped promote a good understanding of patients on going condition.
- We observed several nursing handovers during our inspection. Staff also had regular 'huddles' to share essential information about patients during a shift. Communication between staff was effective and included information regarding risks and concerns relating to each patient.
- The service had recently been included in the use of an electronic handover (e-handover) system in three pilot areas. Staff told us this was highly effective and due to be rolled out to all areas over the coming months.
- All wards allocated one qualified nurse and one healthcare assistant to each bay so that they could work together, get to know the patients and provide a constant presence within the bay.
- We found nurse staffing levels in the discharge lounge did not reflect the variability of patient numbers. There were no risk assessments in place for staff lone working in this area. There was no guidance indicating which patients were suitable for transfer to the discharge lounge and staff told us that they had to stay late for up to three evenings per week during the winter because of the delay to discharges caused by patients waiting for their medication or transport.

Medical staffing

- Consultant cover was available on site from 8am to 9pm Monday to Friday and two consultants were available on site at weekend mornings. Out-of-hours and weekend cover was provided by junior medical staff with on-call consultant support if required.
- The associate medical director informed us that there was an under allocation of trainee doctors by the deanery. In response to this the service and the trust was attempting to recruit to some posts from overseas and appoint advanced nurse practitioners to carry out some of the roles traditionally performed by trainee doctors. The service was also experiencing challenges in recruiting to vacant consultant posts. In order to make the posts more attractive the trust were working with another local trust to recruit jointly appointed consultants.
- While there had been no reported safety incidents relating to medical staffing at the time of our inspection, trainee doctors told us that night time staffing was lean and there was a risk that they would be unable to respond to all patients at night during the busy winter pressures period. One junior doctor told us: "It has occasionally felt unsafe, but no untoward incidents have been reported."
- Consultants told us that the appointment of advanced nurse practitioners within the trust was a significant mitigating factor in managing trainee doctor workloads.

Major incident awareness and training

- Ward managers had copies of the trust's major incident policy.
- There was an escalation policy in place and we saw staff using this appropriately at the time of our inspection.
- Since April 2014 the service had been contributing to the planning for 2014 winter pressures and a task and finish group chaired by the deputy director of operations and performance had been meeting fortnightly to ensure the service was ready for the increased demand that winter brings, readiness plans were in place at the time of our inspection,
- All staff had been encouraged to have a flu vaccination to protect them and patients from the virus.
- The trust had circulated information to staff regarding Ebola risks and actions to take if a case was suspected.

Medical care (including older people's care)

Are medical care services effective?

Requires improvement

Outcomes for patients in some areas needed improvement. Analysis of data from October 2013 to March 2014 as part of the Sentinel Stroke National Audit Programme (SSNAP) placed the hospital as one of the worst trusts in England for the effective management of stroke patients. Improvements were also needed in the management of patients with diabetes. Medical wards had clinical pathways for care in place for a range of medical conditions based on current legislation and guidance.

There were delays in discharge letters being sent to general practitioners (GPs). This meant there was a risk that patients would not receive timely follow-up care or diagnostics because their GP was not aware of their needs.

Staff did not systematically receive clinical supervision. However they did receive annual appraisal and training opportunities. Multi-disciplinary team meetings were well established and the trust had a plan to move towards seven day working practices by 2017.

In practice staff were not following the trust's policies and procedures on mental capacity as they were unfamiliar with the two stage assessment of capacity. This assessment was not documented in patient records where it was appropriate. Patients were supported to manage their pain and their nutritional and hydration needs were generally being met.

Evidence-based care and treatment

- Best practice guidelines were used throughout the division to standardise care. The trust monitored compliance with NICE guidance and were taking steps to improve compliance where further actions had been identified.
- Care pathways were displayed in ward areas to support staff and records showed evidence that patient care following appropriate pathways.
- The trust participated in local and national audits to review the care and treatment they offered. Remedial actions were implemented and monitored.

Pain relief

- Pain relief was managed on an individual basis and was regularly monitored for efficacy. Patients told us that they were consistently asked about their pain and supported to manage it. We saw that pain scores were actively recorded on early warning score (EWS) documentation.

Nutrition and hydration

- Where possible there was a period over meal times where all activities on the ward stopped, if it was safe for them to do so. These protected meal breaks enabled staff to assist patients who needed help.
- A coloured tray system was in place to highlight which patients needed assistance with eating and drinking. Every ward had a nutritional champion with their name and photograph displayed on the wards. The champions could be called on to provide advice and support for patients who had special or specific dietary needs.
- Fluid balance charts were consistently completed in patient records.
- Dieticians working within the trust were allocated to wards. This meant that they were part of the ward team and were on hand to advise regarding patients' nutritional requirements.
- All patients we spoke with said they were happy with the standard and choice of food available.
- However during our unannounced inspection, we found that one patient on the PAA had not received water or been offered a hot drink for a period of four hours although they had been given food. When we brought this to the attention of nursing staff they responded immediately with an offer of fluids.

Patient outcomes

- An analysis of data submitted by the trust from October 2013 to March 2014 as part of the Sentinel Stroke National Audit Programme (SSNAP) placed the hospital as one of the worst trusts in England for the effective management of stroke patients. SSNAP is a programme of work that aims to improve the quality of stroke care by auditing stroke services against evidence-based standards. The trust scored well for the provision of physiotherapy to stroke patients but poorly in every other indicator including speech and language therapy, occupational therapy, specialist assessments and

discharge processes. The trust had an action plan in place to address concerns raised by the SSNAP Audit. However the plan had not yet been fully implemented at the time of our inspection

- The 2012/2103 heart failure audit showed the hospital performed better than average for all four of the clinical (in hospital care) indicators and four out of seven of the clinical (discharge) indicators. They performed slightly worse than average for referrals to heart failure liaison services and cardiology follow-up services. The trust had an agreement in place with another local trust for the transfer of patients with chest pain and two consultants posts were shared appointments.
- An analysis of the Myocardial Ischaemia National Audit Project (MINAP) data showed that the trust was performing worse than the England average for care of inpatients with non-ST segment elevation myocardial infarction (nSTEMI).
- An analysis of the National Diabetes Inpatient Audit 2013 (NaDIA) showed the hospital performed worse than the England average against 14 out of the 20 indicators. Of particular concern was data showing that only ten percent of patients received a visit by a specialist diabetes team compared with an England average of 34%. Only 21% of patients received a foot risk assessment during their hospital stay compared with an England average of 42% and only 65% of staff were aware of diabetes compared with an England average of 81%. At the time of our inspection we were not aware of any action plan in place to improve diabetes care within the hospital.
- Three months prior to our inspection the trust had introduced an acute kidney injury care bundle. There were plans to audit this pathway to evaluate the impact on outcomes for patients.
- Delayed transfer of care figures for the trust show that a total of 24% of patients had delays while waiting for a care package in their own home, or a residential or nursing placement. At the time of our inspection one ward of 24 patients had two who were medically fit and had been waiting in excess of a week for nursing home placements.
- Nursing staff told us it was not possible to allocate a named social worker to a patient on a Friday or a weekend due issues outside the trust's control. The trust told us of discussions taking place with the clinical commissioning groups (CCGs) to establish improved links with care of the elderly services in the community. At the time of our inspection a proposal had been agreed for a community based geriatrician to improve discharge rates.

Competent staff

- Staff told us they received an annual appraisal. According to trust figures for the period April 2013 to March 2014 most wards had achieved 100% appraisal completion rate. However on one ward only 57% of nursing staff had been appraised.
- Staff told us there was no formal system for clinical supervision. The assistant director of integrated governance told us that staff did receive clinical supervision but confirmed there was no trust policy in place for a formal clinical supervision process. Trainee doctors told us their opportunities to undertake clinical supervision were limited due to workload. The purpose of clinical supervision is to provide a safe and confidential environment for staff to reflect on and discuss their work and their personal and professional responses to their work. The focus is on supporting staff in their personal and professional development and in reflecting on their practice.
- Trainee doctors told us that the shortage of medical staff reduced their opportunities for continuing professional development.
- Advanced nurse practitioners were given opportunities for clinical supervision but these were not formalised.
- Some training was delivered to staff at ward level, for example catheterisation and intravenous fluid administration. Staff told us there were assessments completed and ongoing monitoring of competency.
- A member of the clinical coding staff told us they had established links with Liverpool University where they attended for updates and training.

Multidisciplinary working

- Multidisciplinary team (MDT) working was well established on the medical wards. MDT decisions were recorded and care and treatment plans amended to include changes.
- MDT meetings took place weekly attended by a consultant, specialist registrar, trainee doctors, a social worker, ward manager and sister as well as a physiotherapist and therapist.

- A hospital alcohol liaison team (HALS) were based at Leighton Hospital. There were good links and working relationships with this team across the division but especially in the acute medical unit (AMU) and primary assessment area (PAA).
- A psychiatric liaison service was available within the trust.
- The trust had agreements in place with another local trust for the delivery of shared cardiology services with some joint consultant post appointments.

Seven-day services

- The medicines division had developed a business case for seven day working to be implemented by 2017. The action plan to develop seven day services was integrated within the clinical services strategy which was monitored through the trust's governance systems.
- Consultant cover was available on site from 8am to 9pm Monday to Friday and two consultants were available on site at weekend mornings. Out-of-hours and weekend cover was provided by junior medical staff with on-call consultant support if required.
- There were daily consultant led ward rounds.
- There was consultant presence and ward rounds seven days a week on the AMU.

Access to information

- All staff had access to the information they needed to deliver effective care and treatment to patients in a timely manner including test results, risk assessments and medical and nursing records.
- Systems that managed information about patients were accessible to staff both electronically and in paper format. The trust had recently introduced the use of an electronic handover (e-handover) system in three pilot areas. Staff told us this was highly effective and due to be rolled out to all areas.
- Prior to our inspection we received information from stakeholders regarding delays in discharge letters being sent to general practitioners (GPs). At the time of our inspection several wards had letters awaiting completion. One ward had 42 letters outstanding. At the time of our unannounced inspection the PAA had over 60 outstanding discharge letters with the most delayed being for a patient discharged over seven weeks previous. This meant there was a risk that patients would not receive timely follow-up care or diagnostics because their GP was not aware of their needs. Nursing staff told us the delays were caused because there were low numbers of trainee doctors within the trust so the time they had available for the preparation of letters was minimal. Consultants we spoke with confirmed this. While the trust had employed doctors for overtime at weekends to reduce this backlog, numbers remained high (more than 20) on several wards. When we asked ward managers about escalation protocols for this issue we were advised that although staff escalated their concerns there was no formal protocol. This is a matter that requires urgent attention so that the ongoing care and treatment of patients is not compromised through poor communication. We have raised this matter with the trust who have assured us they will take action to make the necessary improvements.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff we spoke with knew about the key principles of the mental capacity act and how these applied to patient care. Part of the care planning records included the key principles and reminded staff to apply them when providing care and treatment. However, a separate document printed from the trust's intranet was required for the completion of a two stage capacity assessment.
- Staffs were not following the trust's policies as they were unfamiliar with the two stage capacity assessment. A two stage capacity assessment should be completed when staff suspect patients are not able to give informed consent about decisions relating to their treatment.
- Staff told us they did involve patients' families and best interests meetings had been held. However a capacity assessment would clearly document what attempts have been made to engage with patients in order to promote decision making.
- Some Mental Capacity Act training had been completed but not all staff had been trained. Generally, staff knew the principles of consent but the trust's policy and procedure was not embedded into practice.
- We saw clear written records that therapists gained verbal consent from patients prior to the start of each therapy session.
- Staff had knowledge and understanding of procedures relating to the Deprivation of Liberty Safeguards (DoLS). We saw several examples of DoLS paperwork completed fully and accurately. Staff told us of examples where DoLS had been applied for and approved and we

reviewed patient records containing DoLS applications. This included an example where a patient without capacity was refusing medication and an approval was in place to allow for covert medication to be given.

Are medical care services caring?

Good

Medical services were delivered by caring and compassionate staff. We observed staff treating patients with dignity and respect. Patients were positive about the way staff interacted with them.

We saw and heard numerous examples of staff providing emotional support to patients and those close to them. One relative wrote, "The care given professionally could not possibly have been better but it was the friendly, personal, caring way in which it was delivered that I will always remember and words cannot express how grateful I am"

Staff at all levels could demonstrate that patients were partners in their care. It was evident that staff had developed positive relationships with patients and those close to them. Staffs were aware of and sensitive to the needs of patients and supported them to stay connected to their families during their hospital stay.

Compassionate care

- Medical services were delivered by, caring and compassionate staff. We observed staff treating patients with dignity and respect.
- All the people we spoke with were positive about their care and treatment. Comments included: "Staff have been brilliant", "Wonderful treatment", "Not one of them dropped below 'outstanding' for the care delivered". One relative had written in to one of the wards and said: "The care given professionally could not possibly have been better but it was the friendly, personal, caring way in which it was delivered that I will always remember and words cannot express how grateful I am".
- The friends and family test (FFT) response scores for eight out of nine wards were better than the England average of 32% with only one ward scoring slightly worse at 30% and three scoring significantly better. The friends and family test asks patients how likely they are to recommend a hospital after treatment. 97% of patients said they would recommend the service with the majority saying they were 'extremely likely' to recommend the service.
- The trust performed about the same as all other trusts in all areas of the 2013 CQC inpatient survey.
- In the cancer patient experience survey for inpatient stay 2012/2013, the trust performed in the top 20% of all trusts for five areas out of 34 including "patient had confidence and trust in all doctors treating them" and "staff gave complete explanations of what could be done". The trust performed in the bottom 20% of all trusts in five out of the 34 areas including "possible side effects explained in an understandable way", "staff explained how treatment had gone in an understandable way", "staff told patient who to contact if worried post discharge", "patient had confidence and trust in all ward nurses" and "patient was able to discuss worries or fears with staff during visit".

Understanding and involvement of patients and those close to them

- All patients we spoke with said that they had received good information about their condition and treatment including written information for them to take home.
- Patients reported seeing a consultant and other doctors regularly.
- One patient described to us how understanding staff were and how hard they worked. They told us that some patients were not good with staff, sometimes because of confusion, but also said that some patients were rude to staff. The patient told us that staff handled this well in a calm and sensitive manner.

Emotional support

- One patient told us they liked to have a bed near the windows as they were claustrophobic and liked to leave the curtains open. They said this had always been arranged for them.
- Psychological support for patients who had experienced stroke was accessed from another trust. Referrals to the service received a prompt response.
- Patients told us that they "could have a laugh with staff" and that they were all nice.

Are medical care services responsive?

Medical care (including older people's care)

Requires improvement

Some patients could not be placed in the area best suited to their needs. Some of the areas used for escalation beds, especially the primary assessment area did not provide an appropriate environment with sufficient facilities for the care of patients for prolonged periods including overnight.

There were gaps in the provision of services for patients with upper GI bleeds and stroke thrombolysis out of hours. In addition, there was no diabetes nurse specialist based on site at the time of our inspection nor did the hospital offer a nurse specialist service in rheumatology (although mitigating plans were in place).

There was a backlog of discharge letters awaiting completion for forwarding to GPs.

Medical care provided a number of services which took into account the needs of different people including those in vulnerable circumstances.

People's concerns and complaints were listened and responded to effectively. Lessons learned from complaints were shared with staff at all levels to prevent a reoccurrence.

Service planning and delivery to meet the needs of local people

- As a result of high patient numbers there were escalation beds in use on wards within the division. This included into the surgical ward and intensive care unit as well as the overnight use of the primary assessment area. During our inspection there were up to 15 patients not placed in the area best suited to their needs (outliers / boarders).
- We spoke with the majority of these outlier patients and reviewed their records. All of them were receiving appropriate treatment for their condition and had been regularly reviewed by a doctor. The trust had a system in place to ensure that medical outliers were reviewed regularly by a consultant. However, some doctors expressed concern that this was a risk which could mean that patients did not receive the care and treatment they required because they were not in the "right bed". One member of nursing staff told us that patients admitted as an outlier on a Friday may not be seen by a doctor until the following week. We raised this with the trust as an issue that must be resolved as a matter of priority.
- At the time of our inspection there was no out of hour's service available for patients presenting with an upper gastrointestinal (GI) bleed. Doctors told us they were concerned about how these patients would be managed. Trainee doctors described patients as "bleeding over a weekend while waiting for treatment and requiring multiple top up transfusions". This appeared as a risk on the trust risk register and we discussed this concern with the trust. We were told of a partnership arrangement with a neighbouring trust to provide this service. This arrangement was to commence on 30 November 2014 and we were advised that informally patients would be able to access this treatment pathway with immediate effect.
- Thrombolysis was available 9.00am to 9.00pm Monday to Friday. Outside of these hours, patients were transferred to adjacent acute hospitals if the time frame for administering thrombolysis could be achieved. We asked the trust for information on how frequently patients had been transferred for treatment but were told this data was not collated so it was not possible to establish the impact of the limited thrombolysis service on patients using the hospital.
- The trust did not have an inpatient diabetes nurse specialist based on site at Leighton Hospital. Staff told us that if the patient needed support they would either refer them to the consultant endocrinologist or call for advice from ward 18 (Endocrinology). This meant there was a risk that patients would not receive timely support and advice for their condition. This risk was not identified on the divisional risk register.
- The trust did not have a nurse specialist service in rheumatology. We discussed this with the trust. There were mitigating plans in place to cover this vacancy and longer term plans in place for the future of the service.
- We saw evidence of a number of patients suffering with moisture lesions. A moisture lesion is skin damage caused by skin coming into contact with excessive moisture and is often linked to incontinence. A key factor in preventing moisture lesions from occurring, and in preventing further complications once they occur, is the investigation and management of incontinence. Ward staff reported that while there was a tissue viability link nurse, they did not have access to a

continence advisor from whom they could gain specialist advice to improve the care of these patients. This had been highlighted by the trust as a gap in service provision.
- Staff working in the discharge lounge was able to provide patients with a 'goody bag' containing food and drinks should their discharge time be too late for their home care package.

Access and flow

- Bed occupancy rate for the trust was consistently 90% and for the most recent quarter 95%. This is worse than the England average. It is generally accepted that, when occupancy rates rise above 85%, it can start to affect the quality of care provided to patients and the orderly running of the hospital.
- We attended bed managers' meetings during our visit which showed there was continual pressure on the availability of beds. In particular, there was a shortage of medical beds and sometimes patients were placed on wards which were not specialist to their needs, these were known as outliers.
- We found that some of the escalation areas were not suitable. In particular we found 16 beds on the primary assessment area unit did not provide patients with required facilities such as appropriate access to a single sex shower, sufficient bathrooms and toilets, personal lockers, windows and privacy. The area did not have side rooms for patients with infections or those susceptible to infection. Patients told us they did not sleep in this area as it was noisy even though staff tried to keep the noise to a minimum.
- At the time of our announced inspection two patients had been in this area for over 36 hours. When we brought this to the attention of managers at the trust they acted immediately by implementing the Golden Patient initiative to ensure that patients did not spend more than 24 hours in this area and were moved to a setting more suited to their needs at the earliest opportunity. However, during our unannounced visit there were three patients on the unit who had been there for longer than 24 hours. The risk of using this area was listed on the division's risk register. It was not acceptable for patients to remain in the PAA for longer than 23 hours.
- Data provided by the trust for the period April to June 2014 showed 7% of patients had experienced three or more bed moves during their hospital stay. We found that this was a direct result of attempts to move patients to the right bed during periods of high occupancy.
- Between the hours of 11.00pm and 8.00am statistics showed that there had been necessary bed moves where patients were relocated to other rooms/bays and wards. From July to September 2014 the figures indicated that this affected 5% of patients.
- Patients were regularly in hospital for longer than they required. Delayed transfer of care figures from April 2013 to July 2014 showed the main reason for delayed discharge was public funding delays. Trainee doctors told us that discharges could be difficult due to issues outside the trust's control. They told us that some patients who were medically fit for discharge could wait weeks for care packages to be put in place. As patients could be prone to develop infections over this period they would then not be medically fit when the care package was in place and the process would repeat again.
- For the period from April 2013 to June 2014 the trust performed better than the England average for 18 week referral to treatment times (RTT).

Meeting people's individual needs

- Nursing staff used standard risk assessment tools to identify patient needs. Patients were assessed for risk of falls, pressure ulcers and malnutrition. One consultant at the trust had developed specific documentation for patients on an alcohol detox pathway and this included a dedicated medication administration chart.
- Staff told us that the trust psychiatric liaison service responded very promptly to requests and were willing to accept a verbal referral over the telephone. However, staff told us that patients had to be medically fit before a referral could be made and that this sometimes led to delays and longer patient stays.
- The trust had a smoking cessation advisor and patients told us they had been put in contact with a smoking cessation clinic. Each ward had a supply of nicotine patches available to help patients manage their cravings for cigarettes. There were also plans to have a stock of nicotine inhalers available as standard on each ward.

We spoke with a member of the smoking cessation team who told us there was a graduated programme of support in place to help patients with cravings or support them to give up smoking if they wished to.

- A hospital alcohol liaison team (HALS) were based at Leighton Hospital. Nursing staff spoke highly of this service. Figures supplied by the trust showed that on average 20 patients with mental and behavioural disorders relating to alcohol were admitted each month to medical wards between October 2013 and September 2014. It was assumed that these patients required a period of detox following admission. However, detox was not necessarily the primary reason for admission. The HALS team continued to provide support for these patients in the community post discharge where appropriate.
- A telephone translation service and interpreters were available to support patients whose first language was not English. Staff confirmed they knew how to access these services and that the trust also encouraged staff with a second language to support communication with these patients. We saw that patient information leaflets were translated into polish and guidance on how to access information in other languages was displayed in those languages on all wards.
- The trust used a hospital passport document called "Information about me to help you", for patients with learning disabilities and those living with dementia. Patient passports provide information about the person's preferences, medical history, routines, communication and support needs. They were designed to help staff to understand the person's needs. We found evidence of completed hospitals passports being used effectively by staff to support patients' needs.
- The trust had a dementia lead and each ward had a dementia link nurse and a dementia display board with information available to patients and relatives. One week prior to our inspection the trust had introduced a dementia care bundle. Although some staff were able to talk to us about this initiative it was too early to evaluate its impact and training had not yet been widely delivered.
- The division had a risk assessment in place to accommodate disability support dogs in the hospital while their owners were inpatients.
- Some locations within the trust did not have a loop system in place with patients with hearing impairments. However communication boards were available for use.
- Telemedicine was available within the trust with an identified ward monitoring results and contacting the appropriate ward where the patient results indicated a need for further treatment.

Learning from complaints and concerns

- Staff we spoke with were aware of the trust's complaints system and how to advise patients and those close to them if they wanted to make a complaint. Ward managers told us that they preferred to meet with complainants to understand and respond to their concerns.
- We saw examples of changes to practice as a result of complaints. For example for housekeeping staff hours had been increased following a complaint regarding the condition and supply of patient blankets.
- A number of wards had changed their staffing so that one qualified nurse and one healthcare assistant was allocated to each bay to reduce the risk of patient falls.
- Managers we spoke with could tell us about the recent complaints that related to their wards and their involvement in the investigations. Staff we spoke with consistently told us they received feedback from complaints and could talk about lessons learned. This showed staff involvement at all levels in complaints management, resolution and learning.
- Ward quality and safety boards showed that patients on several wards were concerned about noise levels at night. Nursing staff were able to tell us what actions they had taken to try to reduce the noise level including closing doors, purchasing new quiet closure bins and ensuring that a nurse was based on each bay to calm patients who were unsettled at night.

Are medical care services well-led?

Good

Managers and staff had a clear vision for the service and had identified risks to achieving this. Governance systems were in place and staff reported that the leadership was visible and approachable. The public and staff were engaged in design and delivery of the service and we there were examples of innovation and improvement.

Medical care (including older people's care)

Vision and strategy for this service

- The trust's vision was summarised as "To Deliver Excellence in Healthcare through Innovations and Collaboration".
- The division of medicine and emergency care's vision was summarised as "right patient under the right team in the right place". Staff we spoke with at all levels referred to this vision.

Governance, risk management and quality measurement

- The risk register highlighted risks across the division of medicine and emergency care and actions in plan to address concerns, for example in relation to conerns regarding access and flow.
- There was a programme of monthly peer audits across the division. Results were reviewed monthly and action plans completed to address concerns as well as weekly spot checks for areas where results had fallen below target levels.
- All wards had a quality and safety board displaying information about numbers of infections, falls, complaints and compliments as well as star ratings for patient experience. There was also a board in each ward for patient feedback letters and cards. All of these boards were full with recent positive feedback.

Leadership of service

- Staff reported there was clear visibility of the trust's board throughout the service.
- All nursing staff spoke highly of the ward managers as leaders and told us they received good support. We observed good working relationships within all teams.
- Consultants told us the chief executive and medical director gave "accessible and responsive leadership".
- Middle grade doctors and advanced nurse practitioners (ANPs) told us they received good support from consultants.
- The trust provided nursing staff working at band five the opportunity to access a leadership programme where they could perform a band six role as part of their development. One nurse spoke positively about the course, which had clear aims and objectives that were assessed as the course progressed.

Culture within the service

- The trust had a better response rate than the national average for the NHS staff survey.
- The General Medical Council National Training Scheme Survey 2013 showed the trust was performing within expectations in 10 out of 12 areas surveyed. For "clinical supervision" and "feedback" the trust performed worse than expected.

Public and staff engagement

- The division of medicine and emergency care published a quarterly newsletter which staff were encouraged to contribute to.
- Ward managers held staff meetings. While the desired frequency was monthly, some staff told us that meeting quarterly was more achievable. We saw minutes of these meetings and updates were displayed in staff areas for those who were unable to attend.

Innovation, improvement and sustainability

- The ward manager on ward 14 told us about a pilot for open visiting which meant that relatives were able to visit the ward at any time, 24 hours a day, and seven days a week. While staff had initially had reservations about this, we were told of significant benefits. There had been a reduction in falls on the ward; staff told us "there are more eyes in the bays". Relatives were available and able to help at meal and drink times. There had been a reduction in complaints as relatives were better informed about the patient's condition and staff were available to discuss issues because conversations were not concentrated into a short period of time during set visiting hours.
- A respiratory consultant told us that respiratory, gastroenterology and cardiology disciplines all participate in National Institute for Health Research portfolio research. At the time of our inspection the trust was participating in a clinical trial on bronchodilators which was accessible to all patients.
- The trust had recently introduced the use of an electronic handover (e-handover) system in three pilot areas. Staff told us this was highly effective and was due to be rolled out to all areas. The trust had won a health service journal award for this initiative.
- One consultant at the trust had developed specific documentation for patients on an alcohol detox pathway and this included a dedicated medication administration chart.

Surgery

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

Information about the service

We carried out a visit as part of our announced inspection on 8 to 10 October 2014. A range of surgical services are provided including ophthalmology, urology, gynaecology, orthopaedics, ear, nose and throat (ENT) and general surgery (such as colorectal surgery and upper gastrointestinal (GI) surgery).There are five surgical wards and 12 theatres that carry out elective (day surgery) and emergency surgery procedures.

As part of the inspection, we inspected the main theatres, ophthalmology theatres, endoscopy suite, ward 10 (surgical specialties ward / surgical assessment unit), ward 9 (elective orthopaedic ward), ward 15 (general orthopaedic and trauma ward), ward 11 (day case admissions and discharge), ward 12 (female surgery and gynaecology ward) and ward 13 (general surgical ward).

We spoke with 10 patients. We observed care and treatment and looked at care records. We also spoke with a range of staff at different grades including nurses, doctors, consultants, ward managers, divisional matrons, clinical leads and members of the senior management team. We received comments from our listening event and from people who contacted us to tell us about their experiences, and we reviewed performance information about the trust.

Summary of findings

Surgical services provided good care and treatment for patients. Patient safety was monitored and incidents were investigated to assist learning and improve care. Patients received care in clean and suitably maintained premises. The staffing levels and skills mix was sufficient to meet patients' needs and staff assessed and responded to patient risks appropriately. The service had action plans in place to address identified risks in relation to staffing levels.

Surgical services provided effective care and treatment that followed national clinical guidelines and staff used care pathways appropriately. The services participated in national and local clinical audits. There were plans in place to improve areas where national clinical and performance standards had not been achieved, such as compliance with the national hip fracture audit.

The majority of patients had a positive outcome following their care and treatment. However, the number of patients that had elective surgery and were readmitted to hospital following discharge was worse than the England average. Patients received care and treatment by trained, competent staff that worked well as part of a multidisciplinary team. Patients spoke positively about their care and treatment. Patients were treated with dignity and received care compassionately. Surgical services were planned and delivered to meet the needs of local people. There was sufficient capacity to ensure patients admitted to the surgical services could be seen promptly and receive the right level of

care. There was clearly visible leadership within the surgical services. There was a positive culture that was focused on patient safety and learning. There was routine public and staff engagement and actions were taken to improve the services. The management team understood the key risks and challenges to the service and how to resolve them.

Are surgery services safe?

Good

Patient safety was monitored and incidents were investigated to assist learning and improve care. Patients received care in safe, clean and suitably maintained premises. Patients care was supported with the right equipment. The staffing levels and skills mix was sufficient to meet patients' needs and staff assessed and responded to patient risks.

Incidents

- The Strategic Executive Information System (StEIS) records serious incidents and never events. There had been two never events reported by the Trust since March 2013 relating to surgery.
- One related to a swab that was retained inside a patient following surgery. This incident was investigated and remedial actions were put in place to prevent reoccurrence. For example, the use of a swab rack for each surgical procedure to ensure that all surgical swabs used per procedure were accounted for.
- The other incident related to a medication error in anaesthetics which was in the division of medicine and emergency care. The investigation for this incident was still ongoing at the time of our inspection and the root cause had not yet been determined. However, we saw that remedial actions had been implemented to prevent this type of error from reoccurring.
- The service reported that between April 2013 and May 2014 there were four serious incidents. Three of these were for patients acquiring grade 3 pressure ulcers and one related to a surgical error. During the inspection, we saw evidence that these incidents were investigated and action plans were implemented to improve patient care and prevent avoidable harm.
- The staff we spoke with were aware of the process for reporting any identified risks to staff, patients and visitors. All incidents, accidents and near misses were logged on the trust-wide electronic incident reporting system. Allegations of abuse were also logged on the electronic incident reporting system.

- Incidents logged on the system were reviewed and investigated by ward and theatre managers to look for improvements to the service. Serious incidents were investigated by senior staff.
- Information relating to lessons learned from incidents, such as falls, pressure ulcers and medication errors was displayed on notice boards in all the areas we inspected. Staff told us incidents and complaints were also discussed during routine staff meetings so shared learning could take place.
- Patient mortality and morbidity was reviewed by individual consultants within their surgical specialty area and reviewed at monthly divisional mortality review meetings, chaired by the clinical lead. This information also fed in to the trust-wide hospital mortality reduction group.

Safety thermometer

- Safety thermometer information between July 2013 and July 2014 showed that the surgical services performed within the expected range for falls with harm, catheter urinary tract infections (CUTI's) and new pressure ulcers.
- Catheter urinary tract infections remained low except for a spike in October 2013. There were no catheter urinary tract infections reported between December 2013 and June 2014. We spoke with the divisional matrons, who told us they could not attribute the increase in October 2013 to any specific factor.
- Information relating to the safety thermometer was not visibly displayed within the wards and theatre areas we inspected.

Cleanliness, infection control and hygiene

- There had been one case of Methicillin-resistant Staphylococcus aureus (MRSA) reported in August 2014. We looked at the investigation report and actions plans for this incident and saw there was clear involvement from nursing and clinical staff, as well as the trust's infection control team. Prevention and control of infection measures were well embedded throughout the service.
- The divisional matrons told us there were two cases of Clostridium Difficile (C.diff) infections in the surgery and cancer division. These were reported in July 2014 and in August 2014.
- The trust's infection control report 2013/14 showed that between April 2013 and March 2014, 86% of elective surgery patients (with minor surgery and endoscopy as exceptions) and emergency admissions received MRSA screening procedures so that any at risk patients could be identified and treated promptly.
- Health Protection Agency (HPA) data showed that the number of surgical site infections following orthopaedic surgery reported by the trust were within expected levels between April 2012 and March 2013.
- The wards and theatres we inspected were clean and hygienic and there were clearly defined roles and responsibilities for cleaning the environment and cleaning and decontaminating equipment.
- There were arrangements in place for the handling, storage and disposal of clinical waste, including sharps. There was a sufficient number of hand wash sinks and hand gels. We observed staff following hand hygiene and 'bare below the elbow' guidance.
- Staff were observed wearing personal protective equipment, such as gloves and aprons, while delivering care. Gowning procedures were adhered to in the theatre areas. Patients identified with an infection were isolated in side rooms and we saw that appropriate signage was in use to protect staff and visitors.

Environment and equipment

- Wards were clean and well maintained. However, we found that some of the wards, such as ward 10 (surgical specialties / surgical assessment ward) were cluttered and the general ward environment and fixtures, such as lockers, workspaces and utility room cupboards were worn and dated. The surgical wards were identified for updating as part of the trust's ongoing ward refurbishment plan.
- The hospital had 12 operating theatres; including eight newly built 'state-of-the-art' theatres that opened in April 2014. These were clean and maintained to a good standard and fully equipped with new operating theatre equipment. The existing "older" theatres were still used for elective (day case) surgery but these were not in use during our inspection. There were two additional theatres used for ophthalmology. We saw that these theatres were also clean and well maintained.
- Equipment was clean and well maintained. Staff told us that all items of equipment were readily available and any faulty equipment was either repaired or replaced on the same day.
- Staff told us they used single-patient-use, sterile instruments where possible.

- Reusable surgical instruments were sterilised on site in a dedicated sterilisation unit. Staff in the theatres told us they always had access to the equipment they needed to meet patients' needs.
- Reusable endoscopes (used to examine the interior of a hollow organ or cavity of the body) and nasoscopes (used for viewing a patient's nasal cavity) were cleaned and decontaminated in a joint advisory group for gastrointestinal endoscopy (JAG) accredited decontamination room.
- Intubation equipment (for placement of tube in patients' airways) was available and routinely checked in the theatres department.
- Emergency resuscitation equipment was available and checked on a daily basis by staff.

Medicines

- Medicines, including controlled drugs, were securely stored.
- Staff also carried out daily checks on controlled drugs and medication stocks to ensure that medicines were reconciled correctly.
- We saw that medicines requiring storage at temperatures below 8ºC were appropriately stored in medicine fridges. Fridge temperatures were checked daily to ensure medicines were stored at the correct temperatures.
- A pharmacist reviewed all medical prescriptions, including antimicrobial prescriptions, to identify and minimise the incidence of prescribing errors.

Records

- The service used paper based patient records and these were securely stored in each area we inspected.
- We looked at the records for seven patients. These were structured, legible, complete and up to date.
- Patient records included risk assessments including: venous thromboembolism (VTE), pressure care or nutrition and these were completed correctly.
- Patient records showed that nursing and clinical assessments were carried out before, during and after surgery and these were documented correctly.
- Standardised nursing documentation was kept at the end of the patient's bed. Observations were well recorded; the timing of such was dependent on the individual needs of the patient.

Safeguarding

- Staff received mandatory training in the safeguarding of vulnerable adults and children.
- Staff were aware of how to identify abuse and report safeguarding concerns.
- Information on how to report adult and children's safeguarding concerns was displayed in the staff room. Each area we inspected also had safeguarding link nurses in place.
- Safeguarding incidents were reviewed by the departmental managers and also reviewed by the trust-wide safeguarding committee.

Mandatory training

- Staff received biennial mandatory update (BEMU) training which included key topics such as infection control, information governance, equality and diversity, fire safety, safeguarding children and vulnerable adults including dementia awareness training.
- Staff also received mandatory training in medicines management, manual handling, conflict resolution and resuscitation training.
- Trust data showed that the majority of staff within the surgery and cancer division had completed their mandatory training. However, the trust's internal target of 90% compliance in mandatory training had not yet been achieved.
- Mandatory training was delivered on a rolling programme and the divisional matrons and divisional general manager told us they were confident the trust mandatory training compliance target would be achieved by year end (March 2015).

Assessing and responding to patient risk

- Staff were aware of how to escalate key risks that could impact on patient safety, such as staffing and bed capacity issues and there was daily involvement by ward managers and the divisional matrons to address these risks.
- On admission to the surgical wards and prior to undergoing surgery, staff carried out risk assessments to identify patients at risk of harm. Patient records included risk assessments for venous thromboembolism (VTE), pressure ulcers, nutritional needs, falls and infection control risks. Patients at high risk were placed on care pathways and care plans were in place to ensure they received the right level of care.

- Staff used early warning score systems and carried out routine monitoring based on the patient's individual needs to ensure any changes to their medical condition could be promptly identified.
- Where a patient's health deteriorated, staff were supported with medical input and were able to contact the critical care outreach team if needed.
- We observed three theatre teams undertaking the 'five steps to safer surgery' procedures, including the use of the World Health Organization (WHO) checklist. The theatre staff completed safety checks before, during and after surgery and demonstrated a good understanding of the 'five steps to safer surgery' procedures.

Nursing staffing

- Nursing staff handovers occurred three times a day and included discussions around patient needs and any staffing or capacity issues.
- The wards and theatres we inspected had a sufficient number of trained nursing and support staff with an appropriate skills mix to ensure that patients received the right level of care.
- The theatre manager told us that five additional band 5 nurses had been recruited and recruitment of band 2 healthcare assistants was ongoing.
- The ward managers used an acuity tool to assess patient dependency levels on a daily basis. The divisional matrons had submitted an acuity report to the trust board in June 2014 which identified shortfalls in nursing staffing and a proposed plan to recruit additional staff.
- We found that the night shift arrangements for ward 9 (elective orthopaedic ward) were for two nurses covering the 18-bedded ward. The ward manager told us that an additional healthcare assistant (HCA) could be deployed if the dependency of patients on the ward increased.
- The evening shift arrangements for ward 10 (surgical specialties ward) were for three nurses and two HCAs covering the 23-bedded ward. The ward manager told us they needed an additional HCA to provide additional cover during busy periods.
- The night shift arrangements for ward 12 (female surgery and gynaecology ward) were for two nurses and two HCAs covering the 32-bedded ward. The ward manager told us they had identified the need for an additional qualified nurse to ensure patient needs were met.
- Information on staffing levels, including actual vs establishment, was clearly displayed near the entrance to the unit and this was updated daily.
- Cover for staff leave or sickness was provided by bank staff made up of the existing nursing team. The divisional matrons and divisional general manager told us they occasionally used agency nurses to provide cover at short notice. They told us that where agency staff were used, they carried out checks to ensure they had the right level of training and understanding to meet patients' needs.

Medical staffing

- The wards and theatres we inspected had a sufficient numbers of medical staff with an appropriate skills mix to ensure that patients were safe and received the right level of care.
- We found that surgical consultants from all specialities were on call over a 24-hour period and there was sufficient medical cover during out-of-hours and weekends.
- The skills mix of consultants, middle grade doctors (e.g. senior house officers) and trainee doctors was in line with the England average. The ratio of registrars was worse than the England average (31% compared to the England average of 37%).
- The associate medical director and divisional general manager had highlighted where additional surgical staff were needed and had appointed two additional orthopaedic consultants and an upper gastrointestinal (GI) consultant that had not yet commenced employment at the time of our inspection.
- The divisional general manager told us that existing vacancies were covered by locum, bank or agency staff.
- Daily medical handovers took place during shift changes and these were consultant led and included discussions about specific patient needs. There were plans in place to implement an electronic e-handover process in the surgical division during 2015.

Major incident awareness and training

- There was a documented major incident and business continuity plan within the surgery and cancer division and this listed key risks that could affect the provision of care and treatment.
- Guidance for staff in the event of a major incident was available in each of the areas we inspected.

- Data showed that all staff within the surgery and cancer division had received training on the trust's major incident plan.

Are surgery services effective?

Good

The surgical services provided effective care and treatment that followed national clinical guidelines and staff used care pathways effectively. The services participated in national and local clinical audits. The surgical services performed in line with similar sized hospitals and performed within the England average for most safety and clinical performance measures. There were plans in place to improve areas where national clinical and performance standards had not been achieved, such as compliance with the national hip fracture audit.

The majority of patients had a positive outcome following their care and treatment. However, the number of patients that had elective surgery and were readmitted to hospital following discharge was worse than the England average.

Patients received care and treatment by trained, competent staff that worked well as part of a multidisciplinary team. Staff sought consent from patients prior to delivering care and treatment. Staff understood the legal requirements of the Mental Capacity Act 2005 and Deprivation of Liberties Safeguards (DoLS).

Evidence-based care and treatment

- Patients received care according to national guidelines. Clinical audits included monitoring of National Institute for Health and Clinical Excellence (NICE) and Royal College of Surgeons guidelines.
- Findings from clinical audits were reviewed at the monthly divisional meetings and any changes to guidance and the impact that it would have on their practice was discussed.
- Staff provided care in line with NICE clinical guidance for the recognition of and response to acute illness in adults in hospital (CG 50) as well as the critical illness rehabilitation (CG83) guidance.
- During 2013/14, the trust participated in 84% of the national clinical audits of the total number it was eligible to participate in. Benchmarking and audit activity was used to measure performance against comparator services. Where shortfalls were identified plans were implemented and monitored to secure improvement.
- Trust data showed that during 2014/15, the surgery and cancer division had 34 local audits planned, of which six had been registered.
- Staff in the surgical wards used enhanced care and recovery pathways, in line with national guidance.
- Staff told us policies and procedures reflected current guidelines and were assessable via the trust's intranet.

Pain relief

- Patients were assessed pre-operatively for their preferred post-operative pain relief.
- Patient records showed that patients received the required pain relief and they were treated in a way that met their needs and reduced discomfort.
- The majority of patients we spoke with felt that pain relief was given and managed effectively.

Nutrition and hydration

- The patient records we looked at included an assessment of patients' nutritional requirements.
- Where patients were identified as at risk, there were fluid and food charts in place and these were reviewed and updated by the staff.
- Where patients had a poor uptake of food, this was addressed by the medical staff who prescribed appropriate dietary supplements.
- Patient records also showed that there was regular dietician involvement where patients were identified as being at risk.
- Patients with difficulties eating and drinking were placed on special diets. Staff told us patients with learning disabilities or dementia were offered finger foods to make it easier for them to eat.
- The patients we spoke with told us they were offered a choice of food and drink. However, the majority of patients told us that the quality and overall taste of the food could be improved. One patient commented that "the food is quite bland".
- We saw that patients were offered snacks such as tea and toast after they had undergone surgical procedures.

Patient outcomes

Surgery

- There was participation in national audits such as the national bowel cancer audit and the national hip fracture audit.
- The national emergency laparotomy audit (NELA) report from May 2014 showed that 15 out of the 28 standards were available at the trust and this was about the same as other trusts nationally.
- The trust had an action plan to address gaps from the audit, such as a lack of 24 hour, seven day access to intervention radiology services.
- The national bowel cancer audit 2013 showed that the trust was performing better than the national average for case ascertainment, data completeness, the number of cases discussed at multidisciplinary team (MDT) meetings (100%) and the number of patients seen by a clinical nurse specialist.
- This audit also showed that the number of patients that had a computerised tomography (CT) scan was worse than the national average (81% compared with national average of 89%).
- The associate medical director and divisional general manager could not attribute the performance data relating to patients receiving CT scans to any specific factors.
- The national hip fracture audit 2013 showed that trust performance was better than the England average for six indicators, including ascertainment rate, percentage of patients admitted to orthopaedic care within four hours and mean total length of stay. The trust performance was slightly worse than the average for the percentage of patients undergoing hip surgery within 48 hours (82% compared to a national average of 87%).
- The hip fracture report also highlighted that only 19% of patients had undergone a pre-operative assessment by an orthopaedic geriatrician compared with a national average of 54%. This meant that best practice guidelines were not being followed effectively.
- The associate medical director and divisional general manager told us the appointment of two additional orthopaedic surgeons would significantly improve the number of patients undergoing hip surgery within 48 hours. They also told us that they were actively seeking an additional orthopaedic geriatrician but had difficulties in recruiting a suitably qualified candidate.
- There was a part-time orthopaedic geriatrician in place who attended the orthopaedic surgical wards twice a week. Patients were also routinely assessed by an orthopaedic clinical nurse specialist.
- Performance reported outcomes measures (PROM's) data between April 2013 and December 2013 showed that the percentage of patients with improved outcomes following groin hernia, hip replacement and knee replacement procedures was similar to the England average.
- The PROM's data also showed that the percentage of patients with improved outcomes following varicose vein surgery was worse than the England average. The divisional general manager told us they only carried out a small number of day case varicose vein procedures at the trust and the PROM's data was based on a sample size of nine patients only.
- The number of patients that had elective surgery and were readmitted to hospital following discharge was worse than the England average. The number of non-elective surgery patients was about the same as the England average. The associate medical director and divisional general manager told us readmission rates were routinely monitored to look for improvements to the service.

Competent staff

- Newly appointed staff went through an induction process and their competency was assessed prior to working unsupervised.
- Trust data showed the majority of staff across the surgery and cancer division had completed their annual appraisals during the past year. Appraisals for the current year (April 2014 to March 2015) were ongoing and the staff we spoke with told us they routinely received their annual appraisals.
- Consultants received peer appraisals using an electronic appraisal system and were overseen by the medical director.
- Nursing and medical staff we spoke with were positive about on-the-job learning and development opportunities and told us they were supported well by their line management.

Multidisciplinary working

- There was effective daily communication between multidisciplinary teams within the surgical wards and theatres. Staff handover meetings took place during shift changes and 'safety huddles' were carried out on a daily basis to ensure all staff had up-to-date information about risks and concerns.

Surgery

- Ward staff told us they had a good relationship with consultants and ward-based doctors.
- There were routine team meetings that involved staff from the different specialties. The patient records we looked at showed there was good levels of input from nursing and medical staff as well as allied health professionals.
- Ward and theatre staff told us they received good support from pharmacists, dieticians, physiotherapists, occupational therapists, social workers and diagnostic support such as for X-rays and scans.
- The surgical service had arrangements in place with neighbouring trusts to provide on-call support for ear, nose and throat (ENT) surgical specialties.
- There were weekly multidisciplinary meetings with urology and upper gastrointestinal (GI) surgery consultants that held outpatient clinics at the hospital and carried out surgical procedures at other external hospitals.

Seven-day services

- Staff rotas showed that nursing staff levels were sufficiently maintained during out-of-hours and at weekends.
- We found that sufficient out-of-hours medical cover was provided to patients in the surgical wards by junior and middle grade doctors as well as on-site and on-call consultant cover.
- Microbiology, imaging (e.g. X-rays), physiotherapy and pharmacy support was available on-call during out-of-hours and at weekends. The dispensary was also open seven days a week.
- Staff told us they did not have dietician or occupational therapy on-call support during out-of-hours and at weekends but told us this had not impacted their ability to meet patient needs.
- Ward and theatre staff told us they received good support during out-of-hours and at weekends.

Access to information

- The service used paper based patient records. The patient records we looked at were complete, up to date and easy to follow. Records contained detailed patient information from admission and surgery through to discharge. This meant that staff could access all the information needed about the patient at any time during the patient journey.
- Staff told us the information about patients they cared for was easily accessible.
- We saw that information such as audit results, lessons learned from incidents and internal correspondence was displayed in the staff rooms in all the areas we inspected. Staff could access information such as policies and procedures from the trust's intranet.
- The theatres department had introduced a new electronic system within the past month that captured information about patient scheduling and theatre performance. Performance data was updated every 15 minutes and displayed in the theatre areas to allow theatre staff to access real-time performance information.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff had the appropriate skills and knowledge to seek consent from patients. The staff we spoke with were clear on how they sought verbal informed consent and written consent before providing care or treatment.
- The patient records we looked at showed that verbal or written consent had been obtained from patients and that planned care was delivered in line with their agreement.
- Staff understood the legal requirements of the Mental Capacity Act 2005 and Deprivation of Liberties Safeguards (DoLS).
- Where patients lacked the capacity to make their own decisions, staff made decisions about care and treatment in the best interests of the patient and involved the patient's representatives and other healthcare professionals, in accordance with the trust's "safeguarding vulnerable adults" policy.
- There was a trust-wide matron that participated in best interest meetings and provided support and guidance for staff.

Are surgery services caring?

Good

Patients spoke positively about their care and treatment. Patients were treated with dignity and received compassionate care. Staff ensured patients and their

relatives were involved in their care. Patients and their relatives were supported with their emotional needs and there were bereavement and counselling services in place to provide support for patients, relatives and staff.

Compassionate care

- We saw that patients were treated with dignity, compassion and empathy. We observed staff providing care in a respectful manner.
- The majority of patients we spoke with said they thought staff were kind and caring and gave us positive feedback about ways in which staff showed them respect and ensured that their dignity was maintained.
- We received negative feedback from one patient relating to the attitude of staff. However, this had been raised as a formal complaint by the patient and was being addressed.
- The NHS Friends and Family Test (FFT) data between April 2013 and July 2014 showed that two surgical wards consistently scored better than the England average and three consistently scored worse than the England average, indicating a mixed response from patients about whether they would recommend the hospital's wards to friends and family.
- The average response rates were either similar or better than the England average across the surgical wards except for ward 10 (surgical specialties ward / surgical assessment unit) where the response rate was 14% compared to the England average of 33%.
- The ward manager told us the response rates were generally lower on this ward because of a greater proportion of young adults that did not want to participate in the survey. In order to improve response rates, a discharge coordinator had been appointed with an additional responsibility to encourage patients to complete the survey.
- A review of the data from the CQC's adult inpatient survey 2013 showed that the Trust was about the same in comparison to other trusts for all 10 indicators.

Understanding and involvement of patients and those close to them

- Staff respected the patient's right to make choices about their care. We observed staff speaking with patients clearly and in a way they could understand.
- Patient records included pre-admission and pre-operative assessments that took into account individual patient preferences.
- Patients told us they were kept informed about their treatment. They told us the medical staff fully explained the treatment options to them and allowed them to make an informed decision. They also told us they could easily arrange to meet a registrar or consultant responsible if they needed to discuss their care or treatment.

Emotional support

- Staff understood the importance of providing patients with emotional support. We observed staff providing reassurance and comfort to patients who were anxious or worried. For example, we observed staff holding the hand of a patient before they went into the operating theatre to calm their nerves. Patients told us they were supported with their emotional needs.
- The ward staff were also supported by volunteer ward attendants that routinely visited the theatres and wards and supported and engaged with patients.
- The areas we inspected were compliant with same-sex accommodation guidelines. We saw that patients' bed curtains were drawn and staff spoke with patients in private to maintain confidentiality. Patients could also be transferred to side rooms to provide privacy and to respect their dignity.
- There were information leaflets readily available that provided patients and their relatives with information about chaplaincy services and bereavement or counselling services.
- Staff told us they were supported by the trust's palliative (end of life care) team and the trust-wide bereavement service manager for support and advice during bereavement.

Are surgery services responsive?

Good

The surgical services were planned and delivered to meet the needs of local people. There was sufficient capacity to ensure patients admitted to the surgical services could be seen promptly and receive the right level of care. There were systems in place to support vulnerable patients. Complaints about the service were shared with staff to aid learning.

Surgery

Service planning and delivery to meet the needs of local people

- The trust provided a range of elective and non-elective surgical services across the communities it served. This included ophthalmology, urology, orthopaedics, ear, nose and throat (ENT) and general surgery (such as colorectal surgery and upper gastrointestinal (GI) surgery).
- Hospital episode statistics (HES) data 2013/14 showed that 63% of patients had day case procedures, 12% had elective surgery and 25% were emergency surgical admissions.
- There were arrangements in place with neighbouring trusts to allow the transfer of patients for surgical specialties not provided by the trust, such as vascular surgery, cardiac surgery, maxillofacial surgery and plastic (cosmetic) surgery.
- There was routine engagement and collaboration with staff from these trusts, such as on-site outpatient clinics and routine multi-disciplinary team meetings.
- Work on the newly built operating theatres had been completed. These were designed to increase capacity and to improve the overall patient experience. Building work on the treatment centre (day surgery) was still ongoing at the time of our inspection. Staff told us the introduction of a surgical assessment lounge adjacent to the theatres would improve patient access and flow.

Access and flow

- Patients could be admitted for surgical treatments through a number of routes, such as pre-planned day surgery, via accident and emergency or via general practitioner (GP) referral.
- During the inspection, we did not highlight any concerns relating to the admission, transfer or discharge of patients from the surgical wards and theatres. The patients we spoke with did not have any concerns in relation to their admission, waiting times or discharge arrangements.
- Patient records showed that patients were assessed on admission to the wards or prior to undergoing surgery.
- Patients undergoing day surgery were given morning and afternoon appointment times. This meant that a patient arriving early in the morning or afternoon could potentially wait for an extended period of time. The divisional general manager told us they planned to introduce staggered appointment times to address this.
- Hospital episode statistics (HES) data 2013/14 showed that the average length of stay for elective and non-elective patients was the same as the England average.
- Staff completed a discharge checklist, which covered areas such as medication and communication to the patient and other healthcare professionals. This ensured patients were discharged in a planned and organised manner. Discharge letters written by the doctors included all the relevant clinical information relating to the patient's stay at the hospital. The majority of patients were discharged from the wards, so staff could continue to monitor them during their wait.
- NHS England data showed that the trust had a high overall bed occupancy rate of 95% between April and June 2014. The bed occupancy rate between January and March 2014 was 90%. Bed occupancy was monitored on a daily basis and patients could be transferred to other surgical wards if no beds were available within a specific surgical specialty.
- During the inspection, we found that all available beds were occupied in the surgical wards we visited. We found that some of the surgical beds were occupied by patients receiving medical care (medical outliers). Where this was the case, patient records showed that these patients were routinely seen by doctors from within the medicine specialities.
- There was a winter pressures escalation plan in place. The divisional general manager told us that surgical specialty doctors worked closely with medical doctors to manage medical outliers during busy periods, such as during the winter.
- There was sufficient bed space in the theatres to ensure patients could be appropriately cared for pre and post-operation.
- NHS England data showed national targets for 18 week referral to treatment (RTT) standards for admitted and non-admitted patients at the end of August 2014 were being met for most specialties. The data showed that the trust was just below the waiting time target of 92% for general surgery (89%) and orthopaedics and trauma (89%) specialties.
- The national hip fracture audit 2013 showed that trust performance was slightly worse than the average for the percentage of patients undergoing hip surgery within 48 hours (82% compared to a national average of 87%).

- The divisional general manager told us they were confident that the appointment of two additional orthopaedic consultants and an upper GI consultant would improve compliance with hip fracture audit and RTT standards.
- NHS England data showed that the number of elective operations cancelled was worse than the England average from October 2011 to March 2014. Trust data showed that between April 2014 and September 2014 there were 148 cancellations and most frequent reasons for cancellations were 'list overrun' (43%) and 'emergencies/trauma' taking priority (24%).
- The trust's internal theatre utilisation target was 84% for the main theatres and 81% for the treatment centre. Trust data showed that these targets were not achieved during July and September 2014.
- Trust data showed that theatre utilisation in the main theatres had increased during September 2014 (78%) compared to 72% in August 2014. The data also showed that theatre utilisation in the treatment centre had increased during September 2014 (80%) compared to 75% in August 2014.
- The divisional manager told us the introduction of a new electronic theatre performance system allowed staff to monitor theatre activities more effectively and this had led to improvements in theatre utilisation.
- There was a theatres productivity plan in place with specific actions to address cancelled operations and to review the way theatres were used to improve theatre utilisation.
- NHS England data also showed that the percentage of patients whose operation was cancelled and were not treated within 28 days was worse than the England average between October 2011 and March 2014.
- The data showed there had been a significant improvement since January 2014, with only three patients that were not treated within 28 days between January 2014 and June 2014. The divisional general manager told us they had introduced a system where staff arranged a new date with the patient on the day of the cancellation and this had reduced the number of patients not treated within 28 days.

Meeting people's individual needs

- Information leaflets about the services were readily available in all the areas we visited. Staff told us they could provide leaflets in different languages or other formats, such as braille if requested.
- Staff could access a language interpreter if needed.
- Staff received mandatory training in dementia care. The areas we inspected also had dementia link nurses in place. Staff were to support surgical patients living with dementia appropriately.
- Where a patient was identified with dementia or learning disabilities, staff could contact a trust-wide specialist dignity matron for advice and support.
- Staff also completed a "me to you" passport document for patients admitted to the hospital with dementia or learning disabilities. This was completed by the patient or their representatives and included key information such as the patient's medical history and likes and dislikes. The ward staff told us the additional records were designed to accompany the patients throughout their hospital stay. We saw evidence of this in the patient records we looked at.

Learning from complaints and concerns

- Ward and theatre areas had information leaflets displayed for patients and their representatives on how to raise complaints. This included information around the Patient Advice and Liaison Service (PALS).
- We saw that notice boards included information such as the number of complaints and compliments received during the current month. Staff understood the process for receiving and handling complaints.
- Complaints were recorded on a centralised trust-wide system. The centralised PALS team managed formal complaints.
- Trust data showed that between April 2014 and June 2014, all complaints raised within the surgery and cancer division were reported, investigated and responded to within the trust's timescales.
- Ward managers told us they aimed to respond to requests from the complaints team within 10 days. We looked at four complaints records and saw that complaints were investigated and requests from the complaints team were dealt with in a prompt manner.
- Staff told us information about complaints was discussed during routine team meetings to raise staff awareness and aid future learning. For example, we saw that an action plan following a complaint had been signed by staff to confirm they had read and understood the remedial actions.

Are surgery services well-led?

Surgery

Good

There was effective teamwork and clearly visible leadership within the surgical services. There was a positive culture within the service that was focused on patient safety and learning. There was routine public and staff engagement and actions were taken to improve the services. The management team understood the key risks and challenges to the service and had plans in place to manage and resolve them.

Vision and strategy for this service

- The service had a clear vision and strategy with clear aims and objectives that reflected the trust's vision: 'To deliver excellence in healthcare through innovations and collaboration'. This was clearly visible and displayed across the wards and theatre areas we inspected.
- The trust quality strategy 2014–2016 incorporated this vision and included specific surgical performance targets relating to patient experience, effectiveness of services and patient safety
- There was also a divisional workforce development plan and surgical transformation plan in place to address key risks relating to staffing needs and theatres performance.

Governance, risk management and quality measurement

- There was an effective clinical governance system in place that allowed risks to be escalated to divisional and trust board level through various committees and steering groups. There were action plans in place to address the identified risks.
- During the inspection, we looked at the divisional risk register and saw that key risks had been identified and assessed. The risk register was maintained by a divisional risk manager and reviewed at routine divisional board meetings.
- In each area we inspected, there were routine staff meetings to discuss day-to-day issues and to share information on complaints, incidents and audit results.
- We saw that routine audit and monitoring of key processes took place across the ward and theatre areas to monitor performance against objectives.

Leadership of service

- There were clearly defined and visible leadership roles within the surgery and cancer division. The division was divided into clinical units based on specific surgical specialties and each speciality had a clinical lead and a service manager.
- The surgical wards were led by ward managers, who reported into three divisional matrons that had responsibility for specific specialties.
- The theatres and ward based staff told us they understood the reporting structures clearly and that they received good management support.

Culture within the service

- Staff were passionate about the care they delivered, highly motivated and positive about their work.
- There was a learning culture in place. Staff told us they received feedback if they had made an error to aid future learning and they were supported with their training needs by the management team within their specific area.
- Trainee doctors and nurses also told us they received a good level of support from their peers and line managers.
- The overall staff sickness levels across the service and the trust were consistently better than the England average over the past year and the low levels of staff sickness were reflected in the wards and theatres we inspected.
- We saw that staff sickness levels were reviewed and staffing levels were maintained through the use of bank and agency staff to ensure patient care was not compromised.

Public and staff engagement

- The theatres and ward based staff told us they routinely engaged with patients and their relatives to gain feedback from them. Information on the number of compliments and complaints was displayed on notice boards in each of the wards we inspected.
- Patient feedback was also obtained through monthly 'open and honest' surveys which were conducted in the surgical wards by independent staff and sampled at least five patients. The survey asked for patient

feedback in areas such as patient safety, cleanliness and the quality of food and drink. The findings from the most recent surveys were displayed on notice boards in each of the wards we inspected.

- The divisional general manager told us they also engaged with the public via patient support groups that were led by clinical nurse specialists.
- Staff told us they received good support and regular communication from their line managers. Staff routinely participated in team meetings across the wards and theatres we inspected. The trust also engaged with staff via newsletters and other general information displayed on notice boards in staff rooms.
- Staff across the surgery and cancer division completed 'Pascal metrics' surveys as part of the trust initiative to improve patient safety and clinical reliability. The survey data was being collated and reviewed at the time of our inspection so we were unable to review the outcomes of the survey.
- The wards and theatres we inspected included 'you said, we did' information on notice boards which listed improvements made by the trust to queries raised by staff.
- The trust had reviewed the findings from the 2013 survey of NHS staff and identified concerns relating to communication between managers and staff, the health and wellbeing of staff, team working, discrimination against staff and violence and bullying and harassment towards staff in surgical specialties.
- The surgery and cancer division action plan 2014/15 listed actions taken to improve these areas including providing conflict resolution training for staff, encouraging staff to report incidents, implementing informal senior management walkabouts to improve visibility and promoting staff breaks and healthy eating.

Innovation, improvement and sustainability

- There was a positive research culture within the surgery and cancer division and surgical staff, including trainee doctors were encouraged to participate in research trials and national and local clinical audits and present their findings at local meetings.
- A consultant told us they were undertaking a research trial of local anaesthetic use in laparoscopic hernia repair and the trust was very supportive of the research.
- The service was financially well managed. The associate medical director**,** divisional general manager and divisional matrons had a clear vision for the service and were confident that that the service was sustainable in the future.
- They told us the building of the new theatres and treatment centre facilities would allow them to meet future capacity demands.
- One of the key risks in the service was identified as not being able to recruit suitably trained surgical staff for the theatres. The associate medical director and divisional general manager had identified areas where additional consultants were needed and had appointed three consultants to address the shortfalls. There was also a programme in place to train healthcare assistants into assistant practitioners that are trained to perform the scrub role for surgical procedures.

Critical care

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

Information about the service

Critical and high dependency care are provided in a new purpose built facility comprising 14 individual critical care bays that opened in March 2014. Two of the bays are equipped to provide isolation facilities, which help to improve infection prevention and control. At the time of the inspection 11 of the 14 beds were commissioned to provide four beds at level 2 and seven beds at level 3 care. The unit admitted and cared for approximately 850 patients each year. For the purpose of management and governance the critical care unit at the Leighton Hospital site sits in the Medicine and Emergency Care division.

We visited the critical care unit on the announced inspection and were able to talk directly with some of the patients and their relatives. We also spoke with many of the staff. These included junior and senior nursing staff, junior and senior doctors and managers. We observed care and treatment and looked at several care records in detail. Before and during the inspection we reviewed performance data from, and about, the critical care service. We also visited the coronary care unit which at times did care for patients assessed as level two in accordance with the Intensive Care Society acuity tool. This unit comprised of four single rooms situated at the end of the cardiology ward (ward 1).

Summary of findings

The trust was providing a good critical care service overall. However, to maintain safe care, some improvements were required relating predominantly to medical and nursing staff numbers. There was evidence of strong medical and nursing leadership in the critical care unit that led to positive outcomes for patients. The service submitted regular Intensive Care National Audit and Research (ICNARC) data so was able to benchmark its performance and effectiveness alongside other units nationally.

There was a clear understanding of incident reporting and an embedded culture of audit, learning and development. However, the unit's risk register contained risks had been there for a number of years and it was not clear whether these had been reviewed as planned or what the actions were.

The unit employed two nurses specifically in practice educator roles, which enabled them to support both new staff and those requiring additional support or performance management. Based in critical care, there was also a well-developed outreach service staffed on a daily basis by experienced band 7 nurses from the critical care unit. On the days of our inspection the unit had five to six empty beds at the start of the morning shift. It was safely staffed with the appropriate number of trained nurses per patient plus a senior co-ordinating nurse, clinical services manager and both junior and consultant medical staff.

Critical care

Are critical care services safe?

Requires improvement

Overall the critical care service required some improvement to maintain safe care. There were robust systems embedded for reporting and learning from incidents. There was an awareness of the need to provide a safe and clean environment for patients and performance against safety thermometer indicators was effectively monitored.

However, there were elements that represented a risk to patient safety. The unit's nurse staffing establishment figures meant that if the unit were full then the Intensive Care Society's core standards (standard 1.2.4) for nurse staffing could not be met. More specifically, the unit's nurse staffing establishment did not allow for a supernumerary clinical co-ordinator (band 7) to be on duty 24/7. In addition, the unit was unable to meet the Intensive Care Society core standard (1.2.5) which states that units with greater than 10 beds require additional supernumerary registered nursing staff over and above the clinical co-ordinator role, to enable the delivery of safe care. The out-of-hours medical cover also represented a potential risk to patients as the medical registrar for critical care also had to cover maternity and any calls for urgent care resuscitation.

During the inspection we also noted inconsistencies in the completion of the written medical discharge documentation from critical care, a lack of clarity concerning the assessment of health care assistants' competency to check equipment and noted two syringe drivers that had missed their planned preventative maintenance date, (April and July 2014 respectively).

Incidents

- All the staff we spoke with knew how to report incidents and "near misses" on the trust wide electronic reporting system and regularly did so.
- Since April 2014 there have been 102 reported incidents. In terms of patient harm, these had been classified as 72 no harm, 29 low harm and one moderate harm. In terms of classification, the majority of incidents related to pressure ulcers. Although closer examination of the data revealed that only three incidents were coded as hospital acquired pressure ulcers with the other incidents being reported as moisture lesions.
- Incident reporting trends were mapped and lessons learned with subsequent actions fed back to staff via a number of different routes. For example at nursing staff handovers feedback was given both verbally and in writing via a communications log. Wider trust incident lessons were also disseminated via this route. We also saw minutes of unit and senior staff meetings where incidents were discussed along with the consequent actions.
- There was a thorough approach to mortality and morbidity directed by clear trust policy. The latest available and ratified National Audit and Research Centre (ICNARC) data for the period October 2013 to March 2014 showed that the standardised mortality ratios for critical care patients were similar to the England average for NHS adult general critical care units.

Safety thermometer

- There were clear safety thermometer performance boards displayed in the corridor outside critical care which showed current performance (October 2014). These provided a quick and simple method for surveying patient safety and analysing results in order to measure and monitor improvement.
- The performance boards showed the current results in respect of falls, pressure ulcers, urinary infections for patients with indwelling urinary catheters and venous thromboembolism (VTE). The data showed that there had recently been three falls reported on the unit, involving a level two patient.

Cleanliness, infection control and hygiene

- Critical care provision was delivered in a new purpose built unit that had opened in March 2014. It had been designed and built in accordance with the then current Health Building Notes (HBN 57 – Facilities for Critical Care), which included the specific purpose of reducing hospital acquired infection. For example, written protocols for daily, weekly and monthly cleaning; every patient having their own room; minimal use of curtaining and designated hand wash basins within each bed space with non-touch taps.

Critical care

- We observed the environment to be clean and saw that staff adhered to good practice guidance for the control and prevention of infection. For example, the unit had adopted a "bare below the elbows" policy in clinical areas, which was adhered to. We saw that wall mounted antiseptic gel dispensers were appropriately sited around the unit and used. Staff washed their hands appropriately and used personal protective equipment such as gloves and aprons.
- Critical care reported no cases of methicillin resistant Staphylococcus aureus (MRSA) in the past two years. The unit performed better than similar adult units for the numbers of unit acquired Clostridium difficile.ICNARC data from October 2013 to March 2014 also showed the unit performed better than similar units for the number of acquired infections in blood, per 100 admissions and per 1000 ventilator days.
- Critical care had reported two infection control related incidents since April 2014, neither of which resulted in any actual patient harm.
- The ward rounds had daily input from the microbiology team.
- There were appropriate arrangements in place for the safe disposal of sharps and contaminated items.

Environment and equipment

- The critical care environment had been designed and built in accordance with HBN 57. This has ensured that the facilities and clinical areas and the support facilities that underpin these are fit for purpose. Examples of these are the increased size of bed areas, strategies for noise reduction and the maximisation of natural light.
- Generally all the equipment was appropriately checked, cleaned and regularly maintained, this included the resuscitation equipment. Safety checklists were completed daily. However, we did observe two syringe drivers, although not being used for a patient at the time that had passed their respective planned preventative maintenance dates. This was pointed out to the unit staff during the visit and was promptly addressed.
- There was an on-going culture of feedback and evaluation of the new infrastructure and equipment. For example it had been decided that the ceiling mounted patient hoist in one of the bed areas was unsuitable for bariatric patients and a replacement hoist fitting was being sourced.

Medicines

- There was a dedicated medicines storage area within the critical care unit. Medicines were stored correctly in locked cupboards and fridges where necessary. The drug cupboards were locked electronically and access was via a smart card held by the nursing staff. The only cupboard requiring key access was the controlled drugs (CD) store. Fridge temperatures were being checked and recorded appropriately.
- Staff conducted a balance check of all CDs each day and a CD audit was carried out quarterly with no issues being identified.

Records

- All patient records and charts were kept safely and confidentially outside the bed area on a dedicated nurse's station which included a computer terminal, giving direct access to blood results and the trust wide intranet.
- We looked at three sets of patients' notes all of which contained daily entries from the multi-disciplinary team. While on critical care the patients had two files, one for nursing documentation and one for doctor's records in addition to the patient's hospital notes, which would provide information regarding their medical history.
- All entries in the doctors notes were signed and dated and included either the author's general medical council (GMC) number or their grade and position.
- Nursing documentation included appropriate risk assessments and the implementation of specific care bundles. For example, for ventilator acquired pneumonia (VAP), pressure ulcer bundle, haemodynamic assessments and cannula insertion (visual infusion phlebitis or VIP scores).
- Some nursing staff did comment on the large volume and duplication of the nursing documentation. We understood that work was underway to review the amount of nursing documentation in use.
- We noted inconsistencies in the completion of written medical discharge summaries. We looked at three sets of notes for patients who had been in-patients in critical care but who were now being monitored by the outreach team on the wards. None of these notes contained a critical care written medical discharge summary. While we understood that a verbal handover took place and there was nurse led documentation in place relating to discharge. However, this omission

could potentially mean that important information relating to the clinical care of a patient on discharge from critical care would not be passed on thus possibly compromising their on-going care.

Safeguarding

- There was an internal system for raising safeguarding concerns. Staff were aware of the process and could describe what constituted abuse. Safeguarding formed part of the mandatory training programme for all staff.

Mandatory training

- Electronic records were kept at both unit and trust level to monitor compliance with mandatory training.
- Records showed that at the time of inspection the following levels of compliance had been achieved for critical care nursing registered nurses, fire training (97%), manual handling (95%), biennial mandatory updates (BEMU 92%), resuscitation (97%), conflict resolution (97%), children's safeguarding (88%), medicines management (94%) and information governance (98%).
- Critical care had two designated nursing staff in practice educator roles, which they undertook in conjunction with their clinical and management band 7 roles. This enabled them to both deliver training and also work clinically to support nursing staff in caring for people in critical care.
- With a computer terminal available for each bed space it was sometimes possible for nursing staff to access and complete electronic training depending on workload and patient acuity.

Assessing and responding to patient risk

- There were tools in place for the early detection and escalation of changes in a patient's condition. The hospital used an early warning system (EWS scoring) and this was also adopted within critical care. An EWS is a system that scores vital signs and is used as a tool for identifying patients who are deteriorating clinically.
- The hospital provided a critical care outreach service (CCOS) which worked collaboratively with patients' multi-disciplinary teams to offer expert advice in relation to acutely ill or deteriorating patients who were cared for in ward environments. The CCOS process was closely linked to the use of EWS to facilitate early detection of the patient at risk of deteriorating.
- The critical care outreach team were collecting data on the completion of EWS scoring and the frequency of escalation as well as the numbers of cardiac arrest calls. The CCOS data for January to June 2014 showed that out of the 785 referrals, 633 had been as a consequence of EWS triggers with another 152 referred due to staff concerns about a patient's condition.

Nursing staffing

- On the day of our inspection critical care was staffed safely and appropriately. The unit was able to provide nurse staffing levels that met the needs of their patients. All level 3 patients were nursed on a 1:1 ratio and all level 2 patients were nursed on a 1:2 ratio. In addition to these numbers there were senior nurses in co-ordinating and educational roles.
- However, it was acknowledged that should the unit be full then the band 7 shift co-ordinator would need to care for a patient and would in such circumstances no longer be supernumerary. This meant that potentially on such occasions the critical care nursing levels would fall short of meeting the Intensive Care Society core standards for nurse staffing. This was a fact recognised by the critical care unit's management team and was included on the department's risk register.
- The Intensive Care Society "Levels of Intensive Care" document was used to determine the acuity of the patients in the unit. This document sets out the criteria for patients being assessed at Level 0 (patients whose needs can be met through routine care) through to Level 3 (patients requiring advanced respiratory and organ support).
- There was a mix of senior, band 6 and junior band 5 nurses on duty. The shift co-ordinator was a band 7 nurse. There was also a clinical services manager on duty.
- We were told that the unit was currently carrying 1.6 whole time equivalent (WTE) vacancies at band 5 level.
- Any shortfalls in nursing numbers as a consequence of sickness were usually met by staff from the existing establishment working additional shifts or those shifts were filled using the unit's bank staff. We were told that agency staff were not used. There were occasions when the occupancy and patient acuity in critical care meant that staff were asked to help out on the other wards in the hospital. The arrangements covering such issues of staff flow and function were set out in the critical care admission, discharge and operational policy document.

Critical care

- The nursing staff in critical care generally worked a three shift system. We observed the shift handover which was led by the band 7 nurse for the outgoing shift. This was conducted away from the patient areas in a multi-disciplinary meeting room and involved all the incoming shift members. The main points of the handover were also recorded on a handover sheet. An opportunity was taken at these handover sessions to communicate important messages such as lessons learned from incidents. Once the general shift handover was completed incoming staff were allocated to patients and then they received a bedside one to one handover from the outgoing nurse.
- During the inspection we also became aware of a four bedded coronary care unit that at times cared for patients assessed as being at level 2 using the Intensive Care Society acuity tool. The four beds were situated at the end of the cardiology ward (ward 1). On the day of inspection all four beds were occupied. None of the patients had been assessed as being at level 2. The coronary care beds were staffed separately to the ward by two registered nurses per shift who had been determined as having the appropriate competencies to work in this speciality. In addition all staff working on the coronary care unit had undertaken advanced life support training. The nursing staff worked a 12 hour shift system and were also responsible for monitoring the patients on telemetry in other ward areas throughout the hospital.

Medical staffing

- Following an internal review of the divisional structure earlier in the year, critical care moved from the Surgery and Cancer division to the Medicine and Emergency care division. As part of this re-organisation the clinical lead for critical care also became the associate medical director for the division. This involved another consultant assuming the role of clinical lead for anaesthesia. It is understood that at the time of our inspection the job plan for the clinical lead for critical care did not include specific remuneration for that role.
- The clinical lead for critical care was not currently allocated one programmed activity (PA) specifically identified for management functions in critical care.
- Critical care operated a consultant of the week rota (Monday to Friday). The consultants were from an intensive care or anaesthetic background. Two consultants were available on the unit for a four hour morning session and then one consultant was unit based in the afternoon. Out of hours a consultant intensivist was on call and capable of attending the unit if required within 30 minutes.
- When participating in the duty rota for critical care (including out of hours) consultants were not responsible for delivering other services within the hospital.
- In addition to the consultant cover there was also a registrar based on the unit for a 12 hour shift during the day time.
- So far as out-of-hours cover was concerned the registrar (middle grade) doctor covering the critical care unit was also expected to cover the maternity unit and potentially the resuscitation area in urgent care. This constituted a risk to patients that was known to the trust and was on the critical care risk register. We were told that a business case was due to be presented to the trust board recommending an increase in the night time middle grade doctor cover. There had been no related incidents reports as a consequence of this potential shortfall in doctor cover during the past six months.
- Consultant led ward rounds took place twice daily and included the involvement of the multi-disciplinary team.

Major incident awareness and training

- Major incident and business continuity policies and protocols were in place and readily available in the critical care office adjoining the main bed areas.
- These included contingency arrangements for the admission of paediatric emergencies should specialist centres be overwhelmed. For example in the event of an influenza pandemic.

Are critical care services effective?

Good

There was good multi-disciplinary team working and a commitment to clinical audit and evaluation. The critical care unit contributed to the collection of data for the Intensive Care National Audit and Research Centre (ICNARC) and continually evaluated its performance against other units.

Critical care

The trust was also part of the Cheshire and Mersey Critical Care Network (CMCCN) and so worked with other stakeholders (acute trusts and clinical commissioning groups) with a commitment to sharing and promoting best practice in critical care services.

Evidence-based care and treatment

- A range of local policies and procedures were in place and easily accessible to staff. These had been developed using National Institute for Health and Care Excellence (NICE) and the Core Standards for Intensive Care Units. For example, in accordance with NICE 83 each patient had an assessment of their rehabilitation needs within 24 hours of admission.
- There were care pathways and care bundles used to ensure appropriate and timely care. For example there were care bundles for the prevention of ventilator associated pneumonia (VAP) and skin integrity.
- As a member of the CMCCN, the unit regularly benchmarked its performance against the network's service specification for critical care. Using a red, amber, green scale this review clearly indicated the areas of compliance with the service specification along with areas where further work was required to demonstrate compliance. The service specification had been developed using the Intensive Care Societies core standards document for intensive care units.
- The unit had implemented the use of capnography for all ventilated patients. This meant that patients had continuous monitoring of the concentration or partial pressure of carbon dioxide in their respiratory gases.

Pain relief

- As part of their individual care plan all patients in ICU were assessed in respect of their pain management. This included observing for the signs and symptoms of pain. Staff utilised a pain scoring tool and referrals were made to the trust pain team as required.
- We saw that epidurals and patient controlled analgesia systems were used in accordance with trust guidelines.

Facilities

- Critical care was delivered in a new purpose built unit that opened in March 2014. This represented a vastly improved environment compared to the 43 year old facilities that it replaced. The unit has been built in accordance with HBN 57, which provided guidance on the emerging principles for planning facilities for critically ill people, including the views of users.

Nutrition and hydration

- Guidelines were in place for initiating nutritional support for all patients on admission, to ensure adequate nutrition and hydration. Nutritional assessments were undertaken within six hours of admission.
- Nutritional risk scores were updated and recorded appropriately.
- The unit had access to a dietetic service and advice at a ratio of 0.05 to 0.1 WTE per bed.

Patient outcomes

- The average length of stay (LoS) in critical care was variable depending on the clinical indicators for admission. For example, for ventilated admissions the mean LoS was approximately seven days, whereas the LoS for elective surgical admissions was much less at around two to three days.
- The most recently verified ICNARC data indicated that standardised mortality outliers for critical care patients were similar to the England average. It should be noted that the most recently verified ICNARC data referred to activity from the period October 2013 to March 2014 when the former intensive care unit and high dependency areas were managed by different specialities. Since the opening of the new critical care unit in March 2014 the two areas have merged.
- Analysis of critical care outreach service (CCOS) activity showed that out of 785 referrals from January to June 2014, 626 patients improved on the ward as a consequence of the outreach input.
- A number of initiatives were put forward to support the noted increase in outreach activity for the first six months of the year. These included: introduction of mortality workshops and the introduction of EWS pocket cards. The CCOS data showed an increase in the number of patients being referred with lower EWS scores and a decrease in the numbers of referrals for scores in excess of seven. This might suggest an increased awareness of the importance of early referral to outreach.

Competent staff

- Nursing staff received an annual appraisal. Senior nurses undertook the appraisals for their junior colleagues. The end of year position for 2013 was a figure of 94% completion. The most recent figures supplied by the hospital were up to and including June 2014 and indicated that only 23% of the staff had had their appraisal at that time. We were told that the move and transition to the new unit had caused a reduction in the number of appraisal meetings held but that plans were in place to soon catch up.
- The figures supplied by the hospital indicated that medical staffing appraisals for anaesthetics were 100% up to date.
- The unit had two band 7 nurses that spent a proportion of their time in practice educator and service improvement roles. They were able to provide practical support for nursing staff identified as having any performance issues.
- All newly trained nurses to the unit completed an induction pack which had been produced jointly by the unit's clinical educators. New staff were assigned a mentor and during their induction period were introduced to the competencies required to work in a critical care environment. Staff completed a training passport document which recorded their signed off competencies.
- All nursing staff had been trained in intermediate life support (ILS) and the band 7 nurses also completed advanced life support training (ALS). Some of the senior nurses had either completed or were undertaking additional training such as master's level modules in physical assessment. We were also informed that the hospital usually funded two places per annum for more junior nursing staff to undertake post graduate qualifications in critical care.
- We had some concerns about how the health care assistant's (band 2) competency was assessed. More specifically, as part of their role they were checking the set-up of the transfer ventilator circuits and we were not assured that their competency to undertake this important task was being thoroughly checked. Once we raised this matter during the inspection visit, the clinical services manager acted appropriately to ensure that competency was checked.

Multidisciplinary working

- Multi-disciplinary ward rounds took place each day that involved nursing, pharmacy, physiotherapy and others as indicated.
- A weekly multi-disciplinary meeting was held in critical care. This meeting was led by the consultant clinical lead and discussed in detail the current condition and plan of care for each patient on the unit. This included input from the medical and nursing teams alongside physiotherapy, microbiology and other allied healthcare professionals as availability allowed.
- The physiotherapists started their day on critical care and assessed the patients requirements although did not have any dedicated critical care time.
- The CCOS team was based on critical care and was led and developed by a nurse consultant.

Seven-day services

- The critical care off-duty rota allocated a ring fenced band 7 nurse for each early and late shift seven days a week. To ensure that ward staff had 24 hour access to an outreach service, the critical care unit also provided a band 7 nurse on night duty. Overnight wherever possible the critical care based band 7 would go to assess any patient triggered for CCOS input. However, if the patient acuity on the critical care unit prevented this they would provide telephone advice. Although a nurse led service, the outreach team had 24 hour access to the on call anaesthetist for additional support and advice.
- A consultant anaesthetist/intensivist was available seven days a week including out of hours.
- Out-of-hours pharmacy, physiotherapy and imaging services were available during the daytime at weekends and then via on call.

Access to information

- The critical care unit used paper based records to augment the hospital wide paper medical records. We were told by staff that there was an ambition to move to electronic patient records but this was still aspirational and some way off. Pathology and haematology results could however be easily accessed via the hospital wide IT systems and viewed at the bedside.
- Patient records were easily accessible and stored confidentially.
- Staff were able to access policies and procedures via the trust's intranet. There were computer terminals available for each bed space as well as in the office and administration areas.

Critical care

- In the multi-disciplinary meeting room there were hard copy files of information that was important for staff to be made aware of, such as lessons learned from incidents.

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

- Staff understood the implications of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). They had the necessary skills and knowledge to enable them to seek consent from patients or their representatives before providing care or treatment.
- Staff also knew that where patients lacked capacity to make their own decisions, for example if unconscious, then best interest decisions about care and treatment should involve the patient's representatives.
- There was a trust wide matron who had a specific role in consent and mental capacity, which included her participation in best interest meetings. She was also able to provide guidance and support to staff.
- Each patient in critical care had a suite of risk assessments which included one about confusion, delirium and their ability to make decisions. Staff understood that such assessments required on-going review.

Are critical care services caring?

Good

We saw people and their relatives being treated with understanding, compassion, dignity and respect. The evidence demonstrated that the unit was good at involving patients, family and friends in all aspects of their care and treatment.

The unit had been designed in accordance with the latest best practice guidance with the aim of reducing delirium and the problems associated with sensory deprivation. For example, the unit made use of sky ceiling photo panels above patient beds, which displayed realistic images of blue skies, white clouds and blossom trees.

Compassionate care

- The critical care unit was able to provide care in single sex purpose built accommodation. The use of blink glass and curtains helped to maintain dignity and ensure that personal care was delivered discreetly.
- The relatives that we spoke with told us their loved ones were cared for in a kind and compassionate manner by staff. Our own observations supported this.
- We observed unconscious patients being communicated with by nursing and medical staff in a compassionate manner.
- Conversations regarding a patient's condition, prognosis, care and treatment options were sensitively managed.

Understanding and involvement of patients and those close to them

- We saw evidence in the clinical notes that patients and their relatives were involved in making decisions about their care and treatment.
- Patients were allocated a named nurse for a span of duty on either a 1:1 or 1:2 basis depending on their acuity. This helped to ensure continuity of care.

Emotional support

- We saw that where necessary, additional face to face meetings were organised to ensure family members were kept informed and had the opportunity to have their questions answered.
- The service actively promoted the use of patient diaries for those patients in critical care longer than four days. This practice assisted patients with reflecting on their critical illness and helped those with critical care unit post-traumatic stress.
- Relatives had access to a 24/7 chaplaincy service.
- We received very positive feedback from patients' families especially with regard to being kept informed by the unit's nurses and doctors.
- The unit had been designed in accordance with the latest best practice guidance with the aim of reducing delirium and the problems associated with sensory deprivation. For example the rooms on one side of the unit benefitted from full length windows incorporating an electronic blind so that natural light was visible. In addition the unit made use of sky ceiling photo panels above patient beds, which displayed realistic images of blue skies, white clouds and blossom trees.

Critical care

Are critical care services responsive?

Good

The critical care unit worked hard to ensure it met the needs of local people and took their opinions into account in trying to improve the service. The new critical care build had incorporated a purpose built relative's room close by. It provided kitchen facilities and was secure so that relatives were able to leave their personal possessions safely while visiting.

Patients were being reviewed in person by a consultant intensivist within 12 hours of their admission. The CCOS had introduced a follow-up clinic for former critical care patients. The clinic was run monthly and patients who had stayed at least four days in the unit were invited to attend. The clinics were run by a multidisciplinary team which included a psychologist.

However, ICNARC figures suggest the unit performed less well than other similar units for out of hours discharges. During the period reviewed by the CQC there had been 19 out of hours discharges, the service suggested that the data was distorted due to: four patients stepped down to HDU as a comparable level of care, one patient was transferred out to a specialist tertiary centre and one patient was discharged home. Therefore, when the number of discharges are adjusted the number of out of hours discharge to ward areas indicated that the unit was not an outlier.

Similarly, the unit performed worse than similar units for patients experiencing a delayed discharge from critical care. We were told that although a patient may have been judged as ready for discharge from critical care, a suitable bed may not be available for them on a hospital ward. In the majority of cases the delay experienced was less than one day and people still received the care and treatment they needed in a safe and effective environment.

Service planning and delivery to meet the needs of local people

- The new critical care build had incorporated a purpose built relative's room close by. It provided kitchen facilities and was secure so that relatives were able to leave their personal possessions safely while visiting. We saw that this space was comfortable and uncluttered.
- Three additional beds had been built in the unit bringing the physical capacity to 14 although currently only 11 were commissioned and staffed. This gave the hospital the opportunity to increase its critical care provision in the future, dependent on local need.
- In the event that more beds would be required than available, for example during an influenza pandemic, there was the provision to utilise beds in the adjoining and also newly built theatre recovery area.
- The opinions of service users and their relatives had been actively sought when planning the unit and there was evidence to suggest that their opinions and suggestions were valued.
- The service provided a useful written guide for patients, relatives and visitors, which gave them general information about what it's like to be in a critical care environment. In addition there was a brief information sheet giving specifics about the unit such a visiting times and telephone contacts. We were told that this information documentation was being reviewed and updated at the time of our inspection.

Meeting people's individual needs

- Patients were being reviewed in person by a consultant intensivist within 12 hours of their admission.
- The care plans that we reviewed demonstrated that people's individual needs were taken into consideration before delivering care.
- There was awareness among the staff of the delirium that patients can experience as a consequence of being cared for and treated in a critical care environment. The unit had a number of design features that were intended to help to normalise the care environment. For example the use of natural light and ceiling panels that were used to project sky and cloud formations.
- We saw and heard evidence that the unit staff supported the national "Hello, My Name is……" campaign, which aimed to encourage all staff, regardless of their role, to introduce themselves to the patients and visitors with whom they came into contact. Research has shown that patients appreciate basic personal touches, and a simple gesture such as telling someone your name can help people feel better about being in hospital.
- Interpreting services were available within the hospital if required.
- The CCOS had introduced a follow-up clinic for former critical care patients. The clinic was run monthly and

patients who had stayed at least four days in the unit were invited to attend. The clinics were run by a multidisciplinary team which was planned to include a psychologist.

Access and flow

- The unit provided a critical care service of 11 beds to the local population of around 300,000.
- The unit provided critical care to adults although in the past three years had admitted three children (teenagers) who had required intensive care for a short period only. Band 7 nurses had training in paediatric advance life support.
- The data provided prior to the inspection indicated low bed occupancy of 40%. However, it was explained that this figure had been calculated using the 14 physical beds on the unit and not the 11 commissioned beds. We were told the more accurate figure was an occupancy of between 60 and 80%.
- We saw that the critical care unit had a clear written operational policy for admission and discharge. This had last been reviewed in September 2014.
- The unit performed worse than similar units for patients experiencing a delayed discharge from critical care. It was suggested that this was a symptom of the wider hospital access and patient flow pressures. Even though a patient maybe have been judged as ready for discharge from critical care, a suitable bed may not be available for them on a hospital ward. In the majority of cases the delay experienced was less than one day. However, people still received the care and treatment they needed in a safe and effective environment despite the pressure on ward beds.
- ICNARC figures suggest the unit performed less well than other similar units for out of hours discharges. During the period reviewed by the CQC there had been 19 out of hours discharges, the service suggested that the data was distorted due to: four patients stepped down to HDU as a comparable level of care, one patient was transferred out to a specialist tertiary centre and one patient was discharged home. Therefore, when the number of discharges are adjusted the number of out of hours discharge to ward areas indicated that the unit was not an outlier.
- ICNARC figures also suggested that there had been the occasional transfer out of the unit for non-clinical reasons. We were told that in actual fact these had been as the result of repatriation.
- Once discharged from critical care, patients had their care overseen by the outreach team. This meant that readmission rates were low because patients individual care needs were usually managed effectively after discharge.

Learning from complaints and concerns

- We found low levels of complaints about critical care and evidence that the service responded promptly to people's comments and concerns.
- Staff were aware of the trust complaints policies and processes and any complaints were handled in accordance with trust policy.
- Critical care kept their own data base of complaints received which tracked the progress of investigation and responses against the timescales required in the policy. It also contained details of involvement with patient advice and liaison (PALS).

Are critical care services well-led?

Good

We found an effective governance structure that promoted a high level of staff confidence. The staff we spoke with felt happy with the level of engagement with senior staff on the unit and felt confident that they could discuss any concerns that they might have and that they would be listened to. We heard from both medical and nursing staff that they felt the unit was well run and that senior staff and peers were supportive.

There was clear clinical leadership at unit level for both medical and nursing staff. However, the unit's risk register contained risks had been there for a number of years and it was not clear these had been reviewed as planned and or what the actions were.

Vision and strategy for this service

- The hospital had clearly given consideration to the limitations of the old critical care unit and in planning the new unit had involved both staff and users to make sure that everyone was engaged and had the opportunity to contribute their thinking.

- The new unit had been "future proofed" in terms of its state of the art facilities and its ability to increase the numbers of beds available. This being dependent on the future needs of commissioners and availability of funding.

Governance, risk management and quality measurement

- The service measured itself against both the Intensive Care Society core standards and the Cheshire and Mersey Critical Care Network (CMCCN) service specifications.
- The service demonstrated a dedicated focus on understanding and addressing the risk to patient care.
- The risks inherent with the delivery of safe care had been identified on the unit's risk register. We found some of the risks had been on the register for a number of years. For example, delayed discharge from critical care (01/02/2010) with a review date of 08/05/2014. This date had already passed and there was no indication on the register if the review had taken place as planned and or what the actions were. However, this had been recognised by the service and remedial action had commenced.
- While the risk register had limitations the staff were able to talk about the current risks and what they hoped to do about them in terms of actions.
- The unit had also recently completed a benchmarking exercise against the service specification set out by the critical care network. This identified many of the same risks but did not give details of the resultant actions for mitigation.
- We saw that a range of meetings were held every month to assist with the communication, learning and management of the unit. For example, staff meetings involving all grades.
- A summary of critical incidents was shared with all unit staff.

Leadership of service

- Senior medical and nurse leaders were committed to providing a safe service for their patients.
- The critical care unit had a designated consultant clinical lead and the nursing team was enthusiastically led by an experienced clinical services manager, who had been nominated for a trust award.
- A consultant nurse was responsible for managing the CCOS.

Culture within the service

- Staff spoke enthusiastically about their work. Staff reported a positive and open culture on the unit and that managers listened to them. For example, through the monthly minuted critical care department meetings.
- Staff were encouraged to report incidents and raise concerns openly.
- Many of the staff had worked in the service for many years and there was a palpable bond and camaraderie among them. Many of the staff we spoke with also verbalised the close knit culture among the staff.
- There was evidence of collaborative working and positive relationships with other departments within the hospital.
- The employment of nurses in dedicated practice educational roles helped to support a culture of learning and development among the nursing team.

Public and staff engagement

- The staff we spoke with all said that they had been engaged with and consulted about the development of the new unit.
- Representatives of service users and their relatives were also consulted and involved in the new unit's development.

Innovation, improvement and sustainability

- The ICU was an active member of the CMCCN. Membership of the network enabled the unit through collaborative working with commissioners, providers and users of critical care to focus on making improvements where they were required. For example the introduction and evaluation of care bundles.

Maternity and gynaecology

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

Information about the service

The maternity and gynaecology services provides care and treatment for maternity, gynaecology and family planning for the population of Mid Cheshire. The maternity unit at Leighton Hospital had undergone significant refurbishment work over the past few years, including a reconfigured labour ward and a new midwifery led unit. Services include a triage unit, delivery suite, antenatal care (outpatients/ inpatient), post natal care (outpatients/inpatient), ultrasound and termination of pregnancy. The service also includes community midwifery services providing antenatal care, home birth and post natal care.

We inspected the maternity and gynaecology services as part of our announced inspection on 8, 9 and 10 October 2014. During our inspection we visited the triage unit, maternity unit, post natal and antenatal clinics, gynaecology clinic and gynaecology ward. We spoke with 24 staff and nine patients and relatives. We observed care and treatment to assess if patients had positive outcomes and looked at the care and treatment records for eight the patients. We gathered further information from data that we requested and received from the trust. We also reviewed information regarding their internal quality assurance and compared their performance against national data.

The service is managed through the women, children and sexual health division and is led by a divisional manager, associate medical director and divisional lead nurse/head of midwifery. The service averaged 2858 births a year; this was lower than the average number of births for a maternity unit nationally.

Summary of findings

Maternity and gynaecology services provided safe and effective care in accordance with both local and national guidance. We found midwifery staffing levels were calculated using a recognised dependency tool. We found the ratio of staff to births was better than the England average of 1:28.

A triage service introduced by the service enabled women to be directed to the most appropriate support in a timely manner. However there was no dedicated list for elective caesarean sections. As a result we found that patients may have their surgery delayed if an emergency arose. In addition, anaesthetic support was provided on a second on call basis from the main critical care service.

There were systems in place for reporting actual and near miss incidents across the maternity and gynaecology services. The service monitored all its risks and had local risk registers. Action plans were in place to ensure that risks had been addressed. Staff had a good knowledge and understanding of the need to ensure that vulnerable people were safeguarded.

Staff we spoke with and who we observed understood and followed best practice infection control guidance. Services were delivered by a hard-working, caring and compassionate staff. We observed that staff treated

mothers and their partners with dignity and respect and planned and delivered care in a way that took their wishes into account. Emotional support was available for both mother and their partners.

Are maternity and gynaecology services safe?

Good

Maternity and gynaecology services provided safe and effective care in accordance with both local and national guidance. We found midwifery staffing levels were calculated using a recognised dependency tool. We found the ratio of staff to births was better than the England average of 1:28.

There were systems in place for reporting actual and near miss incidents across the maternity and gynaecology services. The service monitored all its risks and had a local register. We reviewed the risks identified by the service. We saw that action logs were in place to ensure that risks had been addressed. The maternity unit had been significantly refurbished over the past few years including the reconfigured labour ward with an adjacent midwifery led unit. Staff had a good knowledge and understanding of the need to ensure vulnerable people were safeguarded appropriately

Staff we spoke with and who we observed understood and followed best practice infection control guidance. Services were delivered by caring and compassionate staff. We observed that staff treated mothers and their partners with dignity and respect and planned and delivered care in a way that took their wishes into account. Emotional support was available for both mother and their partners.

A triage service introduced by the service enabled women to be directed as to the most appropriate support in a timely manner. We found that the service had identified a need for more dedicated anaesthetic cover and to be able to run a dedicated elective caesarean section list to provide a more responsive service for women.

Incidents

- There were systems in place for reporting actual and near miss incidents across the maternity and gynaecology services. Staff told us they were confident in reporting incidents and were able to show us how they would report an incident through the electronic system. We found that the majority of incidents reported were found to result in no harm.

- Incidents logged on the system were reviewed and investigated by the appropriate manager to look for improvements to the service. Serious incidents were investigated by senior staff.
- There had been two reported never events in the maternity service which were in relation to retained swabs. The incidents had been investigated and remedial actions had been put in place to prevent reoccurrence.
- We found that a serious incident had also occurred. The incident was related to the management of a haemorrhage and again the use of swabs. During the inspection, we saw evidence that this incident had been investigated and action plans implemented to improve patient care. Staff were aware of both the never event and the serious incident and had been involved in the learning and implementation of new processes within the maternity unit to prevent further incidents of this nature
- Maternity and gynaecology service monitored all its risks and had local risk registers in place. Action logs were in place to ensure that identified risks had been mitigated and addressed. The maternity service had begun the process of addressing an identified risk for lone workers in the community and was scoping new tracking devices for mobile phones.
- Mortality and morbidity meetings were held monthly and were attended by the multi-disciplinary team. These meetings discussed any complex cases that had occurred and included any learning or recommendations. This showed that there was a culture of no blame and learning from incidents.

Safety thermometer

- Information from the NHS safety thermometer (a tool designed to be used by frontline healthcare professionals to measure harm such as falls, infections and blood clots) indicated that maternity and gynaecology services were performing within expected ranges for these measures. This information was displayed on the units/wards and was freely available for patients and staff.

Cleanliness, infection control and hygiene

- The areas we inspected were clean and tidy and were stocked with appropriate personal protective equipment.
- We observed good use of personal protective equipment, staff were observed to be wearing gloves or washing their hands between patients. Staff observed 'bare below the elbow' guidance. There was easy access to hand gels at the entrance to all patient areas.
- Information about infections such as methicillin-resistant staphylococcus aureus (MRSA) and Clostridium difficile (C. difficile) was displayed on the unit. There were no recent reported incidents of either of these infections in the maternity services.
- Staff followed best practice infection control guidance such as the management of sharps, contaminated waste and laundry. Results of audits indicated high levels of compliance with infection control practices. Staff were required to attend mandatory training for infection and prevention control.

Environment and equipment

- The maternity unit had been significantly refurbished over the past few years including the reconfigured labour ward with an adjacent midwifery led unit. This included a secure outdoor courtyard for women to use during the summer months.
- We found that the termination of pregnancy clinics and the gynaecology and maternity outpatient clinics were still in need of refurbishment but staff were positive about future plans for these areas
- Resuscitation equipment was clean well maintained and ready for use.
- Emergency equipment was available for treating adverse events such as excessive bleeding after the delivery of a baby (post-partum haemorrhage).
- Cardiotocography (CTG) equipment was available in the delivery rooms. The maternity unit was fully supplied with appropriate technical equipment including resuscitaires in the delivery rooms and the midwifery led unit. Each delivery room in the midwifery led unit was fully equipped and had its own birthing pool.

Medicines

- Medicines were stored, managed, administered and recorded safely and appropriately. We were shown the policies and procedures for the management of medication. Staff were able to show us how they accessed the policies on the trust's intranet.
- Staff records showed they had received appropriate training in line with professional standards for the management of medicines.

- Medicines that required storage at temperatures below 8ºC were appropriately stored in medicine fridges. Fridge temperatures were checked daily to ensure medicines were stored at the correct appropriately

Records

- The "child health record" (red book) was issued to mothers and advice was available on how to keep the record as the main record of the child's health, growth and development.
- The trust used paper based patient records and these were securely stored in each area we inspected.
- In all the records we looked at, documentation was accurate, legible, signed and dated, easy to follow and gave a clear plan and record of the patient's care and treatment. Risk assessments were in place for different care pathways for both high and low risk pregnancies, these were reviewed as part of the woman's ongoing pregnancy. Care plans contained clear accounts of actions in place to reduce and manage risks to patient safety.
- Records showed that patient consent had been obtained and recorded appropriately. Patient records showed that nursing and clinical assessments were carried out before, during and after surgery and these were documented correctly.

Safeguarding

- Staff had a good knowledge and understanding of the need to ensure vulnerable people were safeguarded. They understood their responsibilities for identifying and reporting any concerns through the safeguarding procedures and knew how to contact the hospital safeguarding team, should this be necessary. We were told that there was a safeguarding midwifery lead that was easily accessible for support and advice.
- Safeguarding training was a mandatory subject for all clinical staff and we saw from training records that the service was on target to achieve over 90% compliance by March 2015.
- We were shown that the maternity service had an abduction policy and emergency procedures to follow if a baby was taken without permission from the unit.
- The doors to the ward were locked and access was via a video/intercom. There was an external courtyard that mothers could access during the summer. We found the area was secure with high fencing around and CCTV.

Mandatory training

- The service had developed a robust training needs analysis to ensure that training was in line with the national recommendations for all professionals working in maternity services.
- There was a good system in place to check that all staff who worked in the division received their mandatory training. Records showed that the service was in line to meet the targets of 95% by March 2015.

Assessing and responding to patient risk

- The midwifery staff used an early warning assessment tool known as the Modified Early Obstetric Warning Score (MEOWS) system to assess the health and well-being of women who were identified as being at risk during their pregnancy. This tool provided a framework for staff to identify a patient's deterioration and seek further medical intervention and support. Records showed that the tool had been used appropriately to care for patients.
- We observed the maternity and termination of pregnancy theatre teams following best practice surgery procedures, including the use of the World Health Organization (WHO) checklist. The theatre staff completed safety checks before, during and after surgery and demonstrated a good understanding of the 'five steps to safer surgery' procedures.

Midwifery staffing

- Midwifery staffing levels were calculated using a recognised dependency tool. We found the midwife to birth was better than the England average of 1:28. Our data showed that in July 2014 the ratio was 1:26. Staff told us and an external report showed that this had improved from 1:29 in the period 2012/2013.The sickness rates at the time of our inspection were 3.7% which is better than the national average.
- The trust reported the percentage of women given 1:1 care from a midwife while in labour was good and usually higher than the expected target of 95%
- Midwifery staff worked twelve hour shifts which some staff told us: "can be very hard and tiring". We were told the managers tried to ensure that staff got a break although they admitted that this may not always be

possible to do if they were busy with a mother. A handover took place between outgoing and oncoming staff. Shift handovers were well managed and promoted clear communication and continuity of care.
- The maternity service had a robust escalation policy and a review of patient severity/dependency (acuity) was reviewed 2 hourly. This meant that the service clearly identified any need for more staff and could be flexible in the deployment of staff.

Medical staffing

- There were sufficient staff with appropriate skill mix to ensure the safe delivery of maternity and gynaecology services. The introduction of the advanced midwifery practitioner had improved the provision of care and released some of the duties from junior medical staff.
- The medical staff carried out regular handovers during the day and in the evening on the labour wards.
- Sessional theatre cover was provided between normal working hours Monday to Friday with out-of-hours on call cover. The proportion of doctors was in line with the England average. We were told that the service had 60 hours of medical staffing a week on the labour ward.
- We spoke with the medical staff who confirmed that there was a process for consultant on call and that usually any gaps were filled internally although locums were used if necessary. We were told that the locum was always met by a consultant and the service was currently reviewing the induction pack for locums.

Major incident awareness and training

- The trust had clear business continuity plans in place and we found major incident action cards in place on the labour suite which staff were aware of. Trust data showed that all staff within the maternity division had received training on the trust's major incident plan.

Are maternity and gynaecology services effective?

Good

The maternity and gynaecology services provided effective care and treatment that followed national clinical guidelines and staff used care pathways effectively. The services participated in national and local clinical audits.

National guidelines were used to treat women and care pathways were followed to support and speed recovery. Standards were monitored and outcomes were good when compared with other maternity and gynaecology services.

Patients' pain relief requirements formed part of care planning and were regularly reviewed and monitored for efficacy.

There were sufficient numbers of supervisors of midwives within the hospital. Supervisors monitored the practices of midwives to ensure mothers and babies receive good quality, care. Supervisors, provided support, advice and guidance to individual midwives on practice issues, while ensuring they practiced within the midwives rules and standards set by the Nursing and Midwifery Council. All midwives had an annual review by their allocated supervisor.

Evidence-based care and treatment

- The maternity and gynaecology services used a combination of National Institute for Health and Care Excellence (NICE), and Royal Colleges' guidelines and quality standards to determine the treatment provided. The delivery of care was provided in line with current best practice issued by professional and expert bodies such as NICE. Records and audits showed that care was provided in line with Royal College of Obstetricians and Gynaecology guidelines (including Safer Childbirth: minimum standards for the organisation and delivery of care in labour).
- The service was very proactive in regards to auditing practice and had undertaken a mock assessment to assess themselves in line with observations currently undertaken in line with the NICE recommendations. The assessment found that the maternity service was carrying out greater observations of new born babies than compared to the NICE recommendation.
- The service was involved in both local and national audits and regular feedback was presented at the divisional governance meeting and multidisciplinary training events. We saw a continuous audit programme including incidents of post-partum haemorrhage which was part of the nationally led audit. The service had also reviewed the percentage of women who had a normal delivery after a previous caesarean section and were reviewing the patient pathway. The service demonstrated a positive and proactive approach to reviewing the effectiveness of service delivery.

- The National Neonatal Audit Programme 2012 showed that the hospital met the standard for only one of the five key standards. Results for the 2013 Audit showed an improvement with three of the five standards met.

Pain relief

- Patients' pain relief requirements formed part of care planning and were regularly reviewed and monitored for efficacy.
- Women who spoke with us confirmed they had been offered and provided with a choice of pain relief. This included for example, delivery under epidural procedure, birthing pool, Entonox or with controlled drugs such as pethidine.
- Women had 24 hour access to their choice of pain relief.
- The maternity service had a dedicated obstetric anaesthetist available to support the pain management needs of women in labour.

Nutrition and hydration

- A food service was provided to women who used the maternity inpatient services. Medical related diets could be catered for such as diabetic or gluten free. The service also catered for cultural and religious specific menus.
- Kitchen facilities were available for patients to get themselves a drink as they wished. Patients were complimentary about the meals served at the hospital.
- Women had been supported to feed their babies using their preferred method. The trust had been awarded the baby friendly stage 2 accreditation from UNICEF. Baby friendly focuses on staff knowledge and skills to support families with their infant feeding choices. The work undertaken by the trust's infant feeding team had resulted in improved health outcomes for mothers and babies, with the highest breast feeding and lowest smoking rates during pregnancy for eight years.
- We observed that women who needed intravenous fluids to support their treatment had been monitored for their fluid intake and output as part of the process.

Patient outcomes

- The maternity service had carried out a comprehensive review of still births in 2009. Since then improvements in practice had halved the still birth rates. The staff told us that this had been done by use of perinatal individualised charts and the proactive use of earlier induction.
- Caesarean section rates for the service were better than the national average.
- We noted that the epidural rate on the clinical dashboard was lower than the target set for the service. Staff told us that the new midwifery unit meant that more mothers were opting for a pool delivery which may have had an impact on the epidural rates. The service was reviewing its clinical dashboard to monitor the change in activity.
- We found that the maternity clinical dashboard required further development with support from the trust information department to ensure that it was populated correctly and the correct parameters were set to allow the service to fully review its clinical activity.

Competent staff

- All midwives had an annual review by their allocated supervisor.
- Appraisals of both medical and nursing staff were undertaken and staff we spoke with had received an appraisal during the last year and spoke positively about the process.
- All nursing staff were subject to an annual registration check and were supported to maintain their continuous professional development.
- Maternity and gynaecology services had a wide range of training opportunities to ensure that staff had the skills and knowledge to carry out their job roles. We also found that additional training was available as required for specific updates such as the interpretation of monitoring equipment or a review of surgical checklists in theatre.
- The maternity service had introduced new roles to support the delivery of care. The assistant practitioner role was a new way of working that complemented existing roles within the ward nursing team. The purpose of the role was to provide patient-focused care, previously undertaken by a clinician, allowing the advanced practitioner to focus on more complex care needs. Staff told us that they had been fully trained to carry out their extended roles and felt competent to carry out more complex and independent procedures.
- The maternity service had several specialist midwife roles to lead specific areas of practice such as quality and safeguarding.

Multidisciplinary working

- The staff were delighted with the new midwifery led unit and felt that its location next to the labour ward enhanced closer working with the wider maternity team.
- Therapy staff were employed by the local community trust but they reported good working relationships with staff on the wards and told us they felt supported as full members of the team.
- There were good links between the community midwifery team and the hospital midwifery team. Close links facilitated timely referral and discharge was possible within two hours of giving birth from the midwifery led unit.
- Staff told us there was good multidisciplinary working across all the maternity and gynaecology services. We found close working relationships between the maternity staff and the special care baby unit (SCBU).From our observations and discussions with members of the multidisciplinary team we saw that staff across all disciplines respected each other and valued each person's individual role in the team.
- Maternity staff met regularly as part of an ongoing training programme and as part of the divisional governance structure to learn from incidents in a multi-disciplinary setting.

Seven-day services

- Services were available seven days a week. Patients had access to a 24 hour a day triage unit with access to medical and midwifery staff.
- Post natal services were available in the community (women were transferred home to the care of the community midwives until at least the tenth day following delivery).
- A consultant was available on an on call rota out of hours after six o'clock at night and at weekends.

Access to information

- The trust used paper based patient records. The patient records we looked at were complete, up to date and easy to follow. Records contained detailed patient information from admission through to discharge within the patient record. This meant that staff could access all the information needed about the patient at any time during the patient journey.
- We saw that information such as lessons learned from incidents and internal correspondence was displayed in staff rooms in all the areas we inspected. Staff could access information such as policies and procedures from the trust's intranet.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff demonstrated the appropriate skills and knowledge to seek consent from patients or their representatives. Staff were clear on how they sought verbal informed consent and written consent before providing care or treatment.
- We noted that consent forms were available in the care records of women who had undergone a caesarean section. These were signed and completed appropriately.
- Staff understood the legal requirements of the Mental Capacity Act 2005 and Deprivation of Liberties Safeguards (DoLS).Staff were aware of their duties and professional obligation relating to the Act.
- We saw staff obtaining verbal consent and explaining to patients about a particular intervention they were going to have.

Are maternity and gynaecology services caring?

Good

Services were delivered by caring and compassionate staff. We observed that staff treated mothers and their relatives with dignity and respect and planned and delivered care in a way that took their

wishes into account. Emotional support was available for both mothers and those close to them.

Clear systems were in place to offer emotional support to people if required and were carried out with sensitivity and compassion. Counselling was available for patients undergoing termination of pregnancy and for any identified foetal abnormality concerns.

The CQC maternity survey results showed that the trust performed above the national average scoring highly for the labour and birth elements of the pregnancy journey.

Compassionate care

Maternity and gynaecology

- Maternity and gynaecology services were delivered by committed and compassionate staff. We observed that all staff treated patients with dignity and respect
- We spoke with nine patients and the majority were positive about the care they had received. One lady who had used the maternity services for previous births told us: "There have been lots of improvements." Another told us: "The staff are very kind and friendly." People told us that the community midwives were very accessible and communicated well with women and their partners.
- One lady told us that staff had stayed on shift to see her through a difficult birth. She told us: "I am absolutely overwhelmed by the kindness and commitment of all staff".
- We found examples of ways in which people were encouraged to share their views on the services. A comments book was available for mothers to write suggestions and views on the service. The triage unit asked patients to complete a satisfaction questionnaire. Some people told us they would prefer more access to facilities for their partners to stay over.
- The trust participated in the friends and family test which is a government initiative focused on improving patient care. The majority of respondents felt that they were extremely likely to recommend the hospital for maternity care. We found that the trust's response rates to the test were lower than the national response rate. We were told by staff that the trust was looking to utilise wider communication methods to improve the response rate.
- Results for the CQC survey of women's experiences of maternity services showed that the trust performed better than the national average (9 out of 10) for the labour and birth elements of the pregnancy journey.

Understanding and involvement of patients and those close to them

- People told us staff had explained what was happening and what the plan of care was.
- Care was planned and delivered in a way that took into account the wishes of the patient. We saw staff obtaining verbal consent and explaining to patients about a procedure. We were told that an anaesthetist had gone to apologise to a patient for the delay in taking her to theatre and had kept her informed of what was happening.
- The use of records held by mothers encouraged them to be aware of their birth plans and provided further information on any specific tests or investigations that may be needed throughout a pregnancy.

Emotional support

- Counselling was clearly available for patients undergoing termination of pregnancy and for any identified foetal abnormality concerns. The sonographers outlined the procedure for supporting women who had abnormal scan results.
- Patients were given privacy and dealt with sensitively by all the staff. This included leaving from another exit to a quiet room for privacy. Clear systems were in place to support patients. Staff understood the need to provide emotional support to mothers and carried out assessments for perinatal mental health. We were told that a debriefing clinic was available for mothers who wished to talk through their experiences after a difficult birth.
- Arrangements were in place to provide emotional support to patients and their families in a sensitive manner. Support was offered for families who had suffered a still birth and was ongoing through the bereavement lead. Staff told us they worked closely with the chaplaincy and counselling services. This included holding an annual remembrance service.
- We spoke with a volunteer who told us that photographs could be provided sensitively if a baby was stillborn as part of the bereavement process.
- Counselling services for staff were available through occupational health.
- Staff told us that they tried to keep all the mothers with babies in the special care baby unit in the same room in order to support each other.

Are maternity and gynaecology services responsive?

Requires improvement

There was no dedicated list for elective caesarean sections. As a result we found that patients may have their surgery delayed if an emergency arose. In addition, anaesthetic support was provided on a second on call basis from the main critical care service. We were told that maternity had

always been a priority for support and staff would record any delays in anaesthetic cover as an incident. Staff told us that they had submitted a business case to secure additional anaesthetic support for the service and were hopeful of a positive response from the trust.

A triage service had been introduced by the maternity service to assess women who had concerns about their pregnancy. This enabled women to be directed to the most appropriate support in a timely manner. This was available 24 hours a day seven days a week.

Complaints were handled in accordance with trust policy. Staff were aware of the trust's complaints policy and were able to direct people wishing to make a complaint to the customer care team if they were unable to deal with their concerns locally.

Staff had access to support for meeting the needs of vulnerable women or children and had close links with the safeguarding team. The maternity service had worked hard to develop a number of specific care pathways and protocols for both high and low risk women. Patients had individual assessments for their medical, social and emotional needs.

Service planning and delivery to meet the needs of local people

- Maternity staff were aware of the local population's needs and were working with other providers to ensure that clear pathways of care were in place to meet those needs.
- Staff told us they had worked closely with the local population regarding the refurbishment of the maternity unit although we did not see evidence of formal meetings. We were told that the service was working with the local commissioning group and other providers to ensure safe pathways of care were in place to meet the needs of mothers and their babies during pregnancy
- We found that clear pathways were in place for specific conditions such as drug abuse, obesity and alcohol abuse. This meant patients were able to access support and appropriate care for their individual needs.

Access and flow

- There was no dedicated list for elective sections. We found that these patients may have their surgery delayed if an emergency arose. We found the anaesthetic support was provided on a second on call basis from the main critical care service. We were told that maternity had always been a priority for support and staff would record any delays in anaesthetic cover as an incident. This did not assure us that this was an appropriate way of managing patient demand and responding to patient needs.
- The divisional managers were fully aware of the ongoing issues across the service to provide responsive care. The staff told us that they had submitted a business case to have dedicated duty anaesthetic and theatre staff for out-of-hours and consultant anaesthetic sessions for elective caesarean sections to provide a more responsive service for women. We were told that currently the provision of a full obstetric anaesthesia service was not fully compliant with national guidance for safer childbirth (RCOG 2007).
- During our inspection, we observed a delay in a patient going to theatre due to the complexity of an earlier case. We observed that the anaesthetist went to see the patient to keep them informed of what was happening.
- We were told about and observed a 'safety huddle' before a theatre list started to discuss the cases and to ensure that all staff were aware of any other issues such as safeguarding or high risk complex cases.
- The service reported one closure in 2014/2015 to date compared with six closures in 2013/2014. Staff told us this was due to the review and implementation of the escalation policy and deployment of staff.
- We were told that women were able to self-refer to the service and were able to choose where they wanted to give birth in discussion with the midwife.
- The new midwifery led unit (MLU) allowed low risk mothers to give birth in a less formal environment. Women were allowed to go home if fit, two hours after giving the birth which gave them more options in regards to the location of their delivery.
- The maternity service had introduced a triage unit to assess women who had concerns about their pregnancy. This was staffed by the advanced midwifery practitioners with access to medical staff and monitoring support if required.
- The maternity service scored well in the maternity survey for the question **"**If you used the call button how long did it usually take before you got the help you needed? ". This showed us that the midwives were responsive to the need of patients using the maternity service.

- The maternity service policy required that the on call consultant must be able to attend within 30 minutes. We found that the service had achieved 100% compliance with this policy. We also found that the service was able to offer one to one support for mothers during labour.
- Patients told us there could be long delays in the antenatal outpatient clinic. This was confirmed by staff who told us that sometimes patients may need to wait if they required further scans or blood tests.

Meeting people's individual needs

- The Big Word translation service was available for patients and their relatives whose first language was not English. We observed staff using the translation line and an interpreter for one patient.
- Information leaflets were available for people in a range of different languages.
- The service had systems in place to meet people's religious and cultural needs.
- Staff had access to support for meeting the needs of vulnerable women or children and had close links with the safeguarding team. Staff told us that they had received training on managing people with complex needs and had also had training on supporting women following female genital mutilation.

Learning from complaints and concerns

- Patients were aware of how to complain and felt that they would be confident to do so if they had any concerns.
- Complaints were handled in accordance with trust policy. Staff were aware of the trust's complaints policy. They told us they would direct people wishing to make a complaint to the customer care team if they were unable to deal with concerns directly. They would be advised to make a formal complaint if their concerns remained.
- Complaints leaflets were comprehensive and available throughout the hospital. Complaints were recorded on the trust's electronic incident reporting system.

Are maternity and gynaecology services well-led?

Good

Maternity and gynaecology services had robust governance and quality systems in place. The risk and governance issues for the sub divisional area of maternity were monitored and detailed within monthly exception reports and quarterly reports. These were presented and discussed during the monthly obstetric governance committee.

Maternity and gynaecology services had key leadership roles in place across different levels of the division. We saw several examples of staff displaying excellent leadership and professionalism across community, hospital, medical and midwifery services.

The majority of staff told us they felt well supported both by the trust as a whole and at a local team level.

Vision and strategy for this service

- The divisional lead for maternity told us of the progress against the service's vision since she had arrived in the trust four years ago. Staff confirmed they have been involved over the last four years and were proud of the improvement in maternity services and understood the changes to patient care. The staff were delighted with the new midwifery led unit and felt that its location next to the labour ward was a key part of the vision for the maternity service.
- Staff told us that they were aware of the trust's vision and were committed to embedding the improvements both in maternity and gynaecology services and as part of the trust as a whole.

Governance, risk management and quality measurement

- Maternity and gynaecology services had robust governance and quality systems in place.
- The risk and governance issues for the sub divisional area of maternity were monitored and detailed within monthly exception reports and quarterly reports. These were presented and discussed during the monthly obstetric governance committee meeting.
- The maternity risk register was monitored monthly through the maternity risk management monthly report

and was presented to the obstetric governance committee. Root cause analysis was undertaken on nine occasions in the last year. In addition there were 35 multi-disciplinary case reviews undertaken for serious maternity incidents including women transferred to the Intensive Care Unit.

- The maternity service had undergone external accreditation this year and had been congratulated by the external assessor for achieving high compliance scores after scoring 48 out of 50 .The clinical negligence scheme for trusts level 3 includes a series of performance indicators such as the care of women in labour, screening of their mental health, whether they are supported to breast feed, staffing and the number of complaints and incidents.
- There were systems in place to monitor the service, ensuring it provided care and treatment in line with the legislative requirements for the termination of pregnancies.

Leadership of service

- Maternity and gynaecology services had key leadership roles in place across different levels of the division. We saw several examples of staff displaying excellent leadership and professionalism across community, hospital, medical and midwifery services. The maternity service was working well to integrate services and the role of the divisional professional lead nurse/head of midwifery was seen by our specialist adviser as inspirational.
- Trainee doctors told us about their experiences of leadership. One told us that the maternity unit was “very friendly and supportive to work in”. Another told us that training was easily available and opportunities for further training and updates were provided on a regular basis.
- Staff felt supported by their line manager. Some staff told us they would prefer more face to face meetings but appreciated that sometimes workload prevented this from happening.

Culture within the service

- Staff spoke positively about the service they provided for patients and the positives changes to the environment. Staff worked well together and felt that they would and could continue to develop and improve services in the future

Public and staff engagement

- Staff told us how they had engaged with patients during the refurbishment of the maternity unit.
- We were also told that sensitive engagement had taken place with bereaved relatives during the transfer of the garden of remembrance in planning for the new building.
- Staff told us that they did have regular communication with managers but felt that they would prefer and benefit from more face to face meetings.
- We did not see evidence of formal meetings to engage with members of the public about the maternity services. We did see strong links with local voluntary groups such as the local still birth support group.

Innovation, improvement and sustainability

- The provision of the newly refurbished maternity unit was seen as a positive change overall and staff felt they were continuing to focus on sustaining the improvement in care and patient experience for mothers, partners and their babies.
- Staff told us they felt engaged in the development of the extended roles and were keen to further explore the use of extended scope practitioners across the service.
- The service was reviewing the use of smart phones to improve communication across community and hospital based services.
- The unit had a lower than national average birth rate on the unit. The clinical lead outlined how the service was working with other local NHS providers to improve the care and strengthen the local network.
- The service leadership acknowledged capacity issues to allow the leadership changes to become further embedded across the maternity unit and sustain the innovation and improvement.

Services for children and young people

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

Information about the service

Services for children and young people consist of a newly built specialist care baby unit. This opened in September 2014 and is situated on the ground floor. The unit has the ability to support 15 babies based on care dependency and has intensive care and high dependency care available within the unit. The unit is able to take babies born at 27 weeks and over. Babies outside of these criteria are transferred to other units as part of existing protocols. The children's ward is based on the ground floor and has 50 beds available in total. It is split across two ward areas to provide a day case service and inpatient area. There are 16 side rooms available and two allocated high dependency beds. The beds are in bays of four, six or single cubicles. There are parent's facilities and play areas on the ward.

There is a dedicated children's outpatient unit set in the grounds of the hospital providing outpatient support for children and young people.

During the announced inspection from 8 to 10 October 2014 we visited children's inpatient and outpatient areas and the special care baby unit. We spoke with seven parents and three patients. We spoke with a range of staff at different grades including: three consultants, four doctors, 13 nursing staff and six allied health care professionals and a health care assistant. We also visited the children's ward as part of an unannounced inspection on 24 October 2014 between 5pm and 8.30pm.

Summary of findings

are provided by services for children and young people was good and supportive to children, young people and their families. People told us that the staff were "lovely" and "very kind". There were processes in place for safeguarding and concerns were identified and referred to the relevant authorities. There were robust arrangements in place to report and monitor incidents and near misses and staff were clear on their responsibilities in this regard. However, the process for reporting safeguarding concerns via the incident reporting system was not as robust. This meant that incident reporting systems may not accurately reflect the safeguarding concerns identified. As a result safeguarding incidents may not have been reviewed properly to identify areas of learning.

Staff were up to date with mandatory training. However, our specialist advisor in children's safeguarding expressed some concern that the time associated with level three safeguarding training in the trust (2 hours) may not be sufficient to support staff learning needs.

There were clear governance arrangements in place that monitored the outcome of audits, complaints, incidents and lessons learned throughout the service. Staff were positive about the culture in children's and young people's services and felt supported by senior managers in the trust. Staff were able to be innovative and introduce new practices to improve quality.

Services for children and young people

Children's and young people's services were forward thinking in how services could to be adapted to provide flexibility and sustainability in the future and were committed to developing relationships across health networks.

Are services for children and young people safe?

Good

The special care baby unit and children's ward were supported with 24 hour consultant cover over a seven day period. The medical and nursing staff used scoring tools to ensure early identification and escalation of deteriorating babies and children. Staffing levels were appropriate to meet the care needs of children at the time of our visit .The trust had procedures in place to monitor staffing requirements based on acuity and had protocols in place to support decision making.

Children's inpatient and outpatient areas were clean and tidy and there was sufficient appropriate equipment available for staff to deliver care. Staff and babies had recently moved into the new special care baby unit that was built with safety and cleanliness at the core of its design.

There were processes in place for children's safeguarding and concerns were identified and referred to the relevant authorities. The trust had robust arrangements in place to monitor incidents and staff were clear about their responsibilities in this regard. Procedures were in place for the trust to learn lessons from incidents and staff were aware of trends associated with incidents. However the process for reporting safeguarding concerns via the incident reporting system was not as robust. This meant that incident reporting systems may not accurately reflect the safeguarding concerns identified. As a result safeguarding incidents may not have been reviewed properly to identify areas of learning.

Staff were up to date with mandatory training and ware aware of emergency planning arrangements and their responsibilities relating to this. However, our specialist advisor in children's safeguarding expressed some concern that the time associated with level three safeguarding training in the trust (2 hours) may not be sufficient to support staff learning needs.

Incidents

- The trust monitored incidents related to services for children and young people through dedicated

integrated governance arrangements which were reportable monthly and provided trend reporting for all incidents associated with children and young people's services.
- Incidents were investigated using a route cause analysis tool and actions were reported through the relevant governance arrangements.
- For the month of August 2014, 34 incidents were reported for children and young people's services of which 27 were identified as causing no harm and seven causing low harm.
- In January 2014, five pressure ulcers were reported for children and young people's services. We investigated this data and found that while all the incidents had resulted in no harm, evidence showed that the trust had since implemented skin care bundles across children and young people's services. Staff told us that the use of skin bundles supported improved clinical practice.
- Staff were aware of incidents relating to their service and knew how to report incidents within the trust. Staff told us they were encouraged to report incidents and they were satisfied that they received feedback from reporting. Lessons learned from incident reporting were cascaded though a weekly risk forum.
- Mortality cases were reviewed and monitored via the division' monthly integrated governance exception report.

Cleanliness, infection control and hygiene

- Equipment was clean and fit for purpose. Ward areas had systems of decontamination in place in order to make it clear to staff when equipment had to be cleaned.
- The trust had a cleaning regime in place for toys which was completed by the play therapy team. We observed there were a large number of toys requiring cleaning on a daily basis throughout children's outpatient and inpatient areas. The play therapy team identified that this was sometimes difficult due to clinical commitments. However, records showed toys had been cleaned appropriately.
- Staff adhered to infection control policies. For example, staff washed their hands appropriately and used personal protective equipment such as gloves and aprons.
- Standards of cleanliness and hygiene were assessed and monitored monthly and monitored through trust dashboards. At the time of our inspection children and young people's services were achieving trust compliance standards as set by the trust for cleanliness and hygiene. This reflected observations made during this inspection.
- Infection prevention policies and procedures were in place for supporting winter arrangements on the children's ward. We found that staff were aware of these plans.
- Staff identified positive relationships between the Infection Control Team and the special care baby unit.
- Staff told us that the implementation of a regional neonatal infection control audit tool in preparation for occupation of the new neo-natal intensive care unit build (September 2014) supported changes in practice within the unit.
- Staff identified that the new special care baby unit had increased isolation facilities and supported flow through the department which was specifically designed to minimise risk associated with healthcare associated infections.

Environment and equipment

- The trust had recently improved the environment of the hospital by introducing colour coded signage and zones to support people using the services. However we found the areas external to children and young people's services, for example corridors and ward entrances did not create a welcoming child-friendly environment.
- The environment within children and young people's services was fit for purpose and offered a variety of age appropriate equipment and accessible facilities.
- Age appropriate resuscitation and emergency equipment was available and were checked regularly. However it was noted that some daily checks were missing on the children's resuscitation trolley.
- A monthly audit programme reviewing security, equipment and the environment was in place and monitored through children's and young people services.
- However, in January 2014, the children's ward reported leaking broken windows. During our visit both staff and patients told us that this fault remained and was intermittently a problem as changes in weather would cause leaking. A patient told us that the room had been closed recently as a result.

- Wi-Fi was not available for children and young people in inpatients areas. Children and young people told us they felt isolated because they were unable to access the internet especially when trying to complete homework.
- Some staff and patients told us that the children's ward could be cold at night.

Medicines

- There was a dedicated pharmacist for the children's ward. Staff told us this role supported appropriate prescribing and administration.
- There was an established audit programme across children and young people's services including drug omission, medicine security, storage of medicines and antimicrobial prescribing.
- Staff were trained in medicine management though the trust's biennial mandatory medicines management training. All staff told us they had undertaken this training in the last two years and stated it supported practice.
- There was weekend pharmacy cover for the trust. However one member of staff told us that it was sometimes difficult to get pharmacy support at the weekend.
- A copy of the national formulary was accessible in all children and young people's services to support prescribers (both hard copies and online).
- Monograph information in children's services was reported as a high risk in August 2014. The trust identified the need to provide staff access to children specific prescribing aids to support medicines management and prescribing. Appropriate action had been taken at the time of our inspection

Records

- Records were kept confidential on the wards and stored in secure cabinets.
- Records across children and young people's services were found to be accurate and legible. However for a small number of records held on the children's ward it was difficult to identify the writer in some instances.
- Records completed in the handover process were reviewed and included checklists that supported clinical prioritisation.
- Work undertaken by play therapists included individual plans for young people attending for procedures. Risks were identified and individual support plans put in place to mitigate risks and ally the child's fears and anxieties.

Safeguarding

- The director of nursing led safeguarding arrangements for the trust. The children and young people's service had a designated named doctor and nurse. The trust had clear governance and quarterly reporting arrangements in place for safeguarding that included both children's and adult's services.
- The lead for safeguarding arrangements had a comprehensive overview of individual cases relating to safeguarding children concerns. There had been no serious case reviews at this trust for a number of years.1253 safeguarding concerns related to children were managed by the trust in 2013/14.
- Between April and June 2014, the trust had received 178 safeguarding concerns related to children. The trust identified an increase in referrals compared to the same period the previous year.
- The trust identified that it had sought social service advice on safeguarding concerns on 71 occasions between April and June 2014 of which 21 formal referrals were submitted.
- The children's ward was visited during both the announced and unannounced inspections. During both of these visits we observed that staff were actively supporting children and young people for who there were safeguarding concerns.
- During the inspection we reviewed a number of safeguarding cases and found that appropriate action had been taken and relevant policies and procedures had been followed. However, in one instance we found that the patient's records had not been updated and did not fully reflect the action that had been taken.
- The trust's safeguarding training matrix clearly identified training needs of staff. Training records showed that appropriate staff had been trained to level three safeguarding standards. However, on speaking with some nursing staff there were inconsistencies in their understanding of what level safeguarding training they thought they had undertaken.

Services for children and young people

- As part of the trusts audit programme 2014/15 the named doctor had been designated to review safeguarding training to review the content and procedures.
- Medical staff were assessed through the deanery as part of a competency based approach prior to employment at the trust**.** Medical staff confirmed that the named doctor provided further training within one month of commencing employment as part of the induction process.
- The process for reporting safeguarding concerns via the incident reporting system was not clear. This meant that incident reporting systems may not accurately reflect the safeguarding concerns identified. As a result safeguarding incidents may not have been reviewed properly to identify areas of learning. For example, during the inspection we became aware of a case similar to one that had previously occurred on the same ward. It was unclear whether the first case had been reported as an incident and investigated to identify lessons learned (thereby supporting staff in the management of the second case).
- Findings from thematic reviews were cascaded. It was unclear how staff who were not part of these arrangements received information related to such reviews. .
- Learning from the Pan Cheshire child death overview panel was shared with medical teams by the named doctor. We did not find evidence that learning had been shared with other staff groups within the trust. However, the named doctor did provide peer support meetings on a bi-monthly basis for medical colleagues.
- The trust had a clinical supervision policy in place relating to safeguarding children. Staff told us that clinical supervision for staff relating to safeguarding children was ad hoc and that this was undertaken on an individual basis. This was reflected in the policy also.
- Security arrangements in place in the children's ward and all areas were appropriately locked.
- Security staff were clearly identifiable within children's services and was supportive of clinical care in the unit.
- The trust had implemented monthly audit programme reviewing security, equipment and the environment was in place and monitored though children's and young people services.

Mandatory training

- Mandatory training was delivered locally though children and young people's services.
- Staff told us that locally delivered mandatory training had improved mandatory training figures and had made training more accessible.
- Records showed staff were up to date with mandatory training.

Assessing and responding to patient risk

- A paediatric early warning score (PEWS) system was in place on the children's ward based on the NHS institute for innovation and improvement PEWS scoring system. This tool supported early identification of children at risk of deterioration.
- Staff spoke of prompt continued support by medical staff to support babies and children in both the special care baby unit and children's ward. Nursing staff spoke highly of the positive relationships between nursing and medical staff and how medical staff responded immediately both in and out of hours to nurses' concerns.
- We found that health and safety risk assessments were in place on the children's ward to support children and staff. During our visit we observed security arrangements in place in the children's ward and observed staff being responsive to the needs of all children on the unit.
- We observed that security staff were clearly identifiable within children's services and observed that this was supportive of clinical care in the unit.
- There was an established flagging system in place to identify children and young people to identify children and young people with specific needs.

Nursing staffing

- Staff in the children's outpatient department, children's ward and the special care baby unit told us that there were enough staff on duty to deliver safe care.
- Staff told us that shortfalls were mostly covered by the services' own staff. We found that low numbers of bank and agency staff were used in relation to the rest of the trust.
- Staff on the special care baby unit told us that it was not always possible to provide a supernumerary co-ordinator as identified as best practice by the British Association of Perinatal Medicine.

Services for children and young people

- The children's ward had recently implemented the 'system to escalate and monitor' (STEAM) assessing acuity and nursing dependency. Clinical staff told us that this tool supported decision making and clearly identified levels of care on the unit.
- Both the children's ward and special care baby unit demonstrated responsive arrangements with regards to staffing levels and acuity to determine bed availability across units.
- Staff told us that two children's ward staff members had recently completed an advanced nurse practitioner qualification. On discussions with nursing and medical leads this role had been put in place to further support the unit and support staff development.
- Staff in A&E, critical care and surgery were suitably trained to provide care and treatment to children and young people.
- Reports from the trust identified that staffing levels for the special care baby unit were monitored monthly. Some staff reported that staffing at night can be difficult and there were occasional shortfalls.
- Nursing staff were not represented at medical handover. Both medical and nursing staff identified that nursing staff time were sometimes pressured but that information was cascaded through the handover lead.

Medical staffing

- We observed four medical handover meetings during our visit and found that these meetings were well-led and clearly identified children and young people at risk of deterioration.
- There were 7.8 whole time equivalent consultants in post which was recently expanded following a benchmarking exercise across local networks. Medical staff told us that a successful business case was accepted and was quality driven in order to provide cover for accident an emergency, the special care baby unit and the children's ward. Staff told us that this had enabled simultaneous ward rounds in both areas.
- There were two named consultants on-call in the morning, one named consultant in the afternoon with peer support and overnight consultant cover. Nurses and doctors and they told us that consultants were always available 24/7 and that they were always able to contact teams and secure medical support.
- On discussions with medical staff it was identified that the team were currently experiencing difficulties in recruiting a middle grade doctor. We were told this was currently being supported by the consultant team and was not impacting on the service.

Major incident awareness and training

- Staff were aware of their responsibilities in the event of a major incident.
- Detailed major incident plans were available an accessible for staff and standard operating procedures were available for children and young people's services.

Are services for children and young people effective?

Good

Children and young people received care and treatment based on best practice guidance. Children and young people's needs were assessed appropriately and care was provided to achieve positive outcomes. Staff were qualified and competent in delivering care.

Children and young people were supported by health play therapists and it was clear that this role contributed to positive outcomes. While play therapists were available across the trust, this was not always available seven days a week and evidence from staff suggested that the demand for the service was increasing.

Evidence-based care and treatment

- Clinical staff on the special care baby unit were active members of regional and national neo-natal networks. The group agreed guidelines for shared working and developed audit tools to assist in consistency of approach, and to provide continual improvement of services.
- The children's ward had established links with a local specialist children's trust. Staff could attend training, conferences and shared learning through this network. There were strong working links in place to support staff, children and young people.
- Policies and procedures were supported by evidence-based guidelines and the service actively reviewed and acted on new guidance through its governance arrangements.

Services for children and young people

Pain relief

- Pain relief included using age-appropriate methods and both analgesic and non-analgesic interventions.
- Pain assessment was part of the paediatric early warning score system (PEWS).
- There was evidence from referrals to suggest that the role of the play therapist was key in supporting young people in managing pain and receiving supportive treatments
- We observed play therapists use diversional techniques to help support children and young people during clinical interventions.
- A pre-operative clinic was in place on the children's ward and helped to identify any pain needs and interventions that were required before admission to the trust.
- Non-medication interventions such as comfort holding were seen as an important part of pain relief for babies.

Nutrition and hydration

- Children and young people were offered a choice of meals that were age appropriate and supported individual needs such as gluten free and low potassium diets. Children told us they were able to choose what they wanted and if they didn't like something staff would bring an alternative. We observed that snacks were available to children and young people. However some children were not aware they could order snacks.
- Staff on the special care baby unit promoted breastfeeding without judgement. Support and advice was available at all times from staff.
- Breast feeding advice was also available from a dedicated team for parents and they told us that this was a useful and helpful service.
- The new special care baby unit supported both mum and baby in feeding and promoted a calm environment that parents appreciated.
- Parents were able to store food while staying on the unit and had a dedicated lounge to have meals. Parents told us that this helped maintain their health and wellbeing as they were often onsite for the duration of a baby's admission.

Patient outcomes

- An established audit programme of children's and young people's care was in place driven by national programmes. These were monitored though dashboard and governance arrangements. 39 audits were registered for 2014/2015 for these services.
- The trust independently took part in a peer review programme for paediatric diabetes and staff were positive about continually developing services.
- Following the last epilepsy audit, the trust had employed a specialist epilepsy nurse and provided specific consultant training to support the service. Staff told us that this had a positive impact on children, young people and their families.
- A dedicated research programme was in place for children and young people's services with staff trained in good clinical practice. This programme had currently recruited to six research studies which were active at the time of our visit. These included adolescence diabetes educational assessment, epilepsy (SANAD II), and slow infant feeding (SIFT).
- The National Paediatric Diabetes Audit 2013 found the trust was an outlier at 31% for a measurement related to Hba1C monitoring compared to a national average of 17%. Since the audit, the trust had initiated a peer review and appointed a diabetes nurse specialist to support children. At the time of our visit the trust was waiting the formal report regarding diabetes care but interim data suggested they were performing well for diabetes care. This report however was not available at the time of our report.
- At the time or our visit the trust were also reviewing options related to the National Paediatric Diabetes Audit which identified that the trust required a diabetic paediatric consultant on-call 24/7. Discussions with staff identified that the trust was actively trying to find a solution to support staff, children and young people.
- The trust monitored readmission rates for epilepsy for all patients and had an alert system in place for this.
- The service was measuring data regarding outcomes and acting on results to develop services and improve pathways of care. Actions were monitored effectively and staff were aware of what goals were in place to improve the service going forward.
- There was an established research programme in place with strong links with regional research networks.

Competent staff

Services for children and young people

- Staff told us that they had appraisals and records showed 100% of staff had received appraisals in the last 12 months.
- A practice education facilitation programme was in place to support children's and special care baby unit staff. In addition, a trial had been completed for scenario based teaching which was being evaluated but following feedback was likely to continue in the future.
- If staff needed information and assistance they told us they could discuss any clinical issues informally with each other, the medical staff or the ward manager.
- The trust has a volunteer programme in place to support the needs of children and young people. Volunteer staff took part in an induction programme which provided ward orientation and training to support young people. Volunteer staff told us: "I like it here, it's really friendly".
- Targeted training had been introduced on the children's ward in 2014 and staff found this beneficial and supported their development.
- Two staff were currently working at another NHS Children's service as part of building relationships and offering development opportunities for staff on the children's ward.
- The special care baby unit was involved in an induction programme for nurses offering a six month flexible regional rotation that was funded regionally and promoted shared learning across the network.
- Staff in the special care baby unit were supported to complete intensive care support training for small babies. At the time of the inspection 26 staff out of 30 had completed the training.
- 76% of staff had received new born life support external training.
- Staff were involved in a reflection forum three times a year on the special care baby unit. Staff said they found this both beneficial and supportive
- It was unclear what opportunities of development were available for staff with the children's outpatient department.

Multidisciplinary working

- Children were supported under shared clinical care arrangements between the trust and a local specialist children's trust for services in oncology and haematology.
- 992 Children were seen in 110 clinics by visiting speciality teams in 2013/14
- The homecare team liaised closely with the local specialist children's trust to support children and young people on discharge from hospital and provide ongoing care. Staff spoke positively about the service that was provided by this team in providing prompt supportive care to children, young people and their families.
- An outreach team was in place to support children and young people at home and reduce re-admissions into hospital.
- For young people with complex health needs requiring transition to adult services, staff identified that it was difficult to co-ordinate a plan due to lack of services available in adult settings. In order to support young people with complex needs, individual care plans were co-ordinated by the lead consultant.
- Psychiatric support was available for children and young people through the psychiatric team. Staff told us that they valued this service and felt it supported children and young people.
- Children's and young people's services had link nurses trained in tissue viability and had access to specialist advice.
- The trust had set up a paediatric committee set up to support staff such as the orthopaedic and surgical teams to promote best practice in paediatric care.
- Staff on the children's ward told us that they liaised with social services regularly but acknowledged that there were sometimes delays within social services to respond

Seven-day services

- A consultant was available seven days a week with cover out of hours provided by an on-call consultant. We spoke with both nursing and medical staff who stated that out of hours it was trust policy that consultant presence was required within half an hour of being notified. Staff told us that on most occasions consultants were on hospital premises immediately and felt supported by senior teams.
- All children and young people were reviewed by a consultant everyday as a minimum. However depending on clinical need this may be increased.
- There was a strong sense of medical staff presence during our inspection and this was supported by what parents and staff told us.
- Provision of diabetic specialist advice was available through an on-call service out of hours.

Services for children and young people

- Play therapy services were not currently offered seven days a week.
- There was no provision for psychiatry support out of hours. However the trust had access to child and adolescent mental health services.

Access to information

- Information leaflets were available on a number of health and social topics including alcohol abuse, drug addiction and bullying were available in both inpatient and outpatient settings.
- Health promotion information and access to local services was available for children and young people.
- Information about health related topics and information about accessing hospital services were available.
- Ward and outpatient areas had trust policies and procedures available to staff on the trust's intranet.

Consent

- Staff were aware of consent procedures in place for children and young people. Staff were aware of the underpinning principles related to Gillick competency and we observed staff undertaking Gillick competency assessments prior to a surgical procedure.
- Staff had a good understanding of trust policies and procedures related to consent.
- Staff we spoke with confirmed that a child's or their parent's consent would be appropriately sought prior to any procedures or tests being undertaken. Children were involved in giving their consent as appropriate.
- Parents/carers told us that they had been involved in decisions relating to the treatment offered.

Are services for children and young people caring?

Good

Children and young people, their families and carers told us they felt safe and supported by staff. Children and young people were included in decision-making and it was clear from our observations that they were supported in making their wishes known. However this was not always recorded in written care plans. Medical and nursing staff were caring, calm and kind when delivering care and interacting with patients and families. They were described as "very good" by both patients and their parents.

Compassionate care

- Children and young people, their families and carers told us they felt well supported by staff. We saw young people being treated with dignity and respect, and observed staff providing child centred, compassionate care.
- Children, young people and their families told us about staff going above and beyond their expectations in terms of supporting their needs. Children, young people and their families spoke positively about the care they received. They told us that "the nurses are brilliant" and "The nurses are so approachable and friendly".
- Nurses told us that all staff were "close knit team" and that "if [you] need to take time to spend with children you can".

Understanding and involvement of patients and those close to them

- Care plans on the children's ward were individualised and the information provided to young people and their families was bespoke to reflect their needs.
- Children, young people and their families were given the opportunity to speak with staff, to ask questions and were kept informed of what was happening.
- Children, young people and their families told us they were involved in their plan of care. However on some occasions this was not reflected in patients' records.
- Some children and young people did not have family support available in terms of involvement in decision making.in such cases we found that best interest meetings were held using a multi-disciplinary team approach to care planning to ensure the child or young person's needs were central to the process.
- Some patients and families told us they were sometimes given differing information by nursing and medical staff.

Emotional support

- Specialist nurses, including diabetes and epilepsy nurse specialists, were available to provide emotional support for children, young people and their families. We observed responsive support from the diabetes team for a child and family who had received a recent diagnosis of diabetes. Parents told us they felt re-assured knowing they had this team available for support.

Services for children and young people

- Specialist nurse led clinics were in place providing emotional support relating to health and emotional needs.
- The trust had good links between children and young people's services and the child and adolescent mental health service (CAMHS). However staff felt that due to the demands in this service there was sometimes a delay in children and young people being seen after being referred.
- Psychologist services were actively involved in supporting children and young people.'
- Play therapy services included preparation for invasive/ non-invasive procedures, distraction therapy, emotional support and pain management.
- Play therapists were seen as a valuable support service for young people by both staff and families.
- The home care team and outreach team offered support for children, young people and families in their own homes.
- Internet access was not available for children and young people to keep in touch with family and friends when in hospital for long periods of time. Children and young people told us that it also made it difficult to complete homework easily. The Service had recognised this as an issue and was working with the trust to find suitable IT solutions.

Are services for children and young people responsive?

Good

Services had been planned to meet the needs of local people. For example, The new special care baby unit had increased the size of space between beds to allow parents and carers to remain with baby and not feel they were in the way.

Systems were in place for staff to identify and respond to any potential pressures on the capacity of the special care baby unit and the children's ward. The advanced nurse practitioner role had been put in place to support the rapid consultation of children who attended the hospital.

There were systems to learn from complaints and concerns.

Service planning and delivery to meet the needs of local people

- The children's ward had single rooms available for teenagers and the ward environment was configured in such a way that young people had separate sleeping areas than young children. Staff felt that building was restrictive in terms of en-suite facilities and advised that the ward was due for refurbishment as part of the trust programme in 2017.
- Children and young people's services were sometimes supporting children who required services external to the trust and some children experienced delays that were out of the trust's control. Similarly, circumstances beyond the service's control also meant that children and young people sometimes stayed in hospital longer than necessary.
- Appropriate escalation of individual cases was led by the director of nursing for the trust to commissioners in order to ensure appropriate care for children and young people. Staff identified that while children continued to be cared for in a safe environment on the ward, children were experiencing delays in continuing care that they were unable to influence. Staff found this frustrating.
- The Baby Life Support Systems (BLISS) action plan identified gaps in the special care baby services such as parents being able to access a lounge area. The new special care baby unit provided en-suite bedroom facilities for families on the unit which were bright, airy and quiet. There were also facilities in place to support women with breastfeeding before going home.
- The new special care baby unit had increased bed space sizing and unit policies had changed to support numbers of visitors at the bedside from two to four people. Parents told us they found this helpful. This meant that visiting times could be spent with family and friends reducing feelings of isolation.
- Medical staff had established relationships with local hospitals to receive support for severely ill babies and children who needed to be transferred. They were aware of the difficulties parents would have travelling long distances and considered this when arranging transfers. The new special care baby unit had been re-designed to allow flexibility for babies being transferred in and out of the unit to support families living in the area.
- The children's outpatient department provided a supportive age appropriate environment offering a

range of activities for children and young people to access while they waited for their appointment. There was a designated teenage area with health promotion materials available.
- Treatment rooms used innovative lighting and diversional aids to support children during appointments and procedures.
- Clinical leadership was well established, supporting young people and transitional services through clinical pathways.
- For young people with complex health needs requiring transition to adult services, staff identified that it was difficult to co-ordinate a plan due to matters outside the trust's control. In order to support young people with complex needs, an individual plan of care was co-ordinated by the lead consultant.

Access and flow

- During periods of increased admissions or staff shortages the service had contingency arrangements in place to ensure that children and young people were cared for in a safe environment.
- The implementation of nursing acuity scores supported staff to demonstrate clinical and staffing requirements for the paediatric unit.
- At the time of our visit the paediatric ward had vacancies for a registered nurse and a health care assistant unfilled. The ward reduced and increased bed stock in summer and winter to support the needs of children but staff told us that opening beds for winter had been delayed while staffing levels were adjusted to meet the increase in demand..
- The new special care baby unit had provision to support babies requiring intensive care, high dependency care and babies requiring special care. Established arrangements were in place with regional networks to provide timely access to appropriate facilities for babies and their families. Staff told us that the new unit provided increased flexibility in reacting to changing demands on the service due to the re-design of the cot flow on the unit.
- Did Not Attend appointment (DNA) rates were monitored by the trust and within the children's outpatient department. Information reported by the trust showed an increase from 14% between April and June 2014 to 17% in July/August 2014. This was being investigated by the department manager and information suggested that school holidays had accounted for the sudden increase in children not attending hospital appointments.
- Children with established health pathways had direct access to the children's ward.
- For some children plans of care were held in the accident and emergency department to provide staff access to current health information.
- The service had a divert policy and procedure in place based on ward occupancy which was escalated through bed management arrangements.
- A parent told us that it had taken ten minutes from attending the accident and emergency department to be seen on the ward. Staff told us that wherever possible children and young people would be assessed in the ward setting.
- An assessment area staffed by advanced nurse practitioners on the children's ward had helped children and young people be assessed in a timely manner. Staff in both accident and emergency and the ward felt that this role improved patient flow and the quality of care for patients.

Meeting people's individual needs

- "You're Welcome" information packs were available in rooms for children and young people and their families to access that provided important information about the children's ward. One parent told us their child had been admitted to the children's ward but they had not been shown around and they were unsure about facilities on the unit. Staff told us that they always tried to show families around the ward. However when the ward was busy there may be a delay.
- Staff were able to support children and young people's individual needs in challenging situations. Ward staff were observed supporting the health and emotional needs of individuals while ensuring the ward area was safe.
- A variety of equipment was available on the children's ward including beds and cots in a variety of sizes, and different chairs including those that converted to beds for parents wishing to stay with their child. There were also two rooms available for parents to stay in should they wish to do so.
- Translation services were available for staff to access and staff were aware of what services where available and how to access them.

- Books were available in a number of languages for children in inpatient areas.
- Materials were available for staff in a number of languages throughout children and young people's services.
- Adolescent facilities were available on the children's ward and staff were able to offer young people either single rooms and/or age appropriate facilities. Due to the layout of the children's ward and bed occupancy, young people were most likely to be offered a single room while an inpatient. Some young people who were in hospital for a long period of time felt that sometimes this could be isolating. Staff told us that plans were in place for the ward to be upgraded in the future and as part of this work facilities for young people to mix with each other would be reviewed.
- There was a large variety of play equipment available to accommodate a variety of ages and needs in both inpatient and outpatient areas. Toys could be provided at the bedside as well as games and books.
- Meeting educational needs and support from schools was provided externally. One young person told us there had been delays in being provided with homework by the school and family members had to intervene to ensure that materials were received.
- Staff told us that children and young people with additional needs had access to a health passport which included important information about their plan of care and included tips, prompts and reminders for staff.
- A member of the special care baby unit staff told us the unit had introduced a record called the kangaroo care record which supported and recorded positive touch between parents and babies. Staff felt that this initiative helped families to bond with babies.

Learning from complaints and concerns

- Children and young people's services had one complaint ongoing at the time of the inspection. Records showed that twelve complaints had been received and investigated in the previous twelve months.
- Children and young people's services were pro-active in investigating concerns and had good reporting and meeting structures in place for learning lessons.
- Information about how to complain was available in both inpatient and outpatient areas.
- The children's ward displayed actions taken from complaints and concerns using a "You said, we did" board.
- Ward and outpatient areas had boards in place displaying compliments and thank you letters. Staff found these really positive and encouraging.
- Staff had a good knowledge of recent complaints and applied the lessons learned from them.

Are services for children and young people well-led?

Good

There were clear governance arrangements in place that monitored the outcome of audits, complaints, incidents and lessons learned throughout the service. Staff were positive about the culture in children and young people's services and felt supported by senior managers. Staff were able to be innovative and introduce new practices to improve quality.

Children and young people's services were forward thinking in how services could to be adapted to provide flexibility and sustainability in the future and were committed to developing relationships across health networks.

Vision and strategy for this service

- The vision and strategy for children and young people's services was driven effectively by clinicians and senior staff based on evidence-based practice and strategic planning. This included looking at opportunities to develop strategic partnerships with other services in order to provide the best treatment options for children and young people.

Governance, risk management and quality measurement

- Monitoring arrangements for risks and quality of care were in place that co-ordinated risks, incidents, patient outcomes and audit results in order to identify areas requiring improvement.
- Established governance arrangements were in place to ensure that staff working in children and young people's services were clear on what needed to be done to manage and continuously improve services.

- Meeting minutes identified that actions were completed quickly and in some instances, where actions required additional staff, managers responded positively.
- Audit programmes were in place for monitoring standards of care and these were carried out effectively throughout children and young people's services.
- There was a positive culture around reporting of incidents and learning lessons. Service managers recognised the importance of staff being able to report concerns and responding to them in a supportive way.
- The children's safeguarding lead nurse prepared a monthly report to the board.
- There was a designated non-executive director for children and young people's services. This meant there was board oversight of the monitoring of quality and safety in the service.

Leadership of service

- Staff told us that both the senior executive team and nursing team were visible in children and young people's services. Staff felt that managers were approachable and supportive of staff.
- Staff in the children's outpatient department felt supported, but felt that sometimes demand in other services meant that senior staff were not always visible.
- Staff told us they felt respected and a valued part of a team.
- There was a defined leadership structure in place for both nursing and medical staff.
- Staff felt that the recent investment in staffing and the new special care baby unit demonstrated the continued commitment to children and young people's services.
- Clinical leadership was well established supporting children and young people using transitional services through clinical pathways.

Culture within the service

- There was a positive culture within teams and staff supported each other well. We saw that staff worked well together in multidisciplinary teams to provide holistic care for children.
- Children and young people's experiences and quality of care were central in all decision making.
- Staff were passionate in wanting to drive the quality of services forward in order to continually improve and they were supported to do this at both ward level and trust level.

Public and staff engagement

- The trust reported the response rate for the staff survey had increased from 65% in 2012 to 70% in 2013; this was the second highest response rate nationally. Staff were proud of this achievement. Staff told us that the trust had identified areas for improvement and were committed to make changes.
- The service participated in the trusts staff recognition awards scheme and staff were very positive and engaged in this process.
- Staff were able to visit the chief executive directly with designated slots available for idea sharing.
- Children and young people's services had representation at the patient experience group.
- Parents, children and young people were able to take part in patient surveys which were offered in age appropriate formats in both inpatient and outpatient areas. Results were displayed for staff, parents and children and were visually stimulating.
- Children and young people's services had introduced "tops and pants" feedback aimed at getting children and young people's views in a fun interactive way.

Innovation, improvement and sustainability

- Children and young people's services were forward thinking in how services could to be adapted to provide flexibility and sustainability in the future and were committed to developing relationships across health networks.
- Senior managers provided opportunities for innovation from all grades of staff.
- We found examples of innovation including a new electronic handover pilot that enabled clinical staff to communicate more efficiently.
- The children's ward was implementing a custom built early warning score system based on the paediatric early warning scoring system. This provided electronic alerting of deteriorating patients immediately to medical staff.
- A consultant led rapid access clinic with an email triage system was in place allowing GPs to get prompt specialist advice on pathways of care for children and young people. The implementation of this had reduced waiting times for treatment and ensured pathways of care began sooner

Services for children and young people

- The trust was part of the regional Northwest Coast Network for research and were an active member of this group.

End of life care

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

Information about the service

End of life care services are provided by a palliative care team based at Leighton Hospital. Patients with end of life needs are nursed on the general wards in the hospital. They are supported by a consultant-led specialist palliative care team (SPCT). This team provides specialist advice and support as requested. The team also coordinates and plans care for patients on the wards who are at the end of their lives. The team consists of one part-time consultant and two specialist palliative care nurses. Individual wards have end of life link nurses who have chosen to take on additional training for this role. The end of life team works closely with primary and secondary health care professionals to adopt nationally recognised best practice tools: Gold Standard Framework, Preferred Priorities of Care and good practice guidance to replace the Liverpool Care Pathway.

The SPCT is available Monday to Friday 9am to 5pm, excluding bank holidays. Out-of-hours consultant support and advice is provided via a telephone hotline to the local hospice, St Luke's.

The hospital's palliative care team saw 326 new patient referrals to the Macmillan Specialist Palliative Care team in 2013/14. In addition there were 35 re-referrals, totalling 361 referrals during 2013/14. Of these the majority (75%) of new patients referred to the service in 2013/14 had a diagnosis of metastatic cancer. This showed the specialist services of the palliative care team was provided mainly to cancer patients.

During this inspection we visited six inpatient wards where end of life care was being provided. We also visited the spiritual centre, the hospital mortuary and the chapel of rest. End of life care was also provided by other members of the multidisciplinary team (for example, acute oncology, chaplaincy, clinical nurse specialists and the bereavement office). We spoke with seven patients and four relatives on the wards. We spoke with a range of staff including domestic staff, portering staff, health care assistants, a mortuary technician, a chaplain, nurses, doctors, consultants, ward managers, matrons and members of the senior management team. We also spoke with the two specialist palliative care nurses, one of whom is the clinical lead for palliative care; the palliative care consultant; the director of nursing and two palliative care link nurses. In addition we met with two Macmillan nurses who provided a support service for staff, patients and their relatives at the hospital.

We observed care and looked at care records. We looked at appropriate policies and procedures as part of our inspection of this service. We received comments from our listening event and from people who contacted us to tell us about their experiences, and we reviewed performance information about the trust.

End of life care

Summary of findings

The specialist palliative care team (SPCT) were clear about their roles and benefitted from good leadership. Patients received person centred end of life care that involved relatives and carers. Care was provided by supportive and compassionate staff who respected patients' need for privacy and dignity. Nursing and care staff were appropriately trained and they were encouraged to learn from incidents. Relatives of patients, nurses and doctors spoke positively about the service provided from the SPCT. The service was responsive to patients' needs; there were systems in place to facilitate the preferred place of care. End of life care services worked collaboratively with both primary and tertiary care.

Staff spoke positively about the rapid discharge pathway that enabled patients to be discharged from hospital to home in the last hours/days of their lives. Staff gave examples of how this policy worked in practice and where this had happened for patients. There were also several examples of how the service met the spiritual, religious, psychological and social needs of patients. Future plans for the service included the introduction of the AMBER care bundle, a system that would provide a systematic approach to manage the care of hospital patients facing an uncertain recovery and who were at risk of dying in the next one to two months.

The trust had policies and a number of monitoring systems in place to ensure that it delivered good end of life care. However there was limited medical input to the SPCT. General medical cover was provided on the wards for patients with end of life care needs. There was only one part-time consultant (two sessions per week) in palliative medicine.

Are end of life care services safe?

Good

End of life care met the needs of patients. There were sufficient numbers of trained clinical, nursing and support staff with an appropriate skills mix to ensure that patients receiving end of life care were well cared for. There were adult safeguarding procedures in place, supported by mandatory staff training. Staff knew how to report and escalate concerns regarding patients who were at risk of neglect and abuse.

The end of life care teams monitored and minimised risks effectively. Staff were aware of the process for reporting any identified risks to patients, staff or visitors. All incidents, accidents, near misses, complaints and allegations of abuse were logged on the trust-wide electronic incident reporting system. Staff had access to the electronic system and confirmed that reporting of incidents was encouraged by managers. The mortuary adhered to infection control procedures. Do Not Attempt Resuscitation forms were appropriately completed and we saw that the decision had either been discussed with the patient themselves or, when that was not appropriate, patients who did not have capacity to consent to end of life care were treated appropriately. However, we found care plans were not always fully completed in line with best practice.

Incidents

- Staff were aware and understood their responsibilities with regard to reporting incidents. All accidents, incidents, allegations of abuse or complaints were logged on the trust -wide electronic reporting system. Staff were supported by managers to report incidents and apply any learning resulting from them. Staff were able to give us examples of where practice had changed as a result of incident reporting.

Medicines

- Anticipatory end of life care medication was appropriately prescribed. This was good practice as it enabled community nurses to give symptomatic relief without delay from the time the patient arrived home and easy access to anticipatory drugs can prevent inappropriate readmissions to hospital

End of life care

- We looked at the medication administration records (MAR) charts for six patients and saw appropriate medication had been prescribed to support good symptom management and patient comfort.
- Access to syringe drivers for people needing continuous pain relief was available. Staff were aware of how to use these effectively. This included checking the needle site, battery and volume of infusion remaining in the syringe. The use of syringe drivers was supported by regular and on-going staff training.
- The SPC nurses were advanced practitioners which enabled them to prescribe medication for patients.
- We saw that staff followed the policy and managed controlled drugs in accordance with the Controlled Drugs Regulations 2013.

Records

- The trust had introduced new end of life care plans in July 2014 in response to the national withdrawal of the Liverpool care pathway. Staff involved relatives where possible and the documentation provided staff with prompts to ensure that patients and those close to them were included and involved in care planning.
- The palliative care team had carried out a 'spot check' audit. The results of this check showed that out of 10 care plans reviewed, five were well completed, particularly around communication and five had shortfalls. The manager was aware that care planning records required improvement and there were plans in place to support better care panning with additional staff training.
- There were also plans to audit care plans following the training period.
- In the mortuary there was a robust system to ensure that people were correctly admitted and placed appropriately. There was also a records management system in place to record the deceased being taken from the mortuary by undertakers.

Safeguarding

- A policy was in place that outlined the processes for safeguarding vulnerable adults and children.
- Staff received mandatory training in safeguarding children and vulnerable adults that included aspects of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.
- Staff were knowledgeable about their role and responsibilities regarding the safeguarding of vulnerable adults and children.

Mandatory training

- Staff training and education for managing the care of patients at the end of life was provided on an ongoing basis by the SPCT. The director of nursing and the SPCT lead who told us: "We do not want palliative care to be a tick box exercise so we have a programme of rolling this out at ward level, face to face". One doctor told us: "I feel education here is extraordinarily supportive".
- The ward based link nurses in palliative care could participate in a six to 12 month secondment to the SPCT to develop their skills and knowledge in this specialist area.
- The end of Life link nurses felt satisfied that their training had a positive impact on improving end of life care on the wards. They believed communication with families and the medical staff was much improved as a result of increased knowledge and training at ward level.
- End of Life information and staff guidance was available on the intranet and staff we spoke with felt this was a useful resource that was easy to access easy to access.

Assessing and responding to patient risk

- Staff used the early warning scores system which would alert nursing and medical staff to changes in the patient's condition deteriorated. Patients would be transferred to an end of life care plan if their condition required this so they could receive appropriate and timely care.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Where DNACPR (Do Not Attempt Cardio Pulmonary Resuscitation) forms were in place, we found that patients were involved in the discussion about their decision or there was a capacity assessment recorded in their medical notes. These showed that best interest meetings had been held and included discussions about DNACPR decisions.
- The forms included a record that next of kin were involved or independent mental capacity advocates (IMCAs) had been involved were appropriate. Medical staff were able to describe the procedures for DNACPR and the decisions were made by a senior clinician.

End of life care

- We found that there were robust consent arrangements in place for managing tissue removal after death. The Human Tissue Authority (HTA) regulated the service as the service removed, stored and used tissue for research, medical treatment, and post-mortem examination.
- We looked at 13 DNACPR forms and found the level of detail varied. We found 10 were completed with full details of the discussions held with the patient and/or relative but three did not provide the same level of information. Staff confirmed the trust had a system in place to audit DNACPR forms. An audit of hospital deaths including DNACPR forms dated September 2014 showed the majority of forms were well completed.

Nursing staffing

- Patients with end of life care needs were nursed on the wards or departments in the hospital, the staffing levels were dependent on the actual staffing levels on the individual wards. Some patients we spoke with told us there were staff when they needed them. One relative commented: "The staff here are attentive and very responsive to my loved ones needs."
- The skill mix and numbers of nursing and support staff were sufficient to meet the needs of patients. Staff rotas were prepared by the ward managers four-weekly. The hospital covered staff shortfalls with the use of bank staff and by allowing existing staff to work additional hours.
- There was a palliative care link nurse on each ward. The trust had 24 well established link nurses.
- The specialist palliative care team consisted of two Macmillan palliative care clinical nurse specialists who supported the ward staff well.

Medical staffing

- We had concerns there was limited medical input to the specialist palliative care team. There was one part-time consultant (two sessions per week) in palliative medicine. We were told this was not always sufficient and the service would benefit from a full-time consultant. However, a good level of support was provided by the two Macmillan palliative care clinical nurses and the service had good links with and support from the local hospice.
- Out-of-hours on call cover was provided by one palliative care consultant and one associate specialist who held a diploma in palliative care. Additional advice and support was also provided by a telephone link to the local hospice.

Major incident awareness and training

- There was a trust major incident plan which listed key risks that could affect the provision of care and treatment.
- There were clear instructions in place for staff to follow in the event of a major incident.
- Staff we spoke with were aware of the plans and described the action they would take in the event of a major incident.
- In the event of a major incident, the mortuary had a system for staff to consult. The medical technical officer for the mortuary talked with us about these arrangements. The trust had additional space that could be cooled in the event of a surge in demand for refrigerated mortuary space, such as following a major incident.

Are end of life care services effective?

Good

End of life care was provided in line with evidence-based national guidance. The trust contributed to the National Care of the Dying audit. Following the National Care of the Dying Audit of Hospitals (NCDAH) results, the trust developed an action plan that included appointment of a non-executive director as a Board lead for End of life care.

The Macmillan specialist palliative care clinical nurse specialists planned and attended weekly palliative care multidisciplinary meetings where new referrals to the service were discussed. Wards had a palliative care 'link' nurse who acted as a resource to support them in their role. Patients told us their pain was well managed and ppeople were provided with a choice of suitable and nutritious food and drink

Evidence-based care and treatment

End of life care

- End of life care was provided in line with national guidance. The SPCT team based the care it provided on the National Institute for Health and Care Excellence (NICE) Quality Standard for End of Life Care for Adults (2013).
- The Macmillan palliative care clinical nurse specialists had access to current, relevant literature and used evidence-based research to underpin clinical practice including Greater Manchester and Cheshire Cancer Network Symptom Control guidelines (2011).
- There was information displayed on wards or available via the trust's intranet on the model the trust used in caring for patients in the last hours of life. This was based on the NICE quality standard.
- The trust contributed to the National Care of the Dying audit. Following the National Care of the Dying Audit of Hospitals (NCDAH) results, the trust developed an action plan that included appointment of a non-executive director as a board lead for end of life care.
- Policies and procedures were accessible on the trust intranet and staff were aware of how to access them.

Pain relief

- Providing effective pain relief for patients receiving end of life care was a critical part of the SPCT's role.
- Appropriate medication was available for the ward staff to use and we saw that anticipatory prescribing was managed well.
- The NCDAH May 2014 showed that 83% of patients had medication prescribed 'as required' for the five key symptoms which may develop at the last 24 hours of life.
- Patients told us their pain and comfort was well managed.

Nutrition and hydration

- The care plan indicated that patients should eat and drink normally for as long as possible, while acknowledging that the need for hydration and nutrition may reduce as people approached the end of their life. The care plan included principles to guide the staff in their ongoing assessment; including ensuring regular mouth care was given, considering thickened fluids and involving the family or significant others as necessary.
- Relatives we spoke with were complimentary about the availability of nutritious snacks and meals. People were provided with a choice of suitable and nutritious food and drink and we observed hot and cold drinks available throughout the day. None of the patients we spoke with were receiving artificial nutrition or hydration. Staff were able to tell us how they addressed peoples' religious and cultural needs regarding food.
- The care plan included a trigger that any decisions about clinically assisted hydration and nutrition must be in line with the General Medical Council 2010 guidance Treatment and care towards the end of life.
- The trust used a screening tool, the Malnutrition Universal Screening Tool (MUST) to identify those patients who were nutritionally at risk.

Patient outcomes

- An audit was undertaken to evaluate the SPCT's effectiveness at discharging patients known to the specialist palliative care team to their preferred place of care. This audit demonstrated that preferred place of care wishes were ascertained and recorded for 96% of patients seen by the team and that preferred place of care was achieved for 84% of this group of patients.
- The National Care of the Dying Audit of Hospitals (NCDAH) 2013 results showed the hospital had performed better than the England average in 11 out of 17 indicators.
- The hospital had performed worse than the England average in three out of the 17 indicators. Following the NCDAH audit, the trust developed an action plan to address these areas. This included rolling out the new careplan for end of life with training and eduction, looking at establishing a seven day 9am – 5pm service, improving communication and documentation.

Competent staff

- Wards had a palliative care 'link' nurse who acted as a resource to support them in their role and all staff told us they had received an appraisal.
- The specialist palliative care team had clinical supervision to support them in their role and all had received an appraisal in the last 12 months.

Multidisciplinary working

- The Macmillan specialist palliative care clinical nurse specialists planned and attended weekly palliative care multidisciplinary meetings where new referrals to the service were discussed. These meetings were also

attended by the palliative care consultant, MDT co-ordinator, social worker, a member of the Integrated Discharge Team and member of the Macmillan therapies team.
- The SPCT worked closely with acute oncology clinicians to coordinate treatment for cancer patients.
- The palliative care consultant worked with consultants from other specialities, for example colorectal and lung specialities.
- The SPCT had close relationships with other health care workers including: medical and nursing staff, site specific cancer nurses, pharmacists, dieticians, occupational therapists, physiotherapists, speech therapists, social workers, chemotherapy sisters, bereavement manager, community nursing staff, the Macmillan therapies team, general practitioners and palliative care teams in other trusts.
- The trust had good, clear links with the local St Luke's Hospice, a 10 bedded hospice in Winsford, providing in-patient care, day care, complimentary therapies and family support services for patients with specialist end of life care needs.

Seven-day services

- The specialist palliative care team were available 9am to 5pm Monday to Friday.
- Out of those hours support was provided via a telephone helpline to the local hospice**.** Staff we spoke with confirmed they could access advice or support at any time.

Access to information

- There was a clear pathway in place for the transfer of care from hospital to community services. The links with the hospice enhanced the partnership working across the community. The care plan and DNACPR forms moved across the partnership with the patient to ensure information was shared appropriately.

Are end of life care services caring?

Good

End of life care services were provided by caring staff. Staff provided the service in a sensitive and compassionate way. Patients were treated with dignity and respect. Patients and relatives were happy with the service they received and were complimentary about their experience on the wards.

Staff demonstrated their passion and commitment to ensuring a duty of care to the deceased as well as to the relatives. Memory boxes were provided on request and included personal memorabilia. The nurses offered reassurance and support to patients and their relatives in a person centred way.

Compassionate care

- Patients and relatives were complimentary about the care they received
- We found several examples of staff providing caring, compassionate and highly individualised care. The acute medical unit had hosted a wedding in the summer for a patient at the end of their life. Catering staff supported by providing a cake, staff gave up their breaks to attend the ceremony.
- Staff on one ward had recognised the need for a patient and their partner to have an opportunity for intimacy during their final days. The relative told us: "The ward sister must have read my mind and asked if I would like to be able to cuddle up to [my partner] for a while. I thought it was lovely of [her] to even think about that when the staff were so busy. She did sort that for me, I loved it and I will never forget [her] for having done that for me".
- We saw the family of a patient who had passed away on the morning of our inspection. The family, although upset, were keen to pass on their thanks to the ward manager for the compassionate way in which they had been cared for during a difficult time.
- Staff continued to treat patients with dignity and respect after their death. We saw that mortuary staff referred to the deceased person in a respectful manner.

Understanding and involvement of patients and those close to them

End of life care

- Relatives of patients told us how the staff treated patients with dignity and respect. Normal visiting times were waived and car parking permits were provided for relatives of patients who were at the end of their lives.
- Patients at end of life were provided with a side room where possible; staff told us this was normal practice and we observed this during the inspection.
- There were relatives rooms on most wards where sensitive conversations could be undertaken and staff confirmed these were used regularly to inform and include those close to patients who were at the end of life.
- Patients who were identified as approaching the end of life were offered and given the opportunity to create an advanced care plan, including end of life care wishes and any advanced directives.
- Patients' records showed detailed discussions had been held with patients and their families; these were recorded in a sensitive way.
- Staff demonstrated their passion and commitment to ensuring a duty of care to the deceased as well as to the relatives. Memory boxes were provided for those who wanted them, which included memorabilia. The nurses offered reassurance and emotional support to patients and their relatives.
- The trust provided a resource pack for relatives or friends for guidance on procedures such as registering a death and arranging a funeral**.** An information leaflet for relatives about what to expect in the last days of life was also available.

Emotional support

- The SPCT (who had undertaken advanced communication skills training), the chaplaincy and the nurses provided emotional support to patients and relatives. We spent time with the Chaplain who informed us that they could call on spiritual leaders from other faiths as necessary to ensure patients religious wishes were adhered to. The specialist nurses and ward staff were able to signpost relatives to additional sources of support such as those provided by the local hospice.
- Relatives were supported to spend time with their loved ones. One relative had spent time in a 'pull out bed' so they could stay in the side room with their relative. They were pleased with this level of support.
- There was a viewing room where relatives could spend time with their deceased loved ones. This room was small but pleasantly decorated.
- There was a small multi-faith room next to the chapel; in addition there was an area in the hospital residency which was used as a mosque for Friday prayers.
- There were three chaplaincy staff employed by the trust that demonstrated a caring and compassionate approach towards patient, relative and staff spiritual welfare. In addition to the chaplains they had a number of volunteers to support them. A monthly service was held on the ward for patients, family members, friends and carers to support their spiritual needs.

Are end of life care services responsive?

Good

The palliative and end of life patient journey was supported by the SPCT that worked in close collaboration with the ward based staff. The skills and commitment of the teams supported responsive and sensitive care that met the individual needs of each patient. Palliative care was offered on all wards and supported by the local hospice. All faiths were able to use the chapel and a prayer room. The chaplaincy service was available 24 hours a day, seven days a week.

The palliative care multidisciplinary team worked across the hospital and worked closely with the Hospice and community teams. This showed us their close working relationships, good communication and how staff could respond to patients' changing needs. Patients referred to the specialist palliative care team were seen promptly. The specialist palliative care team worked hard to ensure patients receiving end of life care had a positive experience.

Service planning and delivery to meet the needs of local people

- The trust had a rapid discharge service for discharge to a preferred place of care (PPC). An audit in March 2014 showed the PPC wishes were ascertained and recorded for 96% of patients seen by the SPCT and PPC achieved for 84% of this group. The audit highlighted that there had been a significant increase in the number of patients referred specifically to the SPCT for end of life care and rapid discharge planning.

End of life care

- Following on from NICE guidance, the End of Life Strategy (2008) was clear that people at the end of life should be able to make choices about their place of death. The rapid discharge pathway was available to enable patients to be discharged from the acute hospital to home in the last hours /days of life. Following a retrospective audit on all rapid discharges between 1 January 2013 and 31 March 2014, results showed that 26 patients were rapidly discharged to their own home, 4 to a hospice and 1 to a nursing home. In addition there further fast track palliative discharges were facilitated led by the Integrated Discharge Team that were not included in this data.
- At the point of diagnosis patients with breast, colorectal, lung, gynaecological, upper GI head and neck cancers and haematology were referred to a specific nurse specialist. The SPCT were used appropriately for end of life in patients who had complex symptoms or psychological problems. In addition any patients who were diagnosed with cancers where there was no site specific nurse also received support from the SPCT at diagnosis and through treatment.
- The service was part of the North West End of Life Model for Advancing Disease. This model considered the patient from one year prior to expected death and provided bereavement support for relatives one year post death.
- The service had direct access to electronic information held by community services, including GPs. This meant that hospital staff could access up-to-date information about patients.

Meeting people's individual needs

- Spiritual and religious care was provided to dying patients and their families by chaplains, who also provided pastoral care to patients, their relatives and staff. There was access to chaplains from a number of Christian denominations and Muslim Imams.
- A multi-faith chaplaincy was available 24 hours a day, seven days a week. Arrangements had been made with the mortuary and local coroners to ensure, where necessary for religious reasons, bodies could be released promptly.
- There was information regarding bereavement support services within the community for bereaved families
- Mortuary staff demonstrated their awareness of and sensitivity to cultural and faith practices.

Access and flow

- Following referral the patient's needs were assessed and suggested solutions would be discussed with the staff clinically responsible for the patient's care. The SPCT would work alongside the patient's own doctors and nurses, while the overall care of the patient would remain with their own medical and nursing team.
- Nurses completed the majority of referrals for patients requiring specialist palliative support made to the service but on discussion, the SPCT often found it to have been requested by medical staff. There had been a total of 361 referrals to the SPCT during 2013/14. The majority of referrals to the service continued to be for control of difficult symptoms. Ward staff confirmed the responses from the palliative care team was always supportive and timely.
- The majority of patients were seen within 24 hours of referral
- There were rapid discharge processes in place that were seen to be effective in getting people to their preferred place of care prior to their death.

Learning from complaints and concerns

- Complaints were handled in line with the trust policy. Any specific complaints about end of life care would be forwarded to the specialist nurses.
- We found the service received a low number of complaints. Staff told us they tried to address any issues at a local level as they arose.
- The complaints process was outlined in leaflets available throughout the department and was shown in several languages.
- Complaints were discussed at department meetings and themes and trends were fed back to staff.

Are end of life care services well-led?

Good

The service was responding effectively to national initiatives and local demand in a prompt and timely manner. The SPCT had a clear vision to improve and further develop the service.

Staff were clear about their commitment to providing care that ensured patients ended their life in a dignified way in their preferred place of care. Care was guided by a

End of life care

knowledgeable team who were supportive and provided good leadership. Although we felt assured end of life care was a priority within the hospital there was only one part-time consultant who provided 2 sessions per week in palliative medicine.

Clinical governance arrangements provided assurance that end of life care was being well managed.

Vision and strategy for this service

- The priorities for end of life care services for 2014/2015 were widely shared and understood.
- There were plans to introduce the AMBER care bundle, a Department of Health's National End of Life Strategy recommendation. This is an approach is used when clinicians are uncertain whether a patient may recover and are concerned that they may have only a few months left to live. The care bundle helps staff to realise when they should talk openly with patients about what treatment and care they would prefer should end of life care be planned.
- There were also plans to roll out the Electronic Palliative Care Co-ordinating System (EPaCCS); an electronic software system that allowed the entire patient journey to be measured and analysed from the initial telephone call, through to arrival, consultation, prescribing, internal and external referral to another department or service and closure.

Governance, risk management and quality measurement

- Governance arrangements for end of life care included an executive director and non-executive director who had responsibility for managing and governing the end of life service in the hospital. There was also participation in the End of Life Partnership (previously known as the End of Life Service Model). This partnership was a charitable collaborative that worked across West Cheshire, Vale Royal, South and Eastern Cheshire.
- There were systems in place to audit the quality of end of life services that were regularly reported and monitored from the ward to the board.
- Staff were clear about incident and statistic reporting and how this was used to improve practice and quality throughout the service.
- The End of Life Service Model Team have supported the SPCT throughout 2013/14 by providing teaching sessions to clinical areas such as the principles of end of life care and advanced care planning.

Leadership of service

- Although the service was well supported by specialist nurses, there was limited medical input to the specialist palliative care team. This was because there was only one part-time consultant (two sessions a week) in palliative medicine.
- Ward staff felt that the SPCT were visible, approachable and supportive.
- The team provided good leadership and support to staff caring for patients at the end of life.
- Managers encouraged staff to take up learning and development opportunities to expand their knowledge and skills to improve and enhance the service provided to patients.
- Staff felt that managers were committed to continuous service improvement and supported staff to be innovative and forward thinking in relation to service provision.

Culture within the service

- Ward staff including the palliative care link nurses were passionate about their roles. The end of life care service was focused on positive outcomes in terms of patient care and experience. Staff were positive and proud of the work they did and were committed to doing the best for patients.
- Staff reported positive working relationships across all disciplines. There was a culture of sharing knowledge and expertise demonstrated through formal training and informal teaching opportunities.

Public and staff engagement

- The service had been part of the National Care of the Dying Audit of Hospitals (NCDAH) in 2013/14. Following the feedback received from patients and those close to them had developed an action plan to improve and enhance services for patients. An action plan was developed and improvements had been made to the service.

Innovation, improvement and sustainability

End of life care

- Plans to introduce the Electronic Palliative Care Co-ordinating System (EPaCCS) in 2014/15 would enable service providers across boundaries to share information.
- The SPCT had plans to integrate end of life care into other specialties; for example heart failure team/ respiratory team/dementia team.

Outpatients and diagnostic imaging

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

Information about the service

A range of outpatient services are provided by Mid Cheshire Hospitals NHS Foundation Trust at Leighton Hospital and at the Victoria Infirmary, Northwich. The main outpatients department at Leighton Hospital is located on the ground floor. There are approximately 78,000 new appointments each year. The outpatients department included a variety of specialist medical teams such as oncology, cardiology, respiratory medicine, endocrinology, gastroenterology, neurology, podiatry and diabetes. There was also a phlebotomy service and a diagnostic imaging service.

The Macmillan Unit at Mid Cheshire Hospitals NHS Foundation Trust consists of a purpose built chemotherapy suite with the capacity to treat 9 patients at any one time. Within the Macmillan Unit there is a combination of outpatient facilities including consulting suites, treatment rooms and dedicated therapy and quiet rooms.

At Victoria hospital the outpatient department also caters for a wide variety of specialities. These include medicine, surgery, orthopaedics, urology, rheumatology, dermatology, gynaecology, paediatrics, ophthalmology, ear, nose and throat, dentals and psychogeriatrics. The dermatologist holds a consultation clinic for a variety of conditions and a minor surgery treatment clinic.

The Department of Medical Imaging provides a comprehensive range of diagnostic and interventional services to the patients of Mid Cheshire Hospitals NHS Foundation Trust, including: General X-ray. CT scanning, MRI scanning, non-obstetric ultrasound, obstetric ultrasound, DEXA scanning, breast care unit

We visited the outpatient department and diagnostic imaging services at Leighton Hospital on 8 and 10 October and the outpatient department Victoria Infirmary on 9 October. We observed several outpatient clinics including orthopaedic, ophthalmology, diabetes and surgical clinics. We also visited haematology, radiology and the McMillan centre.

During our inspection spoke with 17 patients and 22 members of staff including volunteers, nurses, health care assistants, technical and clerical staff, senior doctors and radiographers.

Outpatients and diagnostic imaging

Summary of findings

Patients attending the outpatient and diagnostic imaging departments were treated in a dignified and respectful way by caring and committed staff. Staffing numbers and skills mix met the needs of the patients in the department. However, consultants were sometimes called away to deal with emergency situations in other parts of the hospital or clinic's over ran the times allocated. This meant that, at times, patients waited a long time to see their doctor.

There was a clear process for reporting and investigating incidents. Learning from incidents was shared and there were examples of changes in practice in response to incidents. Staff received training in safeguarding adults and children, the mental capacity act, health and safety, patient confidentiality and infection control. Staff were confident and competent in their roles and responsibilities in relation to these matters. There were appropriate systems and processes for the storage and disposal of medicines.

The outpatient and diagnostic imaging departments were clean and well-maintained although the outpatient departments were sometimes quite cramped in terms of space and seating arrangements.

Patient records generally were available for clinics and were secured and stored securely. There were occasions in the dermatology clinics at Leighton Hospital when patient records were not available for an appointment. In such cases staff prepared a temporary file for patients that included the most recent diagnostic and test results coupled with essential patient information so that the patient's appointment could go ahead. Staff acknowledged that this was not ideal; however it meant the patient did not have to reschedule their appointment.

There was good local leadership and a positive culture within the service. Staff worked well as a team and supported each other.

Are outpatient and diagnostic imaging services safe?

Good

There was good practice in the department to promote the safety of patients and staff. Incidents were reported, investigated and shared learning was applied to secure improvement and prevent reoccurrence.

There was a good supply of clean and well maintained equipment to ensure that patients received the treatment they needed appropriately. Cleanliness and hygiene in the department was of a good standard and there was sufficient personal protective equipment to protect patients and staff from cross infection and contamination. Regular hand hygiene audits demonstrated a good level of compliance.

Staff were aware of the policies and procedures in place to protect and safeguard adults and children. Mandatory training was well attended and staff were positive about the training provided. Staff had also been trained in the management of major incidents. There were sufficient well trained and competent nursing and medical staff within the department to deliver the service.

The radiology department was funded for 13.3 consultants. However, there were only 7 substantive and 3 locum consultants in post. The service was experiencing difficulty in recruiting to the additional posts despite strong efforts to address the shortfall. Staff were committed and working well together to maintain a robust service for patients in the interim.

Incidents

- There had been 3 serious incidents (STEIS) reported. One serious incident was in relation to a medication incident and additional learning had been put in place for the staff member involved. Another serious incident related to a patient acquiring a grade 3 pressure possibly attributable to a piece of equipment. A full root cause analysis and investigation was underway.
- Staff were familiar with and encouraged to use the electronic reporting system to report incidents within the department. There was evidence of shared learning from incidents supported with staff training to reduce the risk of reoccurrence.

Outpatients and diagnostic imaging

- Mangers used incidents positively to underpin service improvement and risk management within the service.

Cleanliness, infection control and hygiene

- There was a high standard of cleanliness throughout the department. Staff followed good practice guidance in relation to the control and prevention of infection.
- There were ample supplies of hand washing facilities and personal protective equipment such as gloves and aprons.
- Regular hand hygiene audits demonstrated high compliance rates throughout the department.
- Staff were vigilant in cleaning furniture, fittings and equipment so they were ready for patient use.
- An 'I've been cleaned' sticker system was in operation to inform staff at a glance as to the cleanliness of equipment and furniture.

Environment and equipment

- The physical environment in the outpatient departments looked tired in terms of décor and seating.
- Appropriate clean and well maintained equipment was available in all clinics and departments.
- Where there was a need for specialist equipment, maintenance contracts were in place to ensure

that equipment was regularly serviced and faults repaired quickly.

Medicines

- There were good systems in place for the safe procurement, administration and disposal of medicines.
- Medicines were stored appropriately and fridges temperatures were regularly checked and recorded.

Records

- Patient records were stored securely and with due regard to privacy and confidentiality.
- There were occasions in the dermatology clinics when patient records were not available for an appointment. In such cases staff prepared a temporary file for patients that included the most recent diagnostic and test results coupled with essential patient information so that the patient's appointment could go ahead. Staff acknowledged that this was not ideal; however it meant the patient did not have to reschedule their appointment.
- Regular audits were undertaken to monitor availability of records and demonstrated only 2% of records were not available for the previous quarter of outpatient appointments. Availability of records was discussed at monthly team meetings attended by clinic and administration staff.

Safeguarding

- All staff had received training in the safeguarding of both adults and children
- Staff were aware of their role and responsibilities and knew how to raise matters of concern appropriately.
- Relevant policies and procedures were available electronically for staff to refer to.
- Managers supported staff in escalating concerns in a timely and appropriate way.

Mandatory training

- Staff were provided with mandatory training on a rolling annual programme. Staff were alerted by email as to when their training was due.
- Staff were positive about the content and quality of their training.
- 73% of staff had completed their mandatory training at the time of our inspection.

Assessing and responding to patient risk

- Staff had clear guidance to follow should a patient's condition deteriorate while they were in the outpatient department.
- The critical care outreach team could also provide prompt support to a patient whose condition had deteriorated.
- Resuscitation equipment was available in the department to assist staff during an emergency was ready for use.
- Policies and procedures were in place should a patient deteriorate or have an adverse reaction to drugs and preparations used in the diagnostic and imaging department.

Nursing staffing

- Nurse Staffing levels had been determined using a recognised management tool.

Outpatients and diagnostic imaging

- Managers determined the number of nursing staff required by the number of clinics running at any particular time but also on the nature of the clinics. This is because some specialist clinics required increased numbers of staff due to patient need and dependency.
- Staff felt that the nursing numbers and skill mix met the needs of patients. However, there was limited capacity to provide additional clinics should they be required.
- Nursing staff worked well together as a team and often tried to covered gaps within the department without the use of agency staff.

Medical staffing

- Medical consultants and other specialists arranged outpatient clinics directly with the outpatient department to meet the needs of their specialty.
- Consultants were supported by trainee colleagues in some clinics, where this was appropriate.
- Medical staff provided cover for colleagues if sickness or absence occurred so that patients could still be seen and the number of cancellations reduced.
- The radiology department was funded for 13.3 consultants. However, there were only 7 substantive and 3 locum consultants in post. The service was experiencing difficulty in recruiting to the additional posts despite strong efforts to address the shortfall.

Major incident awareness and training

- Staff had been trained and were able to describe their role and responsibilities should a major incident occur.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

Patients attending the outpatient and diagnostic imaging departments received effective care and treatment that was evidence based and followed national guidance. Staff worked well together in a multidisciplinary environment to meet patient's needs. Medical staff were supported well by specialist nurses.

Information relating to a patient's health and treatment was obtained from relevant sources before clinic appointments; information was shared with the patient's GP and other relevant agencies after the appointment to promote seamless care for the patient.

Evidence-based care and treatment

- Care and treatment followed evidence-based national guidance. For example, the NICE guideline 66/87: management of type 2 diabetes and NICE guideline 101: management of chonic obstructive pulmonary disease (COPD).
- NICE and best practice guidance was available to staff via the trust's intranet.
- Staff were provided with regular updates if and when guidance was reviewed or practice changed.

Pain relief

- Staff could access appropriate pain relief for patients within clinics and diagnostic settings.
- Prescribed pain relief was monitored for efficacy and changed to meet patients' needs where appropriate.

Patient outcomes

- Following a local audit, the ophthalmology department had robust plans in place to ensure the service met best practice guidance and national targets. This was closely monitored and demonstrated that the service was providing timely care and treatment for patients.
- The outpatients department also took part in audits such as hand hygiene, cleanliness and record keeping. Managers had responsibility for implementing and monitoring action plans to secure improvement when remedial action was required.
- Records of local audit demonstrated a high rate of compliance with good practice across the service.

Competent staff

- Staff were trained in core subjects such as infection control, safeguarding and health and safety. In addition, staff were provided with training relevant to their speciality such as ophthalmology and care of patients with diabetes. Staff were also trained in meeting the needs of patients living with dementia.
- Staff were supported in their development through the staff appraisal processes. Staff, in the main were positive about the process and felt supported in their learning by their managers.

- 68% of staff had received an appraisal over the last 12 months.

Multidisciplinary working

- There was evidence of good multidisciplinary working in the outpatient and diagnostic imaging departments. Doctors, nurses and allied health professionals worked well together.
- Letters were sent out by the outpatients department to people's GPs to provide a summary of the consultation and any recommendations for treatment.
- There was good evidence of patient pathways within the service. Further work was underway with commissioners to implement additional pathways to improve patient experience and outcomes. (A pathway is the route a person will take from their first contact with a member of staff to the completion of their treatment).

Seven-day services

- The outpatient department occasionally ran clinics at a weekend. However most activity within the outpatient department happened between Monday and Friday.
- Radiologists provided a 7 day service.
- The diagnostic and imaging service used 'Nighthawk Radiology' services out of hours during the week for reporting on radiology images. (Nighthawk radiology services support hospitals by examining medical scans remotely, reviewing and interpreting the scans, and creating interpretive reports for the hospitals.)

Access to information

- The Radiology Information System (RIS) did not link with the image archive system (PACS). This could lead to wrong images being aligned to incorrect details. The service was aware of this risk and staff were vigilant in this regard. This matter was being addressed by the installation of a new RIS over the next 6 months.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff were confident and competent in seeking consent from patients. Training had been provided and staff were able to explain benefits and risks in a way that patients understood.
- Staff were aware of the duties and responsibilities in relation to patients who lacked capacity and involved relevant professionals so that a decision could be made in the patient's best interest.

Are outpatient and diagnostic imaging services caring?

Good

Outpatient and diagnostic imaging services were delivered by caring, committed and compassionate staff. Staff treated people with dignity and respect. Care was planned and delivered in a way that took into account the patients' wishes. Patients' confidentiality and privacy were respected and promoted wherever possible.

Staff actively involved patients and those close to them in all aspects of their care and treatment.

Patients were very positive about the way staff looked after them.

Compassionate care

- Throughout our inspection we witnessed patients being treated with dignity and respect.
- There were arrangements in place to provide patients with a chaperone during appointments that required an intimate examination, or when requested.
- Staff listened to patients and responded positively to questions and requests for information.
- Patients spoke positively about the care provided by staff. One patient said they had received "excellent care" and another said that staff had been "marvellous".
- We found that vulnerable patients were managed sensitively and attended to as quickly as possible.
- However we found the room used for assessment in the eye care centre was cramped and offered patients little privacy and dignity.

Understanding and involvement of patients and those close to them

- We spoke with 17 patients regarding the information they received in relation to their care and treatment.
- Patients stated they had been involved in decisions regarding their care and staff had explained their treatment options and plans to them clearly.
- Patients knew why they had received an appointment and who they were seeing whilst in the department.
- Staff responded positively to patients' questions and took time to explain things in a way the patient could understand.

Outpatients and diagnostic imaging

Emotional support

- Staff were sensitive to the needs of patients who were anxious or distressed about their appointment. In the diagnostic and imaging department, staff worked hard to allay patients' fears and anxieties about the proposed test or procedure. They explained the procedure through each step and stayed with the patient to provide comfort and reassurance.
- Staff had a good awareness of patients with complex needs and could tailor their response accordingly so the patient was reassured and supported throughout their visit to the department.

Are outpatient and diagnostic imaging services responsive?

Requires improvement

The organisation of the outpatient departments at both Leighton Hospital and the Victoria Infirmary was not always responsive to patients' needs. Some clinics frequently over-ran and some patients experienced long delays in their appointment time. Clinics were sometimes cancelled at short notice which meant patients had appointments cancelled and re-scheduled.

There were high numbers of patients who failed to attend for their appointments despite reminders from the service about the time and location. Patients who drove themselves to their appointment told us they found car parking at Leighton Hospital difficult because the demand for spaces was high. This situation was improving with the recent addition of 40 more car parking spaces.

The entrance to Leighton hospital had recently been refurbished and a new signing system had been put in place. Patients found this helpful in finding the correct location for their appointment.

Good systems were in place to ensure that the service was able to meet the individual needs of people such as those living with dementia, a learning disability or physical disability. There was a good system in place to meet the needs of patients whose first language was not English.

Staff had worked well to capture the views of patients and to take action to improve the experience of patients where required. There were plans in place to introduce the family and friends test within the department.

Service planning and delivery to meet the needs of local people

- Good systems were in place to ensure that the service was able to meet the individual needs of people, such as those living with dementia and those who had a learning disability or physical disability.
- Although the outpatient departments were sometimes cramped and crowded there were facilities such as toilets, coffee shops and a newsagent outlet nearby so that patients could buy drinks, snacks and reading material. Patients were concerned that some clinics were so busy they felt disorganised and chaotic.
- There were easy access toilet facilities available for patients who had a physical disability, however some would benefit from upgrading.
- Patient information was in good supply and covered a range of topics including explanations of conditions and related diagnostic tests.
- Car parking at Leighton Hospital remained of concern to patients and some were concerned as to how far they had to walk once a parking space was secured. However the provision of an additional 40 car parking spaces was helping to alleviate this problem.
- There was easy access to public transport services with local buses stopping within the hospital grounds within easy walking distances to the main entrance.

Access and flow

- Clinics and diagnostic appointments were planned and arranged to meet the needs of patients and national Referral to Treatment Targets (RTT).
- Cancer wait times were consistently better than the England average for 31 day and 62 days targets. Since February 2014 RTT times for patients with incomplete pathways had fallen below the England average on three occasions.
- RTT times for non-admitted patients are below the England average
- Diagnostic waiting times are below the England average
- Patients waited for over 2 hours past their appointment time in some busy clinics.

Outpatients and diagnostic imaging

- Patients who attended outpatient appointments on a regular basis said they 'often' or 'always' waited in excess of an hour to be seen.
- This was sometimes due to doctors being in other parts of the hospital in response to emergencies. In other cases it was due to patient appointment times overrunning.
- Appointment booking systems were such that they did not take into consideration the variable needs of patients. This was particularly evident in the ophthalmology department where patients may require a longer appointment slot for macular degeneration or diabetes treatment. This also contributed to appointments overrunning.
- Patients were very matter of fact about the waiting times and in many cases accepted that long waits were inevitable.
- The patient non-attendance rate was 9% across the trust and continues to remain worse than the national average. Rates of non-attendance are important as this means resources are not being used well and can have a negative impact on patients receiving their treatment in a timely way.
- Over 6% of patients had their appointment cancelled or rescheduled by the service. This was a cause of frustration for patients who found the rearranging of their appointment and transport arrangements inconvenient.

Meeting people's individual needs

- Patients with dementia were seen quickly and calmly; similarly patients with a learning disability were seen quickly and their needs were managed well. Staff were able to adapt their approach so that vulnerable patients were managed sensitively.
- There was a good system in place to meet the needs of patients whose first language was not English. This could be done over the phone using a telephone translating system that could be accessed at any time with no requirement for prior arrangement.
- Personal interpreting services were also available and used effectively so patients understood what was happening to them and why.
- Staff never used family members as interpreters and this is considered good practice.

Learning from complaints and concerns

- Complaints were handled in line with the trust policy. Initial complaints were dealt with by the outpatient manager, who resolved locally where possible. Where complaints were not resolved, patients were directed to the Patient Advice and Liaison Service (PALS). If they still had concerns following this, they would be advised to make a formal complaint. This process was outlined in leaflets available throughout the department.
- There were low numbers of complaints for the service, however staff responded positively when patients raised matters of concern and used complaints to make improvements in the department.

Are outpatient and diagnostic imaging services well-led?

Good

The trust's vision and values were understood or fully supported by all staff in the department. Staff felt supported by their local clinical managers and were positive about the engagement opportunities offered by the Chief Executive. Nursing staff felt they would like to see senior nurse leaders more visible within the service.

Staff were proud of the work they did; they worked well together and supported each other when the service was under pressure from increased demand.

Managers had a good knowledge of the performance in their areas of responsibility and understood the risks and challenges to the service. Risks were identified in a departmental risk register.

There were monthly governance meetings to discuss and address service planning and performance issues. Following targeted work there was good utilisation of the outpatient facilities within the hospital with 94% of the possible number of sessions being used. This was an increase from 89% for some months in 2013.

Vision and strategy for this service

- Staff understood the organisation vision and values. Staff were kept informed of proposed service changes and improvements via the intranet, team meetings, the CEO's forum and information issued to all staff in their payslips (pay slip press).

- Staff were aware of service challenges and the plans proposed or in place to address them.

Governance, risk management and quality measurement

- Monthly governance meetings were held with managers and representatives of staff from all departments.
- Complaints, incidents, audits and quality improvement projects were discussed at monthly departmental meetings.
- Risks that affected the delivery of the service were identified clearly on the divisional risk register. The risks were then assessed and categorised into departmental, divisional or trust risks and mitigated and monitored accordingly.

Leadership of service

- Managers had a strong focus of the needs of patients and the roles staff needed to play in delivering a good service. They were visible and respected by their colleagues.
- Staff were comfortable and able to discuss a range of issues with their line manager and felt able to contribute to influence the running of the department. However, there was some concern expressed about the pace of the managers' response to increased demand in services particularly in ophthalmology.

Culture within the service

- There was a positive culture in the departments; staff were committed and proud of their work.
- Radiologists felt well supported and that there were good opportunities for professional development.
- Staff supported each other and there was a good team working within the departments.

Public and staff engagement

- Staff were keen to engage their patients and the public to improve the patient experience.
- At the time of inspection trust governors were in the outpatient areas talking to patients and those close to them about their work and the opportunities for patients and the public to contribute to service development.
- There was a volunteer scheme in place and volunteers were contributing positively to the service by supporting, directing and assisting patients. The volunteers were positive about their inclusion and felt valued and supported within the wider team.

Innovation, improvement and sustainability

- There were plans in place to improve the environment and quality of the patient experience in the outpatient departments. These were not fully implemented at the time of our inspection; however staff were positive about the plans and were confident that the improvements would be delivered.

Outstanding practice and areas for improvement

Outstanding practice

- In medical care, the trust had introduced an electronic handover tool (e-handover) for which they had received a Health Service Journal Award. Medical staff at the trust had developed documentation for the care of patients on an alcohol detox pathway.
- The new critical care unit had been designed in accordance with the latest best practice guidance with the aim of reducing delirium and the problems associated with sensory deprivation. For example the rooms on one side of the unit benefitted from full length windows incorporating an electronic blind so that natural light was visible. In addition the unit made use of sky ceiling photo panels above patient beds, which displayed realistic images of blue skies, white clouds and blossom trees.
- The end of life care service had direct access to electronic information held by community services, including GPs. This meant that hospital staff could access up-to-date information about patients, for example, details of their current medication.
- The hospital had a rapid discharge pathway to enable patients to be discharged from the acute hospital to home in the last hours /days of their lives. An audit in March 2014 showed the preferred place of care (PPC) wishes were ascertained and recorded for 96% of patients seen by the SPCT and PPC achieved for 84% of this group.

Areas for improvement

Action the hospital MUST take to improve

- Ensure that medical staffing is sufficient to provide appropriate and timely treatment and review of patients at all times including outpatient clinics and out of hours.
- Ensure that medical staffing is appropriate at all times including medical trainees, long-term locums, middle-grade doctors and consultants.
- Improve patient flow throughout the hospital to reduce the number of patient bed moves and patients' length of stay – particularly in the medical division.
- Take action to clear the backlog of discharge letters and implement an effective system for managing discharge letters so that GPs receive accurate and robust information about their patients in a timely way
- Ensure that escalation areas are appropriate environments for the care of patients and provide them with ready access to bathing and toilet facilities

Action the hospital SHOULD take to improve

The trust should:

- Consider improving arrangements for clinical supervision to ensure they are appropriate and support staff to effectively carry out their responsibilities, offer relevant development opportunities and enable staff to deliver care safely and to an appropriate standard.
- Ensure that, where patients are deemed not to have capacity to consent, staff are establishing and acting in accordance with the best interests of the patient and that this is appropriately documented.

In emergency & urgent care services:

- Ensure that all staff complete their mandatory training in a timely manner.
- Consider updating their sudden death checklist for paediatrics to include a "do not leave child alone with parents" step.
- Ensure they have a list of appropriate staff that have been trained with the required scene safety and awareness training.

In medical care services:

- Ensure timely access to treatment for upper gastrointestinal bleeds and stroke thrombolysis, including out of hours.
- Ensure action is taken to improve outcomes for patients with diabetes or who have had a stroke.

Outstanding practice and areas for improvement

In surgery services:

- Ensure that appropriate action is taken to reduce the number of patients that underwent elective surgery and were readmitted to hospital following discharge.
- Continue to monitor and fully implement the proposed actions in order to reduce the number of cancelled operations and improve theatre utilisation.

In maternity & gynaecology services:

- Review and improve the provision of consultant anaesthetic sessions for elective caesarean sections to provide a more responsive service for women.

In services for children & young people:

- Consider reviewing safeguarding children training to ensure that the format, content and duration is in line with best practice guidance, in particular the provision of inter-agency training, and that the time allowed for level 3 training is appropriate to support the learning needs of staff
- Ensure that safeguarding concerns are reported via the incident reporting systems to make sure that incidents are fully investigated, and provide assurance that all relevant staff are aware of lessons learned.

In outpatients and diagnostic imaging services:

- The trust should take action to ensure that waiting times for outpatient clinics are improved and that clinics do not over run leading to cancellation of appointments.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing Appropriate steps had not been taken to ensure that there were sufficient numbers of suitably qualified, skilled and experienced nursing and medical staff working in the hospital to meet the needs of service users. There was a shortage of medical staff within the medical and emergency care division, particularly in relation to trainee doctors and medical support out of hours. There was insufficient medical staff out of hours in the critical care services.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services People who use the service are not always protected against the risk of receiving care or treatment that is inappropriate or unsafe, because flow across the hospital meant that some patients could not be placed in the right bed at the right time for their needs. This led to extended lengths of stay and multiple bed moves. Some of the areas used for escalation beds did not provide an appropriate environment for the care of patients overnight. Discharge letters were not prepared and issued promptly, leading to a possible delay in follow-up care and treatment for patients.