Kettering General Hospital NHS Foundation Trust

Kettering General Hospital NHS Foundation Trust

Quality Report

Rothwell Road
Kettering
Northamptonshire
NN16 8UZ
Tel: 01536 492000
Website: www.kgh.nhs.uk

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

The Care Quality Commission (CQC) carried out a comprehensive inspection between the 2 and 4 September 2014. We carried out this comprehensive inspection because the Kettering General Hospital NHS Foundation Trust had been identified as potentially high risk and was scored band 1 (the highest) on the Care Quality Commission's (CQC) Intelligent Monitoring system in July 2014.

The trust was inspected by the CQC in January 2014, and was subsequently issued with compliance actions in respect of Regulation 22 (staffing) and Regulation 13 (medicines) due to the serious failings identified on the Deene Floor. The trust reported that in respect of Regulation 13 they returned to compliance by March 2014, and in respect of Regulation 22 they returned to compliance by end of August 2014. This was reassessed at this inspection.

The trust remains non-compliant with the compliance action issued on medicines. This is because we found significant issues in respect of the storage, prescription and administration of medicines within a number of areas within the hospital.

The comprehensive inspections result in a hospital being assigned a rating of 'outstanding', 'good', 'requires improvement' or 'inadequate'. Each section of the service receives an individual rating, which, in turn, informs an overall trust rating. The inspection found that overall, the trust has a rating of 'requires improvement'.

Our key findings were as follows:

- The trust encouraged staff to learn from incidents that occurred, to improve the care received by patients.
- The new management team had plans in place to deal with some of issues we found, and had already addressed some of the issues highlighted in previous CQC reports.
- The trust had used complaints in a positive way to enhance the care received by patients.
- Many staff felt empowered to make or suggest changes to improve care.
- The trust had reduced usage of agency cover in the A&E department by half during the previous year.
- The trust was not following Intensive Care Society Guidelines on the nursing staffing in critical care.
- The trust had a shortfall of permanent clinical staff, which at times led to poor care being given. The trust have employed temporary staff to mitigate this risk.
- Poor environment meant that potentially infection control practices could not be effective. We also found poor documentation in relation to infection control.
- Equipment and facilities particularly in the theatre department and in Maternity were old, and required some improvements.

We saw several areas of outstanding practice, including:

- Excellent multidisciplinary working was noted across the trust, ensuring that patients received appropriate and timely care.
- Staff described a supportive response in the trust, where learning from incidents and staff issues was seen as important to improve safety and quality of patient care.
- The practice in maternity of sharing 'hot' topics at handover ensured that all staff were aware of these issues.
- The caring and responsive approach to bereaved families by staff in the mortuary, including support with viewings, and support with funeral arrangements, was outstanding. Staff in this service went beyond the call of duty to support families, particularly those bereaved of children and babies, during difficult times.

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

Importantly, the trust must:

Summary of findings

- Review staffing levels in the surgery and critical care units. This should include the use of junior doctors overnight within surgery.
- Review the environments in maternity and outpatients, to ensure that infection control measures, and privacy and dignity issues, can be addressed.
- Ensure that best practice guidelines from 'The Safe and Secure Handling of Medicines: A Team Approach', published by the Royal Pharmaceutical Society, are implemented to improve the safety and efficacy of medications.
- Ensure that 'do not attempt cardio-pulmonary resuscitation' (DNA CPR) forms are completed appropriately.

In addition the trust should:

- Take action to ensure that staff in the A&E department are aware of current risks and actions to be taken in relation to communicable diseases, such as Ebola.
- Ensure that the checking of resuscitation equipment in the A&E department, and across the trust, occurs as per policy.
- Review the usage of storage facilities throughout the hospital, but especially in A&E and maternity.
- Ensure that patients' medical records are stored in a way that maintains patient confidentiality within the A&E department.
- Review the availability and uptake of training on caring for patients living with dementia, to improve the service to patients living with dementia.
- Ensure that staff receive appropriate appraisals, in order that they remain competent to carry out their roles.
- Review the consent procedures for emergency patients.
- Review the end of life service, to ensure that patients requiring this service receive care at an appropriate time.
- Improve record keeping throughout the trust, but especially in medical areas, to ensure that it reflects the needs of individual patients.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	Requires improvement 	The A&E department had recently undergone significant improvements to develop the function and care within the unit. However, we found that further improvements were required to ensure that the unit was safe and responsive to the needs of patients attending the A&E department. There were systems in place to manage deteriorating patients, although a sepsis pathway had not yet been established in the service. Medical and nursing vacancies had decreased, although a significant number of locum doctors were still being used, especially at night and at weekends. We found that the children's area was not observed at all times by the staff working in the department. Clinical guidance for the treatment of patients with specific needs or diseases was available and being used appropriately by staff. Staff were caring. Patients felt that they were listened to by health professionals, and were involved in their treatment and care. Patients were confident in staff abilities to deliver high quality care. The service was well-led. The leadership structure had changed, and staff were supportive of the new management structure. They felt empowered, and told us morale had improved; however, the cascading of information could be improved.
Medical care	Requires improvement 	The medical care service required improvement as staff training was variable, and not meeting the trust's targets in most areas. There were not always reliable systems in place to ensure that all people were monitored effectively, and some documentation was poor. Some people's care plans were not effective in providing guidance to staff as to how to safely provide the care and treatment to meet patients assessed needs. The service was addressing concerns regarding staffing levels, staff skill mix, and monitoring the condition of deteriorating people. Staff recruitment was in progress to fill staff vacancies. All wards had introduced clearer systems for sharing information about the ward's performance with staff and

Summary of findings

visitors. The medical care service had higher falls rates and development of pressure areas than the trust targets. People we spoke to were, in the majority of cases, very complimentary about the staff and the care they received. Staff felt well supported at a ward level, but not all staff had a clear understanding of the board's vision and strategy.

Surgery — **Requires improvement**

The surgical service requires improvement because there were risks and deficiencies evident across three areas of our inspection domains. Generally, we saw that patients had been cared for safely, but there were practices and issues that posed risks to patient safety. There were risks due to limited medical staffing cover out of hours and at times of increased workload, and pressure on beds resulting in cancellations; the nursing teams were concerned about maintaining safety. We saw that older facilities and equipment posed a risk to safety due to failure of critical equipment. Infection control was compromised due to pressure of activity, meaning that screening was not comprehensively completed. Infection was also a risk, due to difficult storage facilities and working practices.
Problems with some of the theatre room configurations, care records tracking, and established working practices meant that patients had their operations cancelled, and theatre facilities were underutilised. We saw that some patients admitted for surgical reasons, but who were also living with dementia, did not have good programmes of care in respect of their confusion and mood, which suffered during their admission. Ward environments were bland, some areas were cramped, and staff did not always respond to the varied needs of patients living with dementia.

Critical care — **Requires improvement**

We found that significant and urgent improvements were required to ensure the safety of patients. Staffing levels were not always related to the dependency of patients as per national guidance, 'Core Standards for Intensive Care Units 2013' and were inadequate to meet the needs of patients. However, once alerted, the trust took action to address this issue. Improvements were required to

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ensure that lessons learned from incidents were shared with all nursing and medical staff. Infection control and medicines management systems were found to be safe.
The ICU was obtaining good quality outcomes, and patients received treatment that was based on national guidelines. Staff cared for patients in a compassionate manner, with dignity and respect. Both patients and their relatives were happy with the care provided.
Improvements were required to the leadership of the ICU, to ensure that the management responded to recommendations previously made on how to improve the service delivered.

Maternity and gynaecology — **Requires improvement**

The maternity service provided to women and babies by Kettering General Hospital required improvement. There was a lack of evidence to show that doctors were always actively involved in reviewing policies and practice changes, where performance was below the national targets, to reduce risks to patients. There was a lack of medical involvement in the development of some guidelines, and minimal evidence that national guidelines were being audited and followed.
The trust had provided adequate clinical staffing levels and skill mix, and had encouraged proactive teamwork to support a safe environment. However, we noted that the provider may wish to consider increasing consultant hours, to manage increased demands, and emergency support, in line with national guideline recommendations.
Concerns were identified and raised regarding the current poor fabric of the maternity building, and the facilities for breastfeeding and medicine management in parts of the maternity wards. We understand that the provider is currently taking action to improve these areas. Infection control standards required improvement.
Staff in all roles put significant effort into treating patients with dignity, and most patients felt well-cared for as a result. There were positive views from patients, and those close to them, about the care provided.
The majority of maternity staff understood the corporate vision, and also the maternity strategy for developing the services at Kettering General

Summary of findings

Hospital. We saw that there were management systems in place, which enabled learning and improved performance, and which were continuously reviewed where required, although we found that there was a lack of corporate scrutiny regarding some of the maternity key performance indicators.

Services for children and young people

Good

We found that the current service provided to children and young people by Kettering General Hospital was safe, effective, caring, responsive and well-led. The trust had provided good, flexible staffing levels, an adequate skill mix, and had encouraged proactive teamwork to support a safe environment.

There were arrangements in place to implement good practice, learning from any untoward incidents, and an open culture to encourage a strong focus on patient safety and risk management practices. Families told us that they felt safe in the hands of the staff, and staff said they felt supported by the trust in managing risk and keeping their patients safe. We saw good examples of care being provided, with a compassionate and dignified approach.

National guidance was being implemented, and monitoring systems to measure performance were in place. There was good collaborative working with partners and other agencies, and the number of staff receiving continual professional development and clinical supervision was satisfactory.

The children and young people's service understood the different needs of the communities it serves, and acted on these to plan and design services. The paediatric department encouraged children, their relatives, and those close to them, to provide feedback about their care, and were keen to learn from experience, concerns and complaints.

The paediatric departments could demonstrate that risks to the delivery of high quality care were identified, analysed and mitigated systematically, before they became issues which impacted on the quality of care. There was strong team-based working, characterised by a co-operative, inter-disciplinary, cross-boundary approach to delivering care, in which decisions were made by teams as well as leaders.

Summary of findings

End of life care

Inadequate

We found that overall this service was inadequate due to the lack of leadership and effective outcomes for patients within the service. We found that access to services was poor and constrained by the agreement with the third party provider. We found that improvements were required to be made to safety and being responsive to people's needs.Care for patients at the end of their life was supported by a specialist palliative care team. Since the phasing out of the Liverpool Care Pathway, the trust did not follow a specific end of life care pathway.Ward staff were not appropriately trained in end of life care, and care was not always delivered appropriately, as staff did not always recognise when patients required specialist end of life care input. There was a failure to recognise patients as being at the end of their life until they were in the final stages of the process.

There were inconsistencies in the completion and review of 'do not attempt cardio-pulmonary resuscitation' (DNA CPR) forms. Some had not been signed by a consultant, and it was not always clear whether discussions with the patient and their representatives had taken place.

The caring and responsive approach to bereaved families by staff in the mortuary, including support with viewings, and support with funeral arrangements, was outstanding. Staff in this service went beyond the call of duty to support families, particularly those bereaved of children and babies during difficult times.

Outpatients and diagnostic imaging

Requires improvement

We found that improvements were required in the outpatients department. The physical environment was poorly maintained and clinical areas were small. Staff were caring, and treated patients with dignity and respect, and patients told us that they were happy with the care they had received while attending their appointments within the outpatients department.

The organisation of clinics was not responsive to the needs of patients. Many clinics frequently over-ran, and some patients were experiencing long delays in their appointment time. Clinics were sometimes cancelled at short notice. This led to patients having appointments cancelled and re-scheduled. We found that the leadership in the

Summary of findings

outpatients department required improvement as communication with staff was poor.; the trust was already aware of the concerns within the outpatients department, and was taking steps to transform the service.

Requires improvement

Kettering General Hospital NHS Foundation Trust

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

Contents

Background to Kettering General Hospital NHS Foundation Trust

Kettering General Hospital is an established 576 bed general hospital, which provides healthcare services to North Northamptonshire, South Leicestershire and Rutland. The trust provides a comprehensive range of specialist, acute, obstetrics and community-based services. The trust also provides regional cardiology services to the wider Northamptonshire and surrounding areas. The trust achieved foundation trust status in 2008.

The average proportion of Black, Asian and minority ethnic (BAME) residents in Kettering (6.1%) is lower than that of England (14.6%). The deprivation index is lower than the national average, implying that this is not a deprived area.

The Care Quality Commission (CQC) carried out a comprehensive inspection between the 2 and 4 September 2014. The inspection was undertaken

Detailed findings

because the trust was identified as having elevated risks in the SSNAP audit (Sentinel Stroke National Audit Programme), delays in discharge, governance procedures and significant numbers of safeguarding alerts. We also received some other concerning information. The trust had two outstanding compliance actions. These issues were reviewed during the inspection.

Our inspection team

Our inspection team was led by:

Chair: Kathy McLean, Medical Director, NHS Trust Development Authority

Head of Hospital Inspections: Fiona Allinson, Care Quality Commission

The team included CQC inspectors and a variety of specialists: seven CQC inspectors, one director of assurance, eight consultants, one junior doctor, seven senior nurses, two student nurses, and two 'experts by experience'. (Experts by experience have personal experience of using or caring for someone who uses the type of service we were inspecting.)

How we carried out this inspection

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

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

The inspection took place between 2 and 4 September 2014.

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

We held a listening event on 2 September 2014, when people shared their views and experiences of Kettering General Hospital. Some people who were unable to attend the listening event shared their experiences with us via email or by telephone.

We carried out an announced inspection visit on 3 and 4 September 2014. We spoke with a range of staff in the hospital, including nurses, junior doctors, consultants, administrative and clerical staff, radiologists, radiographers, pharmacy assistants, pharmacy technicians and pharmacists. We also spoke with staff individually as requested. We carried out unannounced visits on Tuesday 9 September to the critical care unit, and on Saturday 13 September 2014 to the critical care unit, Deene Wards and Naseby Wards. During these unannounced visits we spoke with staff and patients.

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

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

Detailed findings

Facts and data about Kettering General Hospital NHS Foundation Trust

Kettering General Hospital:

- Has 576 beds - 524 acute inpatient, 40 maternity and 12 critical care
- Serves 330,000 people
- Employs 3,100 staff
- Has an annual turnover of approximately £178 million
- Achieved foundation trust status in 2008
- The trust ended 2013/14 with a deficit of -£14m

Between April 2013 and March 2014, the trust had:

- 42,336 inpatient admissions
- 250,000 outpatient attendances
- 72,440 A&E attendances
- 3,537 deliveries

Kettering General Hospital has been inspected eight times, with the most recent in January 2014, where it was found to be Non-Compliant for two Outcomes. Outcome 9 – Medicines management and Outcome 13 – Staffing. Compliance actions were issued for both outcomes.

Detailed findings

Our ratings for this hospital

Our ratings for this hospital are:

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

Notes

Urgent and emergency services

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

Information about the service

The emergency department at Kettering General Hospital comprises of accident and emergency (A&E), a medical admissions unit caring for up to 26 patients, and an observation ward, which can care for up to seven patients. CQC normally report on a medical assessment unit in the medical section however as this is managed by this area we have reported this here.

During evenings and weekends a GP is available in A&E to see those who can be treated as primary care patients. This is funded by the local clinical commissioning group (CCG), and this service was not part of this inspection.

The A&E department was built in the 1960s for an attendance of 40,000 patients per year. The department had been renovated since this time, and between April 2013 and March 2014 saw 72,440 attendances. Approximately 20-25% of these admissions were children under the age of 18 years. Children had their own waiting and treatment area, able to care for four patients at a time. The waiting area was suitably equipped with play materials.

Summary of findings

The A&E department had recently undergone significant improvements to develop the function and care within the unit. However, we found that further improvements were required to ensure that the unit was safe and responsive to the needs of patients attending the A&E department. There were systems in place to manage deteriorating patients, although a sepsis pathway had not yet been established in the service. Medical and nursing vacancies had decreased, although a significant number of locum doctors were still being used, especially at night and at weekends. We found that the children's area was not observed at all times by the staff working in the department. Clinical guidance for the treatment of patients with specific needs or diseases was available and being used appropriately by staff.

Staff were caring. Patients felt that they were listened to by health professionals, and were involved in their treatment and care. Patients were confident in staff abilities to deliver high quality care. The service was well-led. The leadership structure had changed, and staff were supportive of the new management structure. They felt empowered, and told us morale had improved; however, the cascading of information could be improved.

Urgent and emergency services

Are urgent and emergency services safe?

Requires improvement

The A&E department required improvement to ensure the safety of patients. Medical and nursing vacancies had decreased in the previous six months, although a significant number of locum doctors were still being used, especially at night and at weekends. A consultant was on-call overnight and at weekends, and children's nurses were available during daytime hours. Medical paediatric support was currently provided by the ward team. The children's waiting area was not observed at all times by the paediatric team, and a paediatrician was not readily available within the department. Equipment was checked regularly, and staff were seen to be using alcohol gel or washing their hands between patients. There were systems in place to manage deteriorating patients.

There were processes in place to ensure nursing and medical staff learned from any patient-related incidents occurring in the department. However, we found that the process for the storage of medicines was not robust. Patient records were not always kept securely. Staff were aware of how to raise concerns about adults and children who may be at risk from harm.

Incidents

- All staff were able to input incidents on the trust's electronic Datix system, and could give examples of when they had done so. Staff we spoke with stated that they always reported incidents and had no hesitation in doing so.
- In the medical assessment unit (MAU) we were informed by a member of staff that "there is a clear pathway for raising concerns and I am happy to do it".
- Staff reported that individual feedback was given on Datix reports. However, we identified an incident in July 2014 on MAU, where a patient had had a fall as a consequence of poor prescribing. The learning from the incident had not been disseminated wider in the trust.
- Issues and incidents were discussed at a variety of meetings within A&E; these included weekly operational meetings, monthly quality assurance meetings, and mortality and morbidity meetings held bi-monthly. A newsletter had also been produced for staff, to heighten awareness of important items.
- A communication book was used to ensure immediate lessons from each shift could be documented and read. Staff informed us that messages from the book were read out at each shift handover. However, a member of staff we spoke to about a particular infectious disease of concern was unaware of the symptoms to be aware of in any patients presenting to A&E. There was no mention of the issue in the communication book. On the MAU, a senior member of staff was aware of the disease and the symptoms.

Cleanliness, infection control and hygiene

- Areas were seen to be clean and odour free. Surfaces and mattresses were clean, and we observed cleaning of equipment and trolleys by domestic staff.
- Hand-washing facilities and alcohol gel were available in all areas we visited. Staff were seen to use them intuitively.
- We saw, from the information displayed, that hand hygiene had been assessed as being 80% in August 2014 in A&E. A comment had been added to the data, which stated that doctors had been informed of the results.
- All trust staff were observed to adhere to the 'bare below the elbows' policy.
- We observed two trolleys in a corridor used by ambulance personnel, when trolleys were not available for transferring patients. We were informed that the two trolleys belonged to an ambulance service. Both had visible dust on them.
- The majority of treatment areas were single bedded, and had walls and a door. They could therefore be used for isolating patients if required. After use, we saw that areas were deep cleaned, and cubicle curtains changed.
- Staff told us and we confirmed by looking at the policy that if a patient with a known MRSA or C.difficile infection attended A&E, all staff were notified and suitable precautions taken.
- We saw that curtains were disposable, and dates for changing had been placed on them.
- We saw staff on MAU caring for a patient who had an infection. They used the appropriate equipment, and wore personal protection; for example, gloves and aprons.

Environment and equipment

- There was sufficient equipment for monitoring and treating all patients; for example, infusion pumps. Staff informed us that they felt they had sufficient equipment for patients.

- Although we did not see any bariatric equipment in use, we were informed by staff in all areas we visited that bariatric equipment was available when required. If such items were not available in the hospital, staff could access the equipment quickly through an external specialist supplier.
- Equipment we examined had been serviced, and was in working order.
- Resuscitation equipment in all areas was appropriate. In MAU we saw the two resuscitation trolleys had not always been checked on a daily basis over the previous five months. We found that one trolley had not been checked for four days in August 2014, and the second trolley had not been checked for 12 days in August 2014.
- We found pieces of equipment, in a drawer in the room used for assessing patients with a mental health problem, which could be used as a ligature. We told staff about this and they were removed promptly.
- The entrance to the children's waiting area in A&E was accessible from the main corridor. The treatment area for children was situated off the waiting area. No member of staff was available in either of the areas on a permanent basis. We saw that other patients, relatives and members of the general public could access both areas unhindered, and children could walk out. This meant that the area was not secure.
- Electronic profiling beds were not always available on MAU. This meant that when staff needed to move patients either in or out of the bed, they could not always use best practice moving and handling procedures. This presented a risk to both patients and staff.
- The temperature in MAU had been regularly high and posed a risk to patients, staff and medicines. For example, on 19 August it had been recorded as being 30.1°C. On 28 August it was 31°C.

Medicines

- The medicines room on MAU had a temperature reading of 28.5°C on 25 July 2014.This placed the integrity of the medicines at risk. Most medicines are required to be stored below 25°C.
- Patients with any known allergies to drugs were identified during the triage process. A note was made on the patient's record.
- We looked at the way in which the areas we visited kept their controlled drugs (CDs); they were kept securely in all areas. We checked CDs at random, and found the numbers stored in CD cupboards tallied with the number in the CD registers. There were processes in place for storing and administering medicines appropriately.
- Staff told us that the hospital pharmacy team were very supportive.
- On the first day of our visit, we saw potentially dangerous medicines stored in a fridge in the resuscitation room that was not secure, although there was a lock on it. We brought this to the attention of a member of staff, but on the second day of our inspection, it remained unlocked. The department was not following best practice guidelines from 'The Safe and Secure Handling of Medicines: A Team Approach', published by the Royal Pharmaceutical Society.
- During our visit, A&E had no glyceryl trinatrate (GTN) spray available for patients suffering with angina. GTN is a commonly used medicine. We were informed it was a restocking issue, and staff had not raised this when the last spray had been taken from the cupboard.
- We saw a copy of the British National Formulary (BNF) in one of the treatment areas in A&E. It was dated 2010. The BNF provides healthcare professionals with authoritative and practical information on the selection and use of medicines, and is updated monthly. We spoke to a senior member of staff who removed it from the treatment area, and told us that the most up-to-date version was available on the trust's intranet for clinicians to use at any time.
- We were informed by a senior member of staff that the main medication room in A&E was due to be upgraded in the near future. This included the addition of a viewing panel in the door and separate areas for the preparation of intravenous and oral medication.

Records

- Records were not kept electronically; paper records were available for all patients in A&E, MAU and the observation unit.
- We looked at patient notes in both areas. We saw nutritional assessments in place, and screening for MRSA had been undertaken.
- One patient's notes on the observation unit did not contain a treatment plan. The patient had been on the unit for 22 hours.
- In A&E, patient records were kept in a plastic folder on the cubicle door adjacent to where the patient had been placed. Although convenient for staff to locate, this

meant that the records were not kept securely at all times. Patient's records in MAU and the observation unit were kept securely and were only accessible to healthcare professionals.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients we spoke with told us that they were asked for their verbal consent before procedures were undertaken.
- We saw the documentation used to support or assist healthcare professionals in assessing capacity. It was a comprehensive document, and included the 'Best Interest' checklist for a patient lacking capacity in relation to a specific decision.
- Staff we spoke to were aware of the Mental Capacity Act. We established that this is part of the mandatory training programme. A member of staff we spoke with on MAU told us that they had been trained to undertake mental capacity assessments for patients whose capacity was uncertain.
- Staff confirmed to us their knowledge of the Deprivation of Liberty Safeguards (DoLS) legislation. We established that a majority of staff had received training on this subject.

Safeguarding

- Staff we spoke with in all areas were aware of the trust's safeguarding procedures for adults and children, what constituted abuse, and how to report it.
- Junior nursing staff and doctors in A&E had received level 2 safeguarding training. Senior nursing staff and doctors had received level 3 safeguarding training. This meant that the senior decision makers within A&E had received additional training, and were aware of the processes to follow if they had concerns about a patient. However it was not clear that staff working directly with children had received the recommended level 3 training.
- Nurses who were trained to care for children, were responsible for ensuring that the notes for all children who attended the A&E during the night, were reviewed the following morning. The nurses made any referrals to the safeguarding team if this was necessary. We observed this being undertaken during the inspection, when a referral was submitted to the safeguarding children's team for a child's injuries.
- Only children who presented to A&E, and who were under 30 days old, were referred automatically to a paediatrician. We were informed that a senior nurse was being appointed in A&E for paediatric (children) development, and to take the safeguarding lead for children within the department.
- A&E had 11 safeguarding cases in the department between April and August 2014. All of them had been in the category of 'neglect'. Cases included unsafe discharge, attempted self-harm and a possible missed fracture. Two of the cases had been partially substantiated; the third investigation had yet to be concluded.

Mandatory training

- Mandatory training was actively encouraged in all areas we visited. Information received from the trust showed mandatory training statistics for the entire workforce; this was not broken down into wards and departments. The information showed that between 85% and 95% of permanent staff had completed their mandatory training. Of the staff who worked for the trust on a temporary basis, 35% had completed the training. However, this was not A&E specific, and A&E specific data was not available.
- Training in caring for patients with dementia was not given as part of mandatory training. Only 25% of staff in A&E had received this training. We were informed that a specialist in undertaking dementia training for staff was soon to be introduced.
- Nursing staff were trained in basic life support and received regular updates.

Assessing and responding to patient risks

- Patients who walked into the A&E department, would be booked in by the receptionist, and directed to the waiting room. It was the triage nurse's responsibility to detect any signs of a deteriorating patient whilst they were in the waiting room. The triage room was near to the entrance to the department and the waiting room; therefore, sight of the patients could be maintained.
- From data we received, the trust was ranked relatively worse than other trusts for ambulance handovers delayed over 30 minutes. We spoke with ambulance personnel, who told us that they did not have to wait long for nurses to receive patients from them in A&E, and staff listened to the information they gave them.
- There was a protocol in place for patients suffering major blood loss.
- Following a patient's initial assessment, observations such as temperature, pulse and blood pressure were

recorded using the national early warning scoring (NEWS) system, or the modified early obstetric warning system (MEOWS) chart. The scores are a simple, physiological score, the primary purpose of which is to prevent delay in intervention or transfer of critically ill patients. It is used throughout the hospital.

- The A&E admission process included the identification of risks to patients; for example, falls and pressure damage. We saw that falls and pressure risk assessments had been recorded, although one falls assessment we examined had not been completed or signed.

Nursing staffing

- We were informed that nursing staff reviews had been undertaken. A&E and MAU were classed as emergency departments, and therefore the baseline emergency staffing tool (BEST) had been used to determine the staffing levels. We found that the outcome of the reviews had highlighted that a significant increase in the number of nurses was required. The trust stated that there had been some inaccuracies in the way in which it had been completed and this is to be reviewed.
- Staff sickness in August was at 7.75%, which was higher than the England average.
- We found, through examination of the staff rota, that if the A&E department was busy, the observation unit was not always fully staffed.
- The ratio of nurses to patients in MAU was 1:5. The baseline emergency staffing tool (BEST) recommends 1:2 or 1:3. Staff in MAU informed us that the acuity of patients had increased, and they felt that there were insufficient staff to care for patients adequately.
- We established that there were nine qualified staff on duty in A&E between 7am and 7.30pm each day, with two healthcare support workers. One of those nurses had the triage duty. We found this to be sufficient whilst we inspected, but lower than the BEST guidelines.
- There was a children's nurse on duty between 9am and 9.30pm. The Royal College of Paediatrics and Child Health had set standards for children and young people in emergency care settings. These included the availability of a qualified children's nurse on each shift. This had not been achieved. There was also no children's nurse on duty at night, and children were seen in the adult A&E area by staff from the adults nursing team.
- To support staffing shortfalls, the service used an internal bank system and agency nurses when required. These staff received an induction to the unit.

Medical staffing

- The Royal College of Emergency Medicine recommends 10 specialist consultants for an A&E department seeing between 50,000 and 80,000 patients per year. This department had three substantive consultant vacancies, and a total of five other medical vacancies in the department.
- The clinical director had recognised that they had 24 hour responsibility for the department, and relied upon staff informing him of important matters.
- At least one consultant was on duty in A&E between 8am and 11pm. Outside of those hours, a consultant was on-call and could reach the department within 30 minutes.
- Of the three vacant junior grades, plans were being discussed to replace them with nurse advanced practitioners (ANPs) in emergency care. ANPs are trained to assess, diagnose, treat and discharge patients.
- At the time of our visit, there was no consultant with a paediatric subspecialty available in A&E. A paediatrician was available on the children's ward when required.
- Use of locum doctors had reduced from 41% over the previous twelve months, to just over 20% at the time of our visit. Information we received from the trust showed that from 1 April 2014 until 2 September 2014, A&E had requested 3,794 qualified doctor shifts. Of those shifts, 3,313 had been filled by agency doctors, many of them at weekends and on night duty; 435 shifts had been filled by the hospital's own bank staff, and 250 had remained unfilled.
- On MAU, junior doctors rotated every week. Nursing staff informed us that there was a degree of frustration about this, because the doctors did not get used to the way in which the ward worked before moving on.

Major incident awareness and training

- There was a major incident policy in place for use by the department.
- Major incident equipment was available and accessible.
- Patients who were contaminated with chemical, nuclear or biological agents (often abbreviated to CBRN) could be treated appropriately.

Urgent and emergency services

Are urgent and emergency services effective?

(for example, treatment is effective)

Not sufficient evidence to rate

Clinical guidance for the treatment of patients with specific needs or diseases was available and being used appropriately by staff. Assessment of pain was undertaken as part of the admission process and dealt with as quickly as possible. Patients present in the A&E department for any length of time were offered something to eat and drink, when this was appropriate and safe to do so.

Patients were confident in staff abilities to deliver high quality care. We saw good team working across disciplines, and staff were trained and supported effectively.

Evidence-based care and treatment

- Protocols were available for some common diseases and needs; however, not all, such as infections (sepsis). We saw the protocols for the management of strokes and major blood loss.
- The use of care bundles or pathways for patients with specific illnesses was not consistent. There were care bundles in place, for example, for patients who had suffered a stroke, although they were not in place for children who had suffered their first fit, for children with a petechial rash (bleeding into the skin), or for patients with a sepsis.
- We found a sepsis pathway in resuscitation, but we were told that it should not be used; the sepsis pathway on the back of the modified early warning (MEWS) chart should be used until a comprehensive sepsis pathway had been devised.
- In our Intelligent Monitoring Report, March 2014, the trust was rated as a 'risk' compared with other trusts in relation to the proportion of cases assessed as having compliance with all nine standards measured within the national hip fracture database. We were informed that emphasis was being put in place for dealing with patients who had sustained a fractured neck of femur.

Pain relief

- We were informed that an assessment of pain was undertaken on a patient's arrival in the hospital as part of the admission process. We observed care, and this mostly supported what we were told.
- One patient we spoke with had not received prompt pain relief and was in distress. They had waited an hour to be assessed by a doctor, and had been given no pain relief. We brought this to the attention of the staff, who responded promptly.
- We did not observe any other patient in pain during our inspection.

Nutrition and hydration

- Patients who were present in the A&E department for any length of time were offered something to eat and drink, when this was appropriate and safe to do so.
- On MAU and the observation ward patients were offered appropriate food and fluids.

Patient outcomes

- The hospital admitted all children and young people under the age of 18 years as per National Institute for Health and Care Excellence (NICE) guidance for those with a history of deliberate self-harm (DSH).
- Unplanned re-attendance rates within seven days ranged from 2% to 4% from April 2014 until July 2014. Patients who left A&E without being seen ranged from around 1% to 2% for the same time period.
- Feedback from the College of Emergency Medicine (CEM) showed A&E had taken part in the consultant sign off audit for 2012/13. Results showed the department was only achieving 86% sign off of patients by a doctor at ST4 grade or above in stipulated patient groups. The England average was 91%.
- Staff informed us that the dependency levels of patients in MAU had risen over the past year. They were concerned that patients who had increased needs were not getting the correct care; for example, when they needed to be moved to intensive care. The manager on the unit was going to take the evidence they had collated on the issue to a meeting, with a view to addressing the problem and improving staffing levels.

Competent staff

- Staff were aware of the trust's guidance for particular illnesses; for example, strokes and pleuritic chest pain.

Urgent and emergency services

- All the nursing staff we spoke with felt competent to undertake their role, and told us that they had opportunities to develop their knowledge and skills.
- Not all staff had received appraisals. Data received showed 48% of qualified nursing staff had received appraisals across the trust.
- Junior medical staff we spoke with told us that they had opportunities for attendance at regular training sessions.

Multidisciplinary working

- We witnessed excellent interaction between doctors and nurses during the inspection.
- Staff in the department informed us that the internal multidisciplinary working (such as between specialties) was generally good.
- There was no rapid pathway for women presenting at A&E with blood loss during early pregnancy. We were informed that this was because the working relationship between obstetricians and A&E needed to be improved. However there is an established pathway for early pregnancy and women are seen in the Rockingham Assessment Unit for direct referrals.
- We were also informed that the reporting of X-rays could be delayed. A policy had been drawn up to correct this, but we were informed that delays still occurred. Liaison between clinical staff and those undertaking CT scans was good, and response times were acceptable.
- Nursing staff reported that patients requiring referral to psychiatric services were generally seen promptly by the crisis team. However, patients who had been treated for a medical condition in A&E were not seen by the psychiatric team until they had been deemed medically fit. This often delayed treatment by personnel who specialised in treating patients with mental health illnesses, and put additional pressure on staff who did not have the relevant experience.
- There were delays in accessing Child and Adolescent Mental Health Services (CAMHS). This was provided by a different trust. This was reported as a concern, with responses to children who attend the department being very slow. This mirrors the evidence seen at similar trusts across the country.

Are urgent and emergency services caring?

Good

Patients felt that they were listened to by health professionals, and were involved in their treatment and care. We saw examples of good caring and compassionate interactions with patients, given in a quiet and dignified manner. We spoke with one relative who felt unsupported by staff.

Patients who walked into the A&E department received a lack of privacy whilst giving confidential information to staff, because of the physical arrangement of the reception area.

Compassionate care

- The A&E Friends and Family Test (FFT) is calculated using the proportion of patients who would recommend the A&E department, minus those who would not recommend it, or who are indifferent. This A&E department scored 55, although the uptake of patients completing the Friends and Family Test was low in A&E. This was above the national average.
- The uptake of patients in the observation ward completing the Friends and Family Test was 80, and almost all comments were positive.
- All the patients we spoke to, in all of the areas we visited, were complimentary of the care they had received, and they had felt respected with regard to their privacy and dignity.
- We saw examples of caring and compassionate interactions with patients, given in a quiet and dignified manner.
- Confidential information could be heard by other people in the waiting area when patients gave details to the receptionists.

Patient understanding and involvement

- We heard and saw staff introducing themselves to patients.
- Patients told us they understood what had been said to them, and had felt informed about their care and treatment options.

Urgent and emergency services

Emotional support

- We spoke with one relative of a young person in A&E who felt very anxious about their loved one, as they had needed to attend A&E in the previous two weeks for the same issue. There was no member of staff available to provide support for the relative at the time.

Are urgent and emergency services responsive to people's needs?
(for example, to feedback?)

Requires improvement

We judged that the A&E department required improvement, as vulnerable people (such as those with an addiction, mental health problem, or a dementia) could be at risk of receiving sub-standard care. There was a lack of joint working with the provider of mental health services which impacted upon the waiting times for people requiring these services.

In the previous quarter, the department had achieved the 95% target for patients being treated within four hours. However, patients were spending longer in A&E than the England average.

Patients we spoke with informed us that they felt they were treated as individuals, and staff had access to translation services through the use of a specialist telephone line. Complaints and concerns were dealt with appropriately, and lessons learned in order to improve patient care. The clinical director met with complainants when it was appropriate to do so.

Service planning and delivery to meet the needs of local people

- The A&E department serves a population of approximately 330,000 across North Northamptonshire, South Leicestershire and into Rutland.
- There were two vending machines in the waiting room, one for drinks and the other for snacks.
- The waiting area in A&E was equipped with metal chairs for patients to sit on. In a report for the trust, undertaken by the disability and sensory impairment working group in April 2014, this had been highlighted as an issue, as patients had complained about it. When busy, there was a lack of space for wheelchair users in the waiting area.
- There was no information provided with regard to waiting times in the department.
- The separate paediatric waiting area had seven chairs. There were a small amount of toys available, but because of the small space, free play was limited.
- The mental health assessment room in the A&E department was being shared by the GP service which meant that potentially at times this facility was not available for those with mental health needs. There was a lack of ownership of this area within the trust.

Access and flow

- An electronic system was in place for tracking how long patients had been in the department, to ensure they were treated in a timely way.
- The number of patients being treated within four hours of arrival had improved, and the department had demonstrated during the previous quarter (April, May, June 2014) that it was now consistently achieving and exceeding the 95% treatment within four hour target.
- However, during our first day of inspection we saw that the department was extremely busy. We were informed that there had been between 27 and 34 breaches on the four hour target every day during that week. We were later informed that this had been partly due to lack of communication with regard to the availability of community beds used for discharging patients.
- The average time spent in A&E per patient was above the England average. An average of 29% of patients attending A&E had been admitted, compared to the average of 23% in other trusts. Staff informed us that they felt the admission delays for patients were due to capacity issues within the hospital.
- The percentage of emergency admissions via A&E, waiting four to 12 hours from the decision to admit until being admitted, had reduced to below the England average since February 2014.
- An intermediate care team worked with the observation ward, to aid safe discharge of elderly patients.

Meeting people's individual needs

- Patients we spoke with felt they were treated as individuals in their own right.
- We did not see any printed information for patients in any language other than English. A language line telephone service was available when required.

Urgent and emergency services

- We saw documentation to assist staff helping people with a learning disability. This included a support risk assessment, and a care plan pro-forma, with mention of the trust's 'Helping Me in Hospital' booklet given to their carer to complete.
- A report from the local voluntary groups highlighted that care for people living with a dementia had been below the expected standard. The trust had a care bundle in place for caring for patients with a dementia.
- We spoke with members of staff about their ability to help patients living with a dementia. We found that there were no designated dementia champions for A&E, MAU or the observation ward, and dementia training had only been delivered to 25% of staff in A&E. This meant that dementia care and understanding required improvement.
- The voluntary group report also stated that alcohol users were not treated with dignity or respect and were often 'looked down' upon. We found that the free telephone service in A&E for drug and alcohol support services had been disconnected, and therefore was not available. There was also no signposting or leaflets available in A&E for patients with addictions.

Learning from complaints and concerns

- Information leaflets about how to make a complaint were available in A&E, MAU and the observation ward, although they were not highly visible for patients.
- The clinical director of emergency care informed us that they preferred to meet with patients who had concerns; this had not been done on a regular basis until their appointment in April 2014.They had found this beneficial to both parties, and lessons had been learned from the meetings.
- Complaints and serious incidents, with any lessons learned from them, were discussed at clinical governance meetings in the department.

Are urgent and emergency services well-led?

Good

The service was well-led. Local leadership in A&E had changed over the previous six months, and staff were supportive of the new management structure. They felt empowered, and told us that morale had improved; however, the cascading of information could be enhanced.

Staff were proud of their work, and were willing to speak to us openly during the inspection. We saw that a good rapport existed between all levels of staff during our visit, and there was good leadership from the lead nurse and clinical director.

Staff informed us that there was an open culture, with the sharing of complaints and incidents. Due to this open environment, lessons were learned, and practices changed as a result.

Vision and strategy for this service

- The senior leadership team in A&E informed us that they had five clear strategic objectives for the department. This included improving the quality of care, and ensuring that the streaming of patients, at point of access to the department, was improved. However, we spoke with staff in the department who were not aware of these objectives.
- The lead clinician, nurse and general manager were pleased with what they had achieved over the previous six months. This was evidenced when speaking with staff, who stated that they now felt supported in the work they did, and felt the 'blame culture' had disappeared.

Governance, risk management and quality measurement

- We asked staff if or how they would raise issues about safety concerns or poor practice in their department. All staff we spoke with told us that they felt confident taking any concerns to their line manager, and knew that they would be dealt with promptly.
- There were structured emergency department meetings in place: operational meetings were held weekly, and quality assurance meetings were held on a monthly basis. In addition, mortality/morbidity meetings were held bi-monthly.
- A&E's local risk register included capacity in the department, number of employed medical staff (including the identification of a paediatrician) , and care of patients with fractured femurs.

Urgent and emergency services

Leadership of service

- A good rapport existed between all levels of staff. We were able to see this during our visit.
- The lead nurse informed us that they had developed a good relationship with the lead clinician and the business manager for the entire emergency department. They worked together and met/spoke with them on a regular basis.
- We spoke with a range of staff in the department. They were knowledgeable about the services they delivered, and proud to work in the department. They all stated that leadership had improved, and that they felt supported in all aspects of their work.

Culture within the service

- Staff we spoke with told us that they felt very well supported by their managers, who had open door policies and who were always approachable.
- Routine management of patients in A&E was devolved to a nurse on shift, who took charge of one of five areas of treatment.
- Staff informed us that there was an open culture, with the sharing of complaints and incidents.
- Discussions were held on lessons learned from complaints and incidents, and practices changed where appropriate.

Innovation, improvement and sustainability

- The manager on MAU had worked with the pharmacy team to develop a learning package for the ward team, following concerns about the number of critical medicines that had been administered late, such as insulin, and drugs for controlling Parkinson's disease. The package was going to be rolled out to staff at an 'away day', and included a questionnaire. If successful, this initiative would be rolled out trust-wide.

Medical care (including older people's care)

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

Information about the service

Kettering General Hospital's medical care service has 12 wards, including cardiology, haematology, gastroenterology, stroke care, respiratory care, care of the elderly, an ambulatory care unit (in the Emergency Department), and a discharge lounge. The trust had commenced a new and innovative programme to become an Academy of Gerontology Excellence (AGE), with the introduction of the trust's AGE programme. The trust has recently opened the new cardiology unit, comprising of the cardiology ward and the coronary care unit (CCU). The cardiac ward has 14 beds and CCU has 12 beds. The cardiac centre also provides three catheter laboratories, to provide a 24 hour primary percutaneous coronary intervention service (PPCI). There are four wards for the care of the elderly, each having 20 beds. The two gastroenterology wards (one male and one female) both have 22 beds. The trust has a new acute stoke unit (ASU) within the stroke care ward, and an added stoke rehabilitation ward. Nephrology services are delivered by visiting consultants from the University Hospitals of Leicester and Northampton General Hospital.

During our inspection, we visited all ward areas and the ambulatory care unit, and spoke with 54 patients, 72 staff, and 10 people visiting relatives. We also looked at the care plans and associated records of 40 people. We carried out an unannounced inspection in the evening and visited two wards.

Summary of findings

The medical care service required improvement as staff training was variable, and not meeting the trust's targets in most areas. There were not always reliable systems in place to ensure that all people were monitored effectively, and some documentation was poor. Some people's care plans were not effective in providing guidance to staff as to how to safely provide the care and treatment to meet patients assessed needs.

The service was addressing concerns regarding staffing levels, staff skill mix, and monitoring the condition of deteriorating people. Staff recruitment was in progress to fill staff vacancies. All wards had introduced clearer systems for sharing information about the ward's performance with staff and visitors. The medical care service had higher falls rates and development of pressure areas than the trust targets. People we spoke to were, in the majority of cases, very complimentary about the staff and the care they received. Staff felt well supported at a ward level, but not all staff had a clear understanding of the board's vision and strategy.

Medical care (including older people's care)

Are medical care services safe?

Requires improvement

We found that the medical services required improvement as numbers of nursing staff were variable, and staff generally said that they felt pressurised, due to high patient dependencies. The hospital was not meeting the trust targets in providing harm-free care for patients for avoidable pressure areas, the percentage of patients having a fall, and the number of patients having a risk assessment completed for blood clots.The introduction of the performance boards across the wards was seen as a positive measure by staff, but not all staff were fully aware of the significance of the issues reported on them. Incidents were reported, but staff teams were not consistently aware of what preventative actions could reduce the risk of harm to people. The storage of medicines was not robust. Regular audits were being carried out on the main risk areas. Staff training was variable across the wards, and only two out of 10 targets for training completion across the service had been met, as of July 2014. We found variable record keeping with regard to people's observations. The systems for storing medicines were not appropriate on some wards.

Incidents

- There were 44 serious safety incidents between April 2013 and March 2014 in medical care wards, of these 17 were due to slips, trips and falls, and 17 were due to the development of grade 3 pressure ulcers.
- From May 2013 to May 2104, there were 344 incidents reported of pressure ulcers above grade 2 or higher; this was slightly higher than average for trusts of a similar size.
- From May 2013 to May 2014, there were 189 falls reported, and 133 reported incidents of catheter-acquired urinary infections.
- In May 2014, the medical care service reported 311 incidents, out of the trust total for the month of 736. For June 2014, there were 369 incidents in the service, out of the trust total of 860 for that month.
- Some staff were able to tell us of how people's falls were investigated, and what plans were in place to reduce the risk of further falls. However, not all staff across the medical care service had an understanding of falls prevention, other than to refer to the trust's falls advisory nurse. We saw some evidence that movement sensors or alarm mats had been used as a potential measure to reduce the risk of falls, but staff told us that the effectiveness depended on how quickly staff could respond to the alarm mat sensor sounding, particularly at night.
- Staff told us how incidents were recorded and reported via the trust's computerised 'Datix' system. Most staff told us that they had had feedback about the incidents, but some staff told us that they did not know what happened to the reported information. Learning from incidents in other areas was not always shared across the trust.
- Senior staff told us that general feedback on patient safety information was discussed at ward staff meetings, and that patient safety information was displayed on ward performance boards.
- Patient safety information was collated and audited, and feedback was given to ward teams on a monthly basis.
- Senior staff were aware of the monthly integrated governance reports, which included quality, safety and performance indicators, but not all junior staff were able to tell us about these reports.

Safety thermometer

- The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing harm to people and 'harm-free' care. Monthly data was collected on pressure ulcers, falls and urinary tract infections (for people with catheters), and blood clots (venous thromboembolism, VTE).
- In the trust's integrated governance report for June 2014, medical wards reported over 93% compliance with blood clots (VTE) risk assessments being completed on admission, which was below the trust target of 98%. For June 2014, the percentage of VTE risk assessments completed on admission had risen slightly to nearly 96%, which was still worse than the trust target of 98%.
- In the trust's integrated governance report for June 2014, medical wards reported that there were 18 falls with harm, out of the trust total of 23 for the month of May 2014. For June 2014, there was a slight increase in falls with harm, to 20 (out of a trust total of 30).
- The rate of falls with harm per 1,000 patients in the medical wards was 4% in June 2014, which was worse than the trust target of 3%.

Medical care (including older people's care)

- The incidence and timing of falls was being monitored on all wards, and some wards had extended visiting times, so that visitors would be able to spend more time with their relatives in the afternoons, which was a peak time for falls on these wards. Certain wards had a higher than expected falls rate, such as one of the respiratory wards; and senior managers and nurses were aware of the concerns and were exploring actions to minimise the risks.
- There was no grade 3 or grade 4 pressure tissue damage reported in the month of May 2014.
- In the trust's integrated governance report for June 2014, medical wards reported that there were eight new cases of hospital-acquired grade 2 pressure ulcers in May 2014. This was worse than the trust target of four cases per month.
- There were six cases of new hospital-acquired grade 2 pressure ulcers reported in June 2014, and two cases of grade 3 pressure ulcers in this month.
- For May 2014, medical wards showed 95% compliance with Waterlow pressure area risk assessments, which was above the trust target of 90%. Compliance with the Waterlow risk assessment had dropped slightly for June 2014 to 93%, but this was still above the trust target of 90%.
- The percentage of patients experiencing pressure tissue damage was 2% in June 2014, which was worse than the trust target of 1.4%.
- Not all staff were able to explain clearly what actions were being taken to prevent pressure ulcer development.

Cleanliness, infection control and hygiene

- Wards and communal areas were visibly clean and odour free. Personal protective equipment (PPE) was available in all areas for staff to use. All wards had antibacterial gel dispensers at the entrances and by people's bedside areas. Appropriate signage, regarding hand washing for staff and visitors, was on display.
- All wards that we visited had facilities for isolating patients with an infectious disease, and we saw appropriate signage on people's doors to indicate that barrier nursing was in place.
- Generally, cleaning schedules had been completed as required.
- Housekeeping staff told us that there were sufficient supplies of cleaning materials available to use.
- Personal protective equipment was available for staff to use, but the trust had not provided latex-free disposable gloves for staff to use.
- We did note that one cleaning trolley was left unattended in ia ward area for 10 minutes, but it was in line of sight of the nurses' station.
- Staff followed universal infection control procedures when we carried out observations.
- One case of hospital-acquired C.difficile was reported for the medical care wards for May 2014, out of a trust total of two cases. This had risen to three cases in June 2014, out of a trust total of four cases. No new cases of MRSA have been reported since August 2012.
- There had been one case of meticillin sensitive staphylococcus aureus (MSSA) during the month of May 2014, which was been attributed to the CCU. This was the first hospital-attributed incident in many months, and an investigation had been completed, which the infection control team were currently reviewing. No new cases were reported in June 2014.
- In the trust's integrated governance report in May 2014, medical wards scored 97% compliance with hand washing audits against the trust-wide target of 95% compliance, and this improved to 99% compliance in June 2014.
- However, we observed poor hand hygiene at lunch time on one of the wards we inspected. Staff served food without washing their hands, and patients were not given the opportunity to clean their hands prior to eating their food.
- We observed one member of staff blowing on a patient's food to cool it down, prior to helping the person to eat it.

Environment and equipment

- A water leak in the ceiling of the discharge lounge was attended to promptly during our inspection. The leak was caused by a faulty toilet in the area above the lounge.
- There were systems to maintain and service equipment as required. Firefighting equipment had been checked regularly. Hoists had been serviced regularly. Portable electrical equipment had been tested regularly, to ensure it was safe for use.
- Side wards used for patients who were at risk from falling were not always visible to the majority of staff.

Medical care (including older people's care)

- Senior doctors reported that the hospital's main building had inadequate ventilation systems. Senior staff reported an inconsistent response from the trust's estates management team, and some staff said that this may due to financial considerations.
- The room temperature in the ambulatory care unit was very warm on both days of the inspection, and whilst there were plans to install air conditioning in this area, there were no clear timescales for this to happen. Room temperatures were not being recorded. Staff were using fans to keep people cool. On the second day of inspection we noted that appropriate shelving units were being installed in the treatment room, to address concerns about adequate work spaces for infection control when preparing dressing packs for use. This had been placed on the area's risk register.
- We noted on some wards that sluice rooms were not always lockable, but staff were aware of the potential risks if people with cognitive impairments went into these areas.
- There were gaps in the required daily check records of resuscitation equipment on some wards. The resuscitation trolley in the ambulatory care unit had not been recorded as having been checked twice in the previous 12 days. On another ward, the resuscitation trolley had not been recorded as checked for 11 days in June, seven days in July, and three days in August 2014.
- We also found that whilst the trust had installed thermostatic valves on hot water pipes to restrict temperatures to no more than 43°C, and that these were routinely checked by the trust's estates management team, the trust had made no provision for staff to be able to check the hot water temperature each time they ran a shower or bath. Senior nurses confirmed that there were no water temperature thermometers available for staff to use. This was brought to the attention of the trust's senior management team.
- The trust had appropriate systems in place to manage the risk from water-borne viruses, and regular tests had been carried out.

Medicines

- All wards had appropriate storage facilities for medicines, and generally had safe systems for the handling and disposal of medicines.
- On one care of the elderly ward, we found that the medicine store was not clean. The ward had not rectified this on our second visit, so this concern was again reported to the senior nurse on duty.
- We found on another ward that six out of forty one medicines were beyond their expiry dates, including an antibiotic medicine. We also found in the same ward that one out of 11 items checked in the fridge was beyond its expiry date. This could potentially reduce the effectiveness of the medicine.
- On most occasions, we saw that medicines were stored safely. However, when we asked a junior staff member on one care of the elderly ward where the medicines were stored, we were given the key to the medicines store, including the key to the controlled drugs cabinet. This was not in accordance with trust policy for the safe holding of medicines keys.
- In the ambulatory care unit, we found that there were no systems in place to monitor the room temperatures where medicines were stored, and we found that some of the controlled drugs in use needed to be stored below 25°C. Intravenous fluids that needed to be stored below 25°C were also being stored in a room where the temperature was not being monitored. We also found that the temperature of the medicine fridge was not being recorded. We brought this to the attention of the nurse in charge, and when we returned the day after, we found that the trust had taken action to ensure that both room temperatures, and fridge temperatures where medicines were stored, were now being recorded.
- We looked at the medicine records for six people, and found that on one occasion a steroid medicine prescription had not been signed by the doctor, so the nurses had not given it. Generally, medicine charts had been completed accurately.
- Medicines reconciliations were carried out on peoples' admission. The trust's audit data in the integrated governance report for June 2014 showed that 66% of patients had a medicine reconciliation carried out within 24 hours of admission, against the trust-wide target of 53%. The National Institute for Health and Care Excellence (NICE) and the National Patient Safety Agency (NPSA) joint recommendation in 2008 details the target as 95% completed reconciliations, with 90% completed within 24 hours of admission. The trust was

therefore meeting its own target for reconciliations' completion, but not meeting the national advisory target for completion. This had risen to 58% compliance for June 2014.

- In the integrated governance report for May 2014, medical wards reported that 10% of patients had medicine doses omitted without a documented reason. This was below the trust target of 16%. For June 2014, this had risen significantly to 21%, and the number of critical medicines omissions was 9%, above the trust target of 6%.
- In the integrated governance report for May 2014, medical wards reported four medication incidents resulting in harm to patients, which was above the trust target of two per month. The trust was working to improve administration protocols and staff awareness. The number of incidents resulting in harm had risen to five in June 2014.
- Medical wards reported 38 medication incidents or 'near miss' incidents in the month of May 2014, out of a trust total of 80 such incidents. Trends for these incidents were omissions, incorrect doses being given, and a lack of clear documentation around controlled drugs medicines that patients were admitted with.
- Staff said they had had relevant training, and that their competencies for medicine administration were assessed regularly.
- We observed staff administering medicines to patients in a safe and appropriate manner. On one ward area we found medicines being stored at the wrong temperature. The medicines fridge was not being monitored as closely as it should have been, and attention had not been paid to expiry dates.

Records

- Senior staff said that the computerised records system was not effective, and made it difficult to access records from other services and other trusts. Nursing staff told us that the trust did not have firm timescales for moving from paper-based records to an electronic record-keeping systems.
- We looked at the documentation kept to record peoples' vital signs observations, fluid balance charts, food intake and repositioning charts. We found inconsistent recording on some of the wards that we visited.
- We also found that staff had not always calculated the national early warning score (NEWS) when required. Observations of vital signs had been taken, but the total score had not always been recorded. For example, on one person's chart, the total NEWS score was not recorded on three occasions in a seven day period.
- On one ward, we found that patient electrocardiogram (ECG) records had not been reviewed or signed by a doctor on seven occasions for five sets of patients' records that we looked at.
- For some people's fluid balance charts, the daily total had not been calculated to give an indication of how much fluid they had had that day.
- We looked at the notes for four people on a stroke ward, and found that two people had gaps in their nutrition records.
- On one ward, we looked at the hydration records for nine people, and found that the recording of what they had to drink was not clear for all nine people. Some charts did not have daily totals calculated, others had gaps, and others did not specify the amount of fluids taken.
- We noted that not all updates and amendments to nursing risk assessments and care plans had been dated or signed, so it may have been difficult to check who had made the entry if required.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We found that staff understanding and awareness of assessing people's capacity to make decisions about their care and treatment was variable. Some assessments correctly recorded specific decisions and the reasons for the judgement made, whilst others did not. The involvement of family members or people's representatives was only recorded in a minority of cases.
- In one case, we saw that a Deprivation of Liberty Safeguards (DoLS) assessment had been authorised six weeks previously on a different ward, yet the rationale for this authorisation was not clear. The staff on the patient's current ward had identified this as an area of concern, and arranged for the DoLS authorisation to be reviewed during our inspection.
- Nearly 83% of medical ward staff had completed the training event for Mental Capacity Act awareness and DoLS awareness, as of July 2014, which was below the trust target of 85%. Staff told us that they had had training sessions regarding DoLS, and that this had met their training needs in this area.

Medical care (including older people's care)

Safeguarding

- Adherence to safety and safeguarding systems and procedures was monitored and audited on a risk basis, and necessary actions were generally taken as a result of findings.
- The trust generally takes a proactive approach to safeguarding, and focused on early identification, so that people are protected from harm, and children and adults at risk of abuse do not experience abuse.
- There were effective safeguarding policies and procedures, which are fully understood and implemented by staff, including agency and locum staff.
- The trust had a safeguarding lead for the hospital. We found that there was effective multidisciplinary communication with safeguarding leads in other organisations, and all referrals and concerns were triaged by the local safeguarding authority. Staff told us that this worked quickly and efficiently to safeguard people from harm.
- We found that the majority of safeguarding investigations were carried out within the target timescale of 28 days, and we saw evidence of effective protection planning to keep people safe, apart from discharge planning. Monthly reports were produced on safeguarding activity for senior managers.
- The commonest theme for safeguarding referrals regarding the hospital concerned poor communication by hospital staff, especially with reference to discharge planning, with a significant number of notifications in the past year regarding poor discharge planning from a variety of wards.
- Staff told us that the trust's target for staff safeguarding training was 85%, and that 86% of staff had had safeguarding adults training, and 86% had had safeguarding children training, as of July 2014.
- The staff we spoke to demonstrated an understanding of the signs of abuse, and how to raise concerns. Staff were able to tell us about the trust's whistleblowing policy, but not all staff said they would be confident in using it.
- The local safeguarding authority had implemented a safe discharge protection plan for the hospital, following a safeguarding strategy meeting on 17 January 2014. We were told that the protection plan was still in place, and being monitored by the trust; however, we found that not all staff involved in discharge planning were aware of this protection plan, including some of the senior managers for the medical wards. This presented a risk, in that not all staff were aware of the risk areas in the protection plan, and what actions should be taken to reduce further incidents.
- There were three safeguarding investigations being completed by the trust, at the time of our inspection, for alleged unsafe discharges in August 2014.
- There were also two ongoing whistleblowing investigations being carried out regarding staffing levels and staff attitudes.

Mandatory training

- Staff told us that they had had mandatory training events annually, which included infection control, moving and handling, and health and safety. Some staff told us that at times, covering the wards took priority over training.
- A dementia awareness session (Tier 0 training) was included in the mandatory training days, and some staff had also completed the managing conflict training offered by the trust. Not all staff were aware of whether the trust provided restraint or managing challenging behaviours training. Additional dementia awareness training (Tier 1) had been provided to some staff, to enhance the basic training, but this was not mandatory training for staff.
- For July 2014, we found that only 76.5% of staff on medical wards had attended manual handling training, which was below the trust target of 85%.
- Of the medical ward staff, 82.7% had completed the training event for Mental Capacity Act awareness and DoLS awareness, as of July 2014, which was below the trust target of 85%.
- For July 2014, medical wards staff did not meet the trust target of 85% compliance with infection control and hand hygiene training, as only 74.9% of staff had had this training.
- For July 2014, we found that only 75.1% of staff on medical wards had completed risk management training, which was below the trust target of 85%.
- For July 2014, we found that only 74.9% of staff on medical wards had completed fire safety training, which was below the trust target of 85%.

Medical care (including older people's care)

Assessing and responding to patient risk

- In the trust's integrated governance report in June 2014, medical wards scored 90.9% compliance with correctly calculated national early warning score (NEWS) audits, which was below the trust-wide target of 98% compliance.
- The trust did not have clear protocols for identifying and managing the risk of sepsis for patients. Some staff did not know of any trust protocols, whilst others told us that it was part of the NEWS documentation records.
- However, when we looked at the observation charts for 16 people, we noted that whilst most had been completed, there were gaps in one person's records, which may indicate that this person's observations had not been completed at the time frequency specified, and that the NEWS score had not been completed.
- Another person had last had their NEWS score taken at 2am, and had a score that triggered escalation for a doctor's review; however, there was no record in either the nursing or doctor's notes that the patient had been reviewed by a doctor.
- Two other patients' NEWS charts had an eight hour gap during the night, with no documented reason why the four hourly observations were not carried out.
- We looked at one person's care plan records on one of the care of the elderly wards, and found that the Malnutrition Universal Screening Tool (MUST) had not been done for six days since admission to the ward, and this person had a pressure area, as well as very poor fluid and food intake. The NEWS score had also triggered a doctor's review, but it had not been documented in the notes as to whether a doctor had reviewed the patient. We raised the concerns with the senior nurses and returned later that day, and found that the ward had taken immediate action to address these concerns.
- In the care of the elderly wards, we saw that the majority of beds did not have protective bumpers in place for the use of bed rails. We also saw, on an evening inspection, that three people, whilst they were on low beds to minimise the risk of falls, did not have protective crash mats on the floor next to their beds.
- On the same ward, we noted that one patient was left unattended for over 30 minutes whilst calling out for assistance, as they were in an uncomfortable position, with one of their legs pressed against the uncovered bed rails. The staff on duty were busy attending to other patients at this time. We brought this to the attention of staff, who responded immediately.
- We also observed one patient becoming verbally and physically aggressive to two staff whilst having personal care. Whilst the staff provided appropriate care with calm and sensitivity, we found that although this person had a diagnosis of dementia, there was no 'Patient Passport', and no care plans in place to give staff guidance as to how to manage difficult behaviours. Staff said this behaviour was common, and that the patient should have had behavioural charts completed, but these had not been done.

Nursing staffing

- The average bed capacity for the trust was 95%, which was above the national average for similar sized trusts, and indicated the demands placed on bed availability. Ward matrons told us that the trust used a safer staffing matrix to report and escalate any areas where staffing levels may pose a risk to patient safety.
- The ambulatory care unit normally had two qualified nurses and a health care assistant (HCA) on duty, and the planned treatment unit for medical day case patients normally had two trained nurses throughout the day. Average patient flow was up to 25 patients a day. The staff we spoke to said that usually staffing levels were adequate, but it depended on the number of patient referrals at any given time. Staff were aware of escalation protocols if required.
- The gastroenterology wards had a nursing rota of three qualified nurses and four HCAs in the mornings, with three qualified nurses and three HCAs in the afternoons, reducing to two qualified nurses at night, with two HCAs. For 22 patients, this gave a qualified nurse to patient ratio of just over 1:7 in the mornings and afternoons, reducing to a ratio of 1:11 at night. Staff said this was not always sufficient to be able to meet patient's needs fully if there were high dependency levels in the ward. The gastroenterology wards had had recent incidents whereby patients were aggressive and no security service was available during the day to support nurses in case of such an emergency. Two new assistant practitioners had been appointed, and were waiting to start to fill two out of the three new posts created by the trust, to support with effective discharge planning.

Medical care (including older people's care)

- Staff considered the skill mix on the gastroenterology wards of 50:50 qualified nurses to HCAs was not adequate to meet the needs of a potentially volatile mix of patients in the wards, given that some patients would have substance misuse concerns or cognitive impairments. This concern had been escalated to senior managers, and had been placed on the wards' risk register.
- On the day of our inspection, one gastroenterology ward had only three HCAs, not four, on duty in the morning. Senior nurses would carry out a risk assessment if the ward was short staffed, and try to cover shifts with bank staff or agency, but this was not always effective. This ward was on an 'Amber' alert due to reducing staffing levels, and this had been reported to senior managers. Wards used a Red/Amber/Green rating to reflect their actual staffing levels.
- On our evening inspection, we found that the two qualified nurses and two HCAs on one of the care of the elderly wards had to support 20 patients with personal care tasks and going to bed; as the qualified nurses were giving out medicines, this left the two HCAs very busy, and not always able to respond quickly to other patient's needs. The staffing levels on the ward at this time of the evening did not meet the needs of the patients, given that most patients were living with a dementia, and some needed support for all activities of daily living.
- Staff told us that at times, the trust required staff to work on different wards if there were staffing shortages elsewhere; not all staff felt confident about working on unfamiliar wards, but most understood the need to maintain safe staffing levels across the entire hospital.
- In the discharge lounge, the planned staffing levels were one qualified nurse and three HCAs, but on the day of the inspection, there were only two HCAs. This would not normally present a concern, unless there were a large number of referrals into the lounge for discharge. Staff knew how to escalate staffing concerns.
- Whilst the majority of people said that they did not have to wait for staff assistance, two people told us that staff did not answer call bells quickly, and one person said that it can take the staff up to 15 minutes to answer the bell at busy times.
- We observed a morning handover between staff on one ward, and we saw that printed handover sheets were used, which listed people's conditions and treatment. Some staff gave detailed handovers, included the person's co-morbidities, but other staff gave a perfunctory verbal handover that did not give all the required information.
- Some wards had seen an increase in staffing levels following our last inspection; however, not all wards had increased staffing levels; we were told that staff were being recruited to complete the staffing complement, and that then the staffing levels would be increased. A patient acuity tool was being used by the trust to review nursing staffing levels required. This was currently being used for two weeks on the care of the elderly wards, particularly to assess staffing levels required during the night.
- The staff to patient ratio ranged from 1:6 to 1:8 during the day, and 1:10 at night on different wards. Some staff told us that there was enough time to attend to people and to sit with them when needed, whilst other staff said there was not enough time and that they were "always busy".
- The staffing skill mix for qualified nurses to healthcare support workers (HCA) varied from ward to ward. Most wards had a skill mix of 50:50, with a patient to qualified nurse ratio of between 1:6 to 1:8.
- Some wards reported higher than average staff vacancies and sickness, and were reliant on bank staff and agency staff to maintain staffing levels. Staff told us that they tried to use the same staff, so there was consistency in the level of care for people.
- The trust was publishing safer staffing data on its website, and made it available on performance boards in ward areas. For July 2014, only two out of 11 wards had an average 100% cover for qualified nurses for the month during the day. For the same period, only three wards were fully staffed for HCAs on average for the month. At night, all wards had 100% average for HCA staff cover, and only two wards did not meet the 100% average cover for the month for qualified nurses. One of the care of the elderly wards only had an average qualified nursing staff cover for July of 76.3%. Senior managers were aware of this issue, and were taking steps to address issues on that ward.
- Some staff told us that there were more agency nurses on duty at night than during the day.
- The newly employed staff we spoke with told us that they had had a good induction, and that there was effective support in this process.

Medical care (including older people's care)

Medical staffing

- Doctors said that during the evenings, the hospital had five junior doctors on the out-of-hours rota, and eight or nine at the weekends. The critical care outreach team provided support to wards until 8pm.
- Doctors said that there was no dedicated 'hospital at night' team for doctors, and that there were no formal face-to-face handovers between day and night doctors. Doctors were reliant on lists of patients, with their treatment actions required, from each ward area.
- There were 53 doctor vacancies across the trust, and these were being filled by locums.
- Ward matrons expressed concern about the level of doctor cover at night and at the weekend, and said "they are stretched at the moment. But it is better than a year ago".
- During the daytime, doctors told us that the level of doctor cover was generally sufficient to meet patient needs. For example, the gastroenterology wards had four full time and one part time consultant, and each day, usually had two junior doctors and two senior doctors, although some of these attended clinics, so at times, there was a lack of junior doctors on the wards.
- The ambulatory care unit had a consultant based in the unit from 10am to 6pm, five days a week, and used the on-call service at weekends.
- Out-of-hours cover was provided by the hospitals on-call rota of doctors, who were from all types of different medical specialisms.
- Staff told us that not all wards had doctors working on them out of hours, and would therefore be reliant on the doctors' on-call system.
- Some staff on the care of the elderly wards told us that there were usually more doctors on the other wards.
- Staff told us that consultant cover was good during the working days in the week, but that consultant cover, out of hours and at weekends, was variable.
- Some wards reported that the doctor's cover rota was reliant on the use of locums.
- The medical handover that we observed was efficient, and there was effective communication displayed regarding people's conditions.
- A doctor we spoke to said that their induction was "very good" and that there was excellent support from senior doctors.
- The majority of people we spoke with said that when they needed to, they saw a doctor quickly.
- Doctors told us of a lack of consultant cover at nights for some specialities.
- Some senior nurses said that there was a lack of junior doctors on the wards at times.

Major incident awareness and training

- The provider had plans in place to manage and mitigate anticipated safety risks, including changes in demand, disruptions to staffing or facilities, or periodic incidents, such as bad weather or illness.
- Senior staff told us that the trust had business continuity plans in place, and had systems and processes in place, to be able to respond to major incidents.
- The trust had made available its business continuity plans on its internal computer system, for staff to access, but not all staff we spoke with were aware of this.
- Staff were aware of emergency protocols and fire safety risks. Staff told us that fire drills were carried out routinely.
- We found that for July 2014, 77.2% of staff had completed fire safety training, which was below the trust target of 85%.

Are medical care services effective?

Requires improvement

Care was generally provided in line with national best practice guidelines, but the trust did not participate in all of the national clinical audits they were eligible to take part in. Performance and outcomes did not meet trust targets in some areas. Not all trust polices were reviewed regularly. The trust did not have clear protocols in place to manage the risks of patients developing sepsis. There was evidence of progress to providing seven day a week services, but this had not been consistently achieved across the medical care service. Most staff said they were supported effectively, but there were limited opportunities for regular supervisions with managers. The medical care service was below trust targets for staff appraisals. Care planning effectiveness was variable, and care plans were not generally person-centred.

Evidence-based care and treatment

- Staff carried out accurate, comprehensive assessments, which covered most health needs (clinical needs,

mental health, physical health, and nutrition and hydration needs), and social care needs. They developed care plans to meet some identified needs. People's care and treatment was mostly planned, and delivered in line with evidence-based guidelines.

- Both the stroke and cardiology wards administered care in line with national (NICE) guidelines.
- The cardiology wards had effective systems in place for assessment of patients' needs, and followed clear protocols for medical procedures.
- The ambulatory care unit had 15 care pathways in place for staff to follow, including managing atrial fibrillation (a heart condition), pleural aspiration, needle biopsy and cellulitis, but they did not all refer to relevant NICE guidance, and these pathways did not have an implementation date, or the name of the author. However, the patient information leaflets did show the implementation date, and some gave references to the relevant NICE guidelines; for example, the patient leaflet for a 'first seizure'.
- The trust did not have clear guidelines in place to follow regarding the recognition and management of patients with sepsis (a potentially life-threatening condition). The trust did not provide sepsis boxes to wards, for staff to use, to provide immediate antibiotic treatment in suspected sepsis cases. Some staff were not able to tell us how the signs of sepsis were monitored, whilst others told us that the trust's NEWS scorecard did have a section for staff to use for cases of suspected sepsis. The trust did not have defined trust-wide policy regarding sepsis, but the antibiotic policy, dated 26 August 2014, did give some guidance on the management of sepsis.
- We found that whilst the trust did have acute kidney injury (AKI) guidelines, dated 18 July 2012, they had not been reviewed on the due date of 17 April 2014, and should have been updated, according to recent information sent by the NHS to all trust medical directors this year.
- The trust was in the process of introducing a dementia care bundle with holistic assessment of people living with a dementia.
- For four patients living with a dementia, two did not have clear care plans in place for staff to follow to meet their needs. ,Patient Passports, had not been completed.
- Generally, for all care plans we looked at, they were not person-specific, were task-oriented, and did not always reflect the holistic needs of the patients.

Nutrition and hydration

- The trust had a nutrition team to improve care for patients with complex feeding issues. The team consisted of staff involved in all aspects of supported feeding, such as parenteral (intravenous tube feeding) and enteral (tube feeding into the stomach). It included a clinical nurse specialist, a dietician, and a specialist pharmacist, and was led by a consultant gastroenterologist. The team helped support trust staff in dealing with complex cases, and advised on the individual cases themselves. Every year, some 300 patients needed supported feeding of some kind. The nutrition team acted as expert advisers to the wards and all departmental staff, to aim to support all patients who needed this type of help.
- The nutrition team also provided advice and guidance for relatives of patients, so that they can be well supported at home once they are well enough to go home.

- At one handover we observed, there was no mention of people's risks of dehydration.
- We also observed on this ward that a patient was given their breakfast on a brown tray, when their care plan stated that a red tray was to be used, to indicate that this person was at risk of malnutrition. We also observed that the tray was left with the patient, and no staff came to assist them to eat their food, despite the care plan stating that they needed assistance.
- We observed that patients who were nutritionally at risk, or required help with eating and drinking, had their meals served on a red tray.
- We observed patients who required support with eating their meals. One person waited for twenty five minutes before a member of staff came to assist them to eat their meal.
- Mealtimes were protected within the ward areas we inspected. This meant that patients could eat their meals without interruption, and staff could focus on providing assistance to patients who were unable to eat independently.
- We observed that the detailing of nutritional intake and fluids was not always accurately recorded within patient's records.
- When we spoke to patients about the food served at the hospital, one person told us "the food leaves a lot to be desired". Another person said "the food is excellent with choices as well".

Medical care (including older people's care)

Patient outcomes

- The trust had an effective system for monitoring patient 'free from harm care' that was delivered in each ward area, and monthly feedback reports were cascaded to staff. The main performance issues and safety risks information were displayed on the wards' performance boards.
- In the integrated governance report for June 2014, the trust reported that its hospital standardised mortality ratio (HSMR) was 83% for March 13 to February 2014, which was better than the national target.
- The trust participates in the Sentinel Stroke National Audit Programme (SSNAP), and for the period October to December 2013, the trust was amongst the worst nationally for the audit results. However as the hospital is not an admitting hospital two domains have been removed from the audit.
- For the care of patients who had had a stroke, the trust reported, in the integrated governance report for June 2014, that 77% of patients who had had a transient ischaemic attack (TIA) had been seen within 24 hours, which was better than the trust target of 70%.
- The trust also reported for the same period that 87% of patients who had had a stroke were treated on the designated stroke ward for 90% of their hospital stay. This was better than the trust target of 80%.
- The heart failure audit for 2013/13 showed that the trust performed better than the national average in nine areas, and slightly worse than the national average in two areas.
- The trust did not participate in the Myocardial Ischaemia National Audit Project (MINAP) audit for the years 2011/12 and 2012/13.
- Data from the year 2012 to 2013 demonstrated that the trust performed better than the national average for people with nSTEMI (a common type of heart attack) being seen by a cardiologist, and for those people who were referred for or had angiography.
- Also, for the same period, the hospital performed better than expected against the national average for those people with nSTEMI who were admitted to a cardiac ward. The quicker a person is admitted to a cardiac ward, the better their prognosis would be.
- In the integrated governance report for May 2014, the trust reported that the number of patients with a urinary tract infection for medical wards was 13.4%, above the trust target of 5.2%. However, this data did not differentiate between patients that had been admitted to the hospital with a urinary tract infection, and those that developed one whilst in hospital. The trust was undertaking further work to analyse this information, and determine trends for relevant specialties. For June, the number had fallen slightly to 11.4% of patients with a urinary tract infection; however, this was still significantly worse than the trust target of 5.2%.
- In May 2014, the integrated governance committee reviewed a report, following a dementia assessment audit that sought to test compliance against the 90% target set by the Commissioning for Quality and Innovation (CQUINs) payment framework. The audit highlighted 64% compliance against the 95% target, and the recommendations for further improvement were developed.
- The month of May 2014 saw the trust reporting itself as achieving nine out of the nine clinical quality and service performance indicators for Monitor compliance.
- The trust reported anticipating failing against the 62 day cancer standard in Quarter 1 2014-15, as a result of the April performance, and following a number of urology patients who had experienced delays during Quarter 4 of the previous year. The trust had taken various actions to address this issue to improve its performance, including employing a staff grade registrar in urology to provide additional capacity.
- A review of NICE compliance was completed for May 2014, and the medical wards reported 48% compliance against the trust target of 70%. Additional work was being undertaken by the medical care service to address three outstanding clinical audits that fell within the remit of this team.
- The trust had a dementia management clinical guidance policy that was implemented in October 2013, taking into account dementia NICE guidance, 'Living well with dementia: a National Dementia Strategy', which included assessment checks and the 'Patient Passport' form, to facilitate greater understanding of patients' individual needs. The trust was in the process of introducing the assessment paperwork into practice.

Competent staff

- Most staff told us that there were no formal systems in place for regular supervision sessions with their line managers, but that any issues were addressed via informal support from managers.

Medical care (including older people's care)

- Senior staff told us that they had regular supervision sessions which did include reviews of their training and development needs.
- Only a small proportional of qualified staff we spoke to said that they had opportunities for clinical supervision. However, there were supervision arrangements in place for newly qualified nurses.
- Most staff told us that they had had an annual appraisal, and their training needs were discussed, and individual development plans completed.
- Newly appointed staff said that their inductions had been planned and delivered well. Permanent staff were provided with induction packs, but not all ward areas had separate induction packs for agency staff.
- For July 2014, medical wards did not meet the trust target of 85% compliance for having an annual appraisal, as only 69% of staff had had an appraisal. However, many staff told us that their appraisal had been booked.
- Doctors told us that there was an effective system for assessment and revalidation.
- Bank nurses told us that there was not an effective system for their supervision or their appraisals.
- Some staff said that additional, vocation training, such as degree courses, was offered by the trust on application. The trust was actively promoting a leadership and management degree course for senior nurses.

Multidisciplinary working

- There was a multidisciplinary collaborative approach to care and treatment that involved a range of professionals, both internal and external to the organisation. There was generally a joined-up and thorough approach to assessing the range of people's needs, and a consistent approach to ensuring assessments were regularly reviewed and kept up to date.
- Meetings on bed availability were held three times a day, to determine priorities, capacity and demand for all specialities. We observed one such meeting, and it was well organised, and clear actions for the attendees were determined.
- Staff told us that multidisciplinary working in the cardiac wards was excellent.
- A daily meeting was held to review discharge planning, and to confirm actions for those people who had complex factors affecting their discharge.
- Staff told us that there was robust multidisciplinary working at ward level, but sometimes links with other departments was not always effective. Staff told us there was effective liaison between nurses and doctors. Doctors told us that nurses knew people's condition, and would report any changes so as to deliver best outcomes for people.
- Some HCAs told us that they were not always kept informed of clinician's assessments and the outcomes from them.
- Staff told us that there was a specialist respiratory nurse, a falls advisory nurse, and dementia care nurse available to support people, and also advise staff on appropriate treatment options.

Seven-day services

- Staff told us that the process for having X-rays taken, and getting the results for people, could be slow at times, particularly in the evenings and at weekends, due to the out-of-hours cover rota.
- Staff told us that the level of cover by doctors in the evenings and weekends varied from ward to ward.
- The ambulatory care unit had now expanded to open seven days a week, and had on-call consultant cover at weekends.
- The hospital discharge team worked at weekends to facilitate effective discharge planning. Some wards had their own discharge co-ordinators, and other were looking to introduce this. Staff reported that the main delays in people leaving hospital were due to social care issues. Staff reported good relations with social work colleagues, but that they were understaffed at times, affecting the discharge planning process.
- Access to therapists was variable in the evenings and at weekends.
- Pharmacists did not work at the weekends, but senior staff told us that patients' discharge medication could be arranged by using the on-call pharmacist.
- The discharge lounge was not open at the weekend, and normally closed by 7pm on weekday evenings. Ward nurses would therefore arrange discharges at other times.
- The trust had a doctor on-call rota for evenings and weekends, and most ward areas did not have dedicated doctor cover out of hours. There was a consultant on-call rota operated by the trust for out of hours.

Medical care (including older people's care)

Are medical care services caring?

Good

Patients told us that the staff were caring, kind and respected their wishes. We saw that staff interactions with people were generally person-centred and unhurried. Staff were kind and caring to people, and treated them with respect and dignity. Most people we spoke to during the inspection were complimentary, and full of praise for the staff looking after them. The data from the hospital's patients' satisfaction survey Friends and Family Test (FFT) was cascaded to staff teams.

Compassionate care

- Patients and those close to them were treated with respect, including when receiving personal care. Staff in all roles put significant effort into treating people with dignity. Patients generally felt supported and well-cared for. Staff responded compassionately to pain, discomfort, and emotional distress, in a timely and appropriate way.
- We saw that interactions between staff and people were positive, respectful and caring.
- Most people we observed were well presented, and appeared comfortable in their surroundings.
- People's dignity was respected whilst they were being supported with personal care tasks, apart from on one occasion, where we saw a nurse take a patient's observations without pulling the dignity curtain around the bed. This was in full view of other patients.
- Staff knew people's names, and spoke in an appropriate tone of voice when supporting people. A doctor told us that the nurses "know their patients and their needs". The majority of people were very complimentary about the staff, and the care they had received. One person said "this hospital is very good; faultless". Another said "the nurses come very quickly". Another said "I would recommend this hospital if you needed to go to a hospital".
- The majority of people told us that nurses checked upon them regularly, and were polite and respectful. The relatives we spoke with were complimentary about the care and attention their relatives had received from staff. Some wards had extended visiting times, to allow people to see their relatives for longer and more easily.
- Most people told us that staff answered their call bells in a timely fashion, but two people told us that they had waited at times for up to 10 minutes.
- Staff were able to tell us how the needs of people from culturally diverse backgrounds were met.
- People told us that there was a good choice of meals available, and that generally, the meals were very good. One person said "the food looks good but tastes bland".
- Friends and Family Test (FFT) results for the medical care service in June 2014 (for those wards with response above 100) showed that from the eight eligible medical wards, seven performed better than the overall trust average of 40%.
- We saw that most ward areas had displays of compliment cards. For example, the ambulatory care unit had 11 recent compliment cards on display.

Patient understanding and involvement

- All staff we observed communicated respectfully and effectively with patients.
- The majority of staff had an understanding of the Mental Capacity Act, and how assessments of a person's capacity were needed if there were reasons to doubt their level of understanding. Staff told us that generally, capacity assessments were carried out by doctors.
- Most people we spoke with said that they had been informed of their conditions and treatment plans. Staff kept people informed of any changes. One patient said they had "been kept well informed of their options and were happy with the discussions".
- Relatives said they were generally kept well informed of how their relative was progressing.
- All wards had appropriate signs in place so that people would know which members of staff were their named nurse and doctor.
- Most care plans that we looked at were not personalised to the individual people, and most did not reflect their involvement in agreeing to the plan of care.
- Some people had the trust's care for people with dementia document, 'Patient Passport', completed and available for staff to read; however, some did not. People's life stories and likes/dislikes included in the document had not been effectively transferred into the main care plan, especially regarding people's behaviours and known 'triggers' for aggressive behaviours.
- Most care plans and risk assessments we looked at had not been signed by the person or their representative.

- Some patients told us that they had not read their care plans, and did not know their treatment plans.
- The cardiac wards had clear and effective pre-assessment and treatment information for patients.
- Two patients told us that not all staff had effective communications skills due to English not being their first language. One patient had not been told what the medicine they were discharged with was for.

Emotional support

- Some staff said that they had sufficient time to spend with patients when they needed support, but other staff felt that time pressures and workload meant this did not always happen.
- Most staff said that an extra staff member could be requested if a person needed specific one-to-one support from staff, but that this did not always happen due to lack of available staff.
- People spoke highly of the hospital's chaplaincy service, and found it easy to access support.
- Staff told us that timely assessment and support was generally available for people from mental health practitioners.
- Some patients said that they had lost some independence whilst in hospital, but that staff kept them informed and did offer choices where appropriate.

Are medical care services responsive?

Good

The trust had systems in place to investigate complaints and compliments. The trusts' ambulatory care service was delivering an effective service to prevent admission or readmission to hospital. There was an elevated demand on bed availability at times, so an escalation area for medical patients had to be used; not all staff thought that this effectively met patients' needs, and some staff had concerns about working on unfamiliar wards areas. However there were problems with the effective discharge of people which were highlighted across the medical care service, from both staff and some of the patients we spoke to. Whilst the trust had implemented a dementia care strategy, there was more work to do in terms of effective care planning and staff training, to provide effective person-centred dementia care.

Service planning and delivery to meet the needs of local people

- In its annual quality report for 2013 to 2014, the trust reported that the hospital was leading the development of Northamptonshire's cardiac services through its 24/7 primary percutaneous coronary intervention service (PPCI). This was the county's fast response service for conditions such as heart attacks, and involves fitting stents (small wire meshes) inside coronary arteries to return restricted blood flows to normal. Since the 24 hour service began in October 2010, the hospital has performed 1,581 of these potentially life-saving coronary procedures in its £4.7m state-of-the-art cardiac centre. In turn, this lead county role has resulted in an increase in demand for acute cardiac beds at the hospital. As a result of this increased demand, the trust opened a third catheter laboratory inside its cardiac centre, to further improve life-saving services for local people. The move had enabled the hospital to speed up treatment processes, to benefit both emergency and routine patients.
- The hospital was committed to working very closely with its NHS and social care partner organisations, to prevent unnecessary admissions to hospital, to make best use of its beds, and to discharge patients home in a timely way. The trust's hospital discharge team worked closely with many different professionals, including doctors and nurses, therapists and the community teams such as the intermediate care team, Serve, the short term assessment and rehabilitation team (START), Age Concern, the community stroke team and community elderly care service (CECS), to improve discharge arrangements.
- The reconfiguration of the cardiac and respiratory service with the move of these wards to the trust's Foundation Wing had reinforced the trust's position as trust lead for all of the county's primary care needs. This had also led to improved recruitment in the cardiology service.
- The trust's strategy plan for 2013 to 2014 said that the trust was aiming to reduce the average length of stay for people from the current eight days to meet the national average of six days, and to reduce the number of readmissions. It was also looking to work closer with commissioners to provide care closer to people's homes, with effective relationships with GP practices.
- The trust had reported that improving dementia care required a sustained improvement in screening and

diagnosing dementias, and during 2013/14 this continued to be a main focus. The trust wanted to ensure that more staff had received enhanced dementia training, leading to improved care, delivered by competent and compassionate staff. The enhanced support of carers and families, of people living with dementia, was also a key area. The trust was in the process of appointing a dementia lead practice nurse, to support the dementia strategy, and assist with staff training.

- In May 2014, an audit for the CQUIN for dementia screening highlighted 64% compliance against the 95% trusts' target, and the recommendations for further improvement were being developed.
- The trust told us that they had a dementia strategy and had a steering group that met regularly.
- The trust had introduced a life history profiling document, 'Patient Passport', but we found that it had not been completed for all people with a dementia. We also found instances where a person's detailed life history had been received from family members, but was not reflected in that person's care plan.
- At busy times, the medical care service had a process for placing people in other wards and to monitor their condition. The trust was developing its winter pressures plan to manage anticipated needs from the local community.

Access and flow

- The ambulatory care unit was opened in June 2013, and had seen more than 8,000 patients since then. It was seeing over 200 patients a week, and its opening hours had been extended to seven days a week. Referrals came from the emergency department, other wards, and local GPs. Patients were seen quickly and treated on the same day, and longer term hospital admissions were prevented. The unit was able to provide planned treatments from consultants, including blood transfusions and biopsies. The trust had received a national award for the way in which this unit had contributed to its continued improved performance in meeting A&E target timescales.
- In the integrated governance report for June 2014, the trust continued to see a high level of days delayed discharges, with the majority of delays caused by waiting for assessment and access to non-acute beds. In May 2014, the trust had seen, on average, 58.0 beds in the trust lost to delayed transfers of care. This continued to impact upon the trusts' bed capacity and added to bed availability pressures.
- Staff views on the discharge process were mixed: some staff thought that it had improved, with better co-ordination, whilst others said "it is difficult and time consuming given other responsibilities".
- A safeguarding protection plan was in place regarding inappropriate discharges, but not all staff were aware of the actions required in this plan, regarding effective and safe discharge planning.
- The hospital had a discharge lounge, which took people from other wards, provided they were medically fit for discharge. The lounge had a discharge transfers form which other wards would complete to ensure that patients main needs were known whilst in the lounge. This form also recorded the patient's main needs for transport, support at home, contact details for next of kin, and their own GP.
- Discharge lounge nurses told us that at times, referrals to the discharge lounge were declined if there were concerns about the patients' medical condition or overall dependency. The trust's bed capacity organiser and the relevant ward would be informed of reasons for the referrals being declined.
- One person in the discharge lounge said that they had been told they were going home that day, but they did not know at what time, as they were waiting for transport.
- The trust had, on average, seen 12.9 medical outliers per day during the month of May 2014; however, this represented a significant improvement on the levels seen during the previous year, at which point the trust had, on average, 59 medical outliers per day.
- Staff told us that ensuring those patients outlying in a different ward were monitored effectively was quite difficult at times. The hospital policy stated that there would be no transfers after 11pm. Staff we spoke to said that this had much improved, and people were not transferred between wards after 11pm, unless there was a bed emergency, or their clinical needs could be better met in an alternative ward.
- Some ward areas were piloting a daily multidisciplinary meeting (called Project Jonah) designed to facilitate effective discharge planning, but it was too early to determine whether this was going to be effective.

- Junior doctors said that trust policy was now not to discharge any patients without the discharge letter being prepared.
- In times, where there was acute demand on bed availability, escalation beds on the Deene Floor (a surgical area) were used for medical care service patients. Staff told us that these beds had been used for the previous three weeks. This escalation area did not have a permanent staffing roster, so staff from other wards were requested to work in this area, supplemented by bank staff and agency nurses. A number of staff we spoke with had had concerns about going to work in an unfamiliar area, and some had felt confident to raise the matter with their line managers, but others had not.

Meeting people's individual needs

- Most people we spoke with knew who their consultant was; but some did not, and said that they did not know what their treatment plans were, and when they may be able to go home.
- Following a letter from Sir Bruce Keogh to the medical director on 21 March 2014, the trust had started to monitor both the number and detail of patient moves between the hours of 11pm and 6am, and was routinely reviewing its practice to ensure that transfers made for reasons other than clinical ones were minimised, and that good practice was followed where such moves were necessary, including ensuring that moves out of hours are properly explained to patients and relatives. During May 2014, the trust had 73 patients with ward moves between the hours of 11pm and 6am, with 67% of these ward moves being associated with transfers from the medical assessment unit, the observation bay and Clifford wards (the trusts short stay admission areas).
- In the annual quality report for 2103-14, the trust stated that it had set up a team to help improve the amount of rehabilitation and support that patients received, particularly for patients who were waiting on hospital wards for community rehabilitation. This acute therapy rehabilitation and assessment team consisted of six staff (three from physiotherapy and three from occupational therapy) with funding from Northamptonshire NHS. The team complemented the hospital's existing occupational therapy and physiotherapy services, and enabled the trust to further improve rehabilitation for patients, particularly those who were waiting for rehabilitation in the community.
- The hospital continued to work to improve the experience for patients with a learning disability. The hospital employed a project worker with a learning disability, to support the learning disability liaison nurse (who was an employee of a different NHS trust) in the education of staff and the provision of resources. The trust was using a learning disability toolkit, which contained specifically produced documents to enable staff to effectively care for any patients with a learning disability. Patients with learning disabilities were identified via an electronic alert, enabling the learning disability liaison nurse to see when a patient with a learning disability has been admitted. The 'Helping me in Hospital Book' was also in use, to assist staff in meeting the needs of these people.
- The trust had not achieved all of the acute CQUIN quality targets during 2013/14 for assessing people over 75 for dementia on admission.
- Care for people with dementia, particularly those who became agitated, and displayed challenging behaviours, was an area that the trust was looking to enhance. Behaviour charts were available for staff to use to help monitor and understand patient's difficult behaviours; but we found that these charts were not always being used, when they have been shown to assist with effective care planning.
- Staff told us that they gave people's relatives the 'Patient Passport' document to complete, but they did not get many completed documents back. This meant that care and treatment was not always delivered to meet people's needs, as staff did not have appropriate guidance to follow.
- Wards did not have activity co-ordinators employed, and staff said that whilst activity equipment and games were provided, there was little time for them to sit with patients to engage with them in meaningful activity. Not all wards had access to televisions for patients.
- Feedback from local charities gave recent examples of where not all staff fully understood the needs of people with a learning disability, or who were living with a dementia.

Medical care (including older people's care)

- The care of the elderly wards were not specifically designed to provide an appropriate environment for people with dementia, such as with dementia-friendly appropriate décor, flooring, and appropriate lounges for activities.
- The hospital had access to a translation service, which staff told us was effective and met people's needs. Posters were on display about how to access this service.
- Some areas had patient information leaflets available, such as in the ambulatory care unit, which contained clear information about a range of medical conditions, and provided aftercare contact details if needed.The trust had a range of information leaflets available for patients and their relatives, to signpost them to other providers of support, including social services, and charities.
- Visiting times met the needs of the relatives that we spoke to.

Learning from complaints and concerns

- People generally knew how to raise concerns or make a complaint. The trust encouraged people who used services, those close to them, or their representatives, to provide feedback about their care. Complaints procedure leaflets were available. People were informed about the right to complain further, and how to do so, including providing information about relevant external second stage complaints procedures.
- People's views of the way in which the hospital dealt with complaints were mixed. One person told us that a concern had been dealt with "on the spot" and that they were happy with the resolution. Another person said "the complaint's procedure takes too long to get a response".
- Some patients knew about the hospital's Patient Advice and Liaison Service, and leaflets were available in all areas we visited.
- For May 2014, the medical care service received 14 complaints, which was above the projected target of 13 for the month. The main themes of complaints related to communication, staff attitudes, and delayed diagnosis of fractures. The trust had identified a specific group of service users that were having delayed diagnosis of fractures, and had taken action to improve this area. The medical care service had also been working to clear a backlog of complaints, and as of May 2014, the backlog was down to 12 unresolved complaints. The number of complaints had risen to 17 in June 2014.
- For May 2014, the percentage of complaints responded to, within the trust timescale for medical wards, was 7%, which was significantly below the trust target of 80%. This had improved to 25% of complaints responded to within the timescale for June 2014, which was still well below the trust target of 80%.
- For May 2014, 86% of complaints were reported as being resolved 'on the spot'; this was below the trust target of 95%. This had risen to 88% of complaints resolved with the first response, for June 2014.
- Ward leaders told us how they were now working to achieve 'on the spot' resolutions to concerns where possible, and would hold meetings with people and their families to seek to resolve the concern.
- Senior managers told us that there had been a significant number of complaints regarding the discharge process, and that these were usually relating to ward discharges rather than from the discharge lounge.

Staff told us that learning from complaints was disseminated via informal staff

Are medical care services well-led?

Good

The medical care service was generally well-led at a ward level, with evidence of effective communication within staff teams, and the implementation of information boards to highlight each ward's performance. The visibility and relationship with the management board was less clear for junior staff, not all of whom had been made aware of recent initiatives. Leadership was good but was not consistent across the medical services area.

Vision and strategy for this service

- Most ward leaders spoke positively about the vision and strategy that the board had for the ongoing development of the medical care service.
- Staff were able to tell us about the 'Victoria's Legacy' initiative, and how this had led to significant changes in the planning and delivery of care.

Medical care (including older people's care)

- Ward leaders were able to tell us how their ward's performance was monitored, and how performance boards were used to display current information about the staffing levels and risk factors for the ward. We noted that the planned and actual staffing levels displayed on these boards were only done for the daytime, and not always for the night shifts. Staff we spoke to did not think that staffing levels were displayed for night shifts.
- Some ward leaders felt that the pace of change in recent months was "overwhelming" and the staff team needed time to ensure that recent changes were fully embedded in the service.
- Staff told us that some new documentation was piloted, with feedback sought from staff to ensure that it was fit-for-purpose; however, at other times, new documents were introduced without a clear explanation to junior staff. Some staff said that the assessment documents and care plans were time-consuming to complete, and needed to be reviewed. Some had raised this with their managers.
- Whilst the trust reported its plans to develop the dementia care service, some staff were not able to tell us about the AGE (Academy of Gerontology Excellence) initiative. Some staff said that there needed to be more staff on duty, to be able to provide a person-centred, dementia-friendly care service.

Governance, risk management and quality measurement

- We were told by senior staff that CQC standards were incorporated into the quality assurance programme for the trust.
- Ward leaders were able to tell us about the ward's performance against the trust's targets and objectives, and were aware of the current risks on the risk register. However, junior staff were not always able to tell us how the ward was performing, or what actions were being taken to mitigate risks to people.
- The trust had in place quarterly governance meetings, and incidents, audits and complaints were discussed. Formal reports about quality, safety and governance were produced, and made available to the public via the trusts' website. Not all staff we spoke to had read these reports, but senior staff were able to tell us about them.
- Each ward had feedback findings from audits, complaints and areas of risk from audits, and information was cascaded down to all staff via team meetings.
- Most staff were able to tell us about the trust's 'I Will' campaign, to promote patient safety and dignity. Posters and information about this initiative were on display in ward areas.

Leadership of service

- Most staff told us that leadership at ward level has improved, with clearer communication. For example, performance boards that highlighted key issues and messages, and also recognised staff achievements, were available for staff to read. A few staff felt that there was a lack of consistency in ward leadership. Most staff felt well supported by local managers. All senior nursing staff said that the director of nursing was visible, accessible and supportive.
- Some ward leaders told us that leadership and management courses were much more accessible for them.
- Senior nursing staff and doctors said that the leadership from the board and the relatively new senior executive team had improved, and that two-way communication was more effective.
- Ward leaders and staff told us about most wards having weekly informal staff meetings that were held for staff, to share their issues, and also to get feedback from senior managers. Staff told us that generally, they were well supported by their managers.
- Not all staff were aware of the concerns found on previous inspections, and thought that the trust's financial situation was the major area of concern.
- All wards had visible performance boards on display, for people and their visitors, which showed performance against key risks areas, current staffing levels, and other information, such as how individual wards were performing on the Friends and Family Test (FFT) surveys.
- Nursing staff were committed to the trust's 'I Will' patient safety campaign, and we saw that all areas had posters and information available on this safety initiative.
- Some HCAs told us that they did not know what the ward performance boards were for, and some of the HCAs were not aware of the trusts' overall vision.

Culture within the service

- Senior staff reported an improvement in staff morale over the last few months, with the increase in some wards' staffing levels being pivotal. However, some staff

reported feeling pressurised, and said keeping morale up was "a struggle", especially when staff were asked to work on different wards that they were unaccustomed to operating on.
- Most staff reported an improvement in effective communication to and from the trust's board.
- Staff in the cardiac wards reported good mutual support and team morale.
- Some support staff felt that work pressure had increased, as the workload was rising due to the increasing dependency of patients.
- Some wards reported a higher than average sickness absence rate; this was usually down to the impact of having staff off on long-term sick leave. Ward leaders told us of the trust's more robust approach to supporting staff with attendance issues. Medical wards had a sickness absence rate of 5.07% for July 2014, which was worse than the trust overall rate of 3.73%.
- Some staff said they felt under pressure to report for work, even when not feeling well, due to staff shortage concerns.
- The majority of ward leaders were very positive, and spoke well of support from senior managers.

Public and staff engagement

- Some people told us that having the board meeting minutes available to the public online helped them to understand more about the hospital and how it was performing.
- Some HCAs told us that they were not well informed of the trust's plans to recruit more nurses to improve permanent staffing levels.
- Feedback from patients was regularly sought, and results displayed in ward areas. For example, the discharge lounge had the results of a recent survey, which found that from 86 responses (from May to July 2014) 89% of patients were satisfied with their experience, that staff were friendly for 100% of the responses, and 92% of people had been kept well informed about their discharge plans.
- A patient representative was present for the care of the elderly user group, and the county-wide stroke group. For rheumatology, four sessions of patient focus groups had been held in the past year.
- A representative from a local sensory impairment charity was also actively involved in user group meetings, and also in the design and planning for new ward areas.
- Feedback from three trust governors was positive, and they said that the trust had made considerable progress in the past year.

Innovation, improvement and sustainability

- Innovation was encouraged, but staff told us that they were not always able to recommend changes, due to time pressures. Some staff felt well supported in being able to voice their opinions on how services should be run, whilst others did not.
- Some staff were aware of the rationale behind recent changes to processes and documentation, but some junior staff had not been made fully aware.
- Ward leaders felt confident about managing the pace of change if it were carried out in a planned fashion.
- Staff had objectives focused on improvement and learning as part of their appraisals.
- Senior staff told us that the information technology (IT) strategy and IT infrastructure were not effective. Not all staff were confident that the new proposed strategy would deliver effective and timely outcomes for clinicians. Some staff said that they had not been consulted about the proposed redesign of the IT service.
- Senior staff said that whilst the trust's own internal website (intranet) contained a wealth of information, it was not well structured, and staff found it hard to find relevant policies and guidance. Staff felt that there was no overall ownership of this intranet; there were plans in hand to review it in the forthcoming weeks.
- Staff said that there was considerable support from the board and senior managers regarding the dementia strategy, and that this was going to be an area for innovation.
- Senior staff felt that the continued success of the ambulatory care unit had been a really positive element for the trust.
- The move of the cardiology and respiratory wards to the Foundation Wing was also seen very positively by most staff.

Surgery

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

Information about the service

The surgery service at Kettering General Hospital includes four surgical wards (Deene A, B and C, and Geddington) and three orthopaedic wards (Barnwell B and C, and Ashton). There are 15 operating theatres, including main theatres, gynaecology and obstetrics, ophthalmology and the treatment centre. The treatment centre also accommodates the pre-assessment and day surgery areas. The hospital saw 28,514 patients in this directorate during the previous year. Surgical service provision includes orthopaedics, trauma care, ear, nose and throat (ENT), dermatology, maxillofacial, gynaecology, vascular, plastics, ophthalmology, orthodontics, interventional radiology, urology and gastroenterology services. There is also a dedicated endoscopy service within the day unit, inclusive of theatres and recovery facilities.

We visited all surgery services as part of this inspection, and spoke with seven medical staff, eleven ward or team managers, 44 registered nurses, other health professionals and health care assistants. We also spoke with seven specialist and lead nurses for the surgical service. We spoke with 25 patients and examined 24 patient records, including medical notes, as part of this inspection.

Summary of findings

The surgical service requires improvement because there were risks and deficiencies evident across three areas of our inspection domains. Generally, we saw that patients had been cared for safely, but there were practices and issues that posed risks to patient safety. There were risks due to limited medical staffing cover out of hours and at times of increased workload, and pressure on beds resulting in cancellations; the nursing teams were concerned about maintaining safety. We saw that older facilities and equipment posed a risk to safety due to failure of critical equipment. Infection control was compromised due to pressure of activity, meaning that screening was not comprehensively completed. Infection was also a risk, due to difficult storage facilities and working practices.

Problems with some of the theatre room configurations, care records tracking, and established working practices meant that patients had their operations cancelled, and theatre facilities were underutilised. We saw that some patients admitted for surgical reasons, but who were also living with dementia, did not have good programmes of care in respect of their confusion and mood, which suffered during their admission. Ward environments were bland, some areas were cramped, and staff did not always respond to the varied needs of patients living with dementia.

Surgery

Are surgery services safe?

Requires improvement

We found that some issues posed a potential risk to the safety and welfare of patients. Junior doctor cover out of hours and at weekends was minimal across the surgery and orthopaedic wards, which meant that some duties were delayed or not completed, such as the prescription of anti-embolism stockings prior to the patient going into operating theatres. Nursing staff told us that it was difficult, as one doctor was covering, for example, three surgery wards, and accident and emergency for admitting emergency cases. However, we saw that staff were competent, and followed procedures and guidelines. Systems were in place to learn from any incidents across surgery.

Some of the facilities and equipment in operating theatres were old, and could be susceptible to failure leading to cancelled operations. Some patients moving between wards did not have completed checks on their MRSA status. Some medication storage fridges were not routinely checked for effective working leading to medications being less effective. In operating theatres, a lack of storage space meant that clean supplies were stored and then brought into operating rooms from the exit 'dirty' corridor, against the safer flow of supplies.

Due to the pressure of bed utilisation, patients were transferred to wards usually used for elective surgery, without necessarily being fully screened for hospital-acquired infections. On Deene C Ward there was additional bed capacity, which was used flexibly to manage high demand. In this area, staff told us that there were times when they considered that there were insufficient staff to manage patients who were acutely ill. Staff told us that it was safe and we saw that patients were receiving care, as they worked hard to manage the care of patients. We found that managers were aware of this highly pressured ward area, were authorising agency staff when required, and were closely monitoring the bed utilisation and medical outlying patients placed in the extra beds.

Incidents

- When incidents happened, these were reported and analysed to learn lessons. Staff in all departments told us that they were informed about incidents, and discussed any changes to practise at team meetings.
- In operating theatres, we found that staff reported incidents appropriately, and told us that they had learnt from a recent incident by analysing the cause, and then implementing measures to protect patients. Lessons were shared across the different operating theatres on the site. Staff were advised of any incidents, and discussed changes to practices or procedures at weekly meetings. We spoke with managers and senior clinicians, who described the improved procedures following learning from incidents.

Safety thermometer

- In the surgery wards and departments we visited, we saw that results of safety audits were displayed, so that all staff were aware of the performance in their ward or department. We saw there were very few infections acquired in hospital. There were no cases of MRSA or MSSA recorded since November 2013. Managers and staff completed audits to check that bacteriological screening of patients had been completed on admission, and before if it was a planned admission. We saw that some patients moving between wards did not have completed checks on their MRSA status.
- On one orthopaedic ward, staff had responded to an increase in falls in June by improving monitoring of patients, and when required, this was supported by the trust with extra staff. We saw there had been a clear improvement in safety.
- The trust had worked with staff to significantly improve the documentation of medication administration. Pharmacy and nursing staff audited drug charts. In one orthopaedic ward, where this had previously been an issue in the months prior to our visit, there had been no omissions in drug administration charting.
- WHO safer surgery checklist records were audited daily for all patients. In operating theatres, the staff had, as part of the trust's 'I will keep you safe' strategy, implemented robust measures to reduce the likelihood of pressure ulcers developing during operations. Risk assessments were made for patients having operations, and appropriate devices were used, such as heel pads and arm supports.

- In the treatment centre, we found no evidence of safety walk-around checks by managers. The temperature of drugs fridges had not been monitored for many months. This could lead to medicines being less effective if temperatures within the fridges rose.

Cleanliness, infection control and hygiene

- The surgery wards visited were visibly clean. Hand sanitizers were available outside the wards, bays and side rooms, as were hand wash basins. Instructions and advice on infection control were displayed in the ward entrances for patients and visitors, including performance on preventing and reducing infection. Personal and protective equipment, such as gloves and aprons, were available in sufficient quantities.
- There was high awareness among staff about infection control. In each ward area, staff had audited performance on ensuring that infection prevention and control measures were adhered to, reports were shared with staff at meetings and on noticeboards. Infection rates for C. difficile and MRSA were below national levels for these infections. The trust data showed that there had been no MRSA infection developed on the hospital site in the past two years. However, patients were transferred to wards usually used for elective surgery, when they may not have been fully screened for hospital-acquired infections. Staff on these wards had begun undertaking full reassessments of patients due to the additional risks that this posed.
- We observed clinical staff in ward areas using appropriate protective equipment, washing their hands, and using alcohol gel.
- In operating theatres, there were dedicated cleaning staff with clear responsibilities; the work was checked and audited. There were, however, no cleaning checklists for clinical staff to use to ensure that all required cleaning of clinical areas and equipment had been carried out in the anaesthetic and theatre rooms.
- We found that some floors and walls in operating theatres were in poor condition through wear and tear, which would make them difficult to clean effectively.
- There were inadequate storage facilities for some consumable supplies. Sterile trays and some fluids in warming cabinets were situated in the 'dirty' corridor, meaning that some supplies were taken against the usual flow, to take account of infection control, of equipment through the operating areas.
- In the gynaecology and obstetrics theatre, we found that although the area was cleaned appropriately, and appeared clean and tidy, there were some areas of damaged walls and floor which would make it difficult to clean effectively. Staff did not have checklists to follow and to record that cleaning for clinical areas was completed as expected.
- Patients at risk of developing venous thromboembolism (VTE) had compression boots applied by staff in operating theatres to help circulation in the lower legs. We also saw this equipment used on a patient at risk in an orthopaedic ward. Staff told us that some patients who required it did not always have preventative compression stockings prescribed by medical staff, and they considered that this was sometimes due to time constraints on the on-call surgical doctor.

Environment and equipment

- Resuscitation equipment, for use in emergency in operating theatres and ward areas, was regularly checked and documented as complete and ready for use. Some equipment in operating theatres was old, and could be susceptible to failure.This could lead to operations being cancelled at short notice.
- Ward managers and shift leaders checked a range of equipment at each shift, to ensure that emergency equipment was always ready for use.
- There was sufficient equipment to maintain safe and effective care, but there was some older equipment in operating theatres. Some anaesthetic trolleys were not being utilised, as they had older equipment that was not safe to use. Some equipment parts were retained by staff to maintain safe use of other trolleys in continued use. A business case had been submitted for improving the facility, and we were told that the trust had secured funding for equipment across the site.

Medicines

- Medicines were checked and reconciled by staff regularly, and an audit was completed quarterly to check stock and utilisation. We observed that pharmacy staff allocated to wards checked medication charts daily through weekdays, and provided advice on such matters as doses and contraindications.
- We examined controlled drug (CD) registers in obstetric theatres, and found these to be appropriately completed, with CDs checked at the beginning and end of each operating session.

- Some drug fridges did not have recent appliance test stickers, which meant that we could not be assured of electrical safety. Some medication storage fridges were not routinely checked for effective working. High fridge temperatures can reduce the effectiveness of medicines.

Records

- In surgery wards and theatres, we examined 24 patient's case records. There were clear assessments made for patients treated in operating theatres. Some patients had specific pathway of care documentation, such as for gynaecology procedures, which meant that staff were able to follow agreed, safe plans of care. In ward areas, we saw that nursing and medical staff used the shared assessment record to ensure risk assessments were completed about skin integrity, risk of blood clots, falls risk, nutritional risks, and assessment for dementia.
- We found care records were completed accurately, and there were good records of observations and the care provided. We found isolated examples of delayed reassessment of risk following the recovery of the patient, and some elements of care planning, in response to risk of pressure sore development, were not recorded.
- There were detailed and comprehensive pre-assessments made on patients prior to admission. Important information was raised as an alert message to anaesthetists and the theatre team, for when patients were admitted for their operation.
- There were records of daily checks on equipment. Staff had handover information in communication books or printed sheets, so that they had key communications from the previous shift about patients that they were caring for.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Some patients having emergency operations did not always sign documentation to agree their consent to the procedure. For some obstetric procedures, the documents were not always signed in anticipation of possible, urgent operations. Staff noted that this could not always be anticipated, and the safety of mother and baby was a prime consideration.

Safeguarding

- Staff in all clinical areas were able to explain safeguarding arrangements, and when they might be required to report issues to protect the safety of vulnerable patients.
- 70% of medical staff had attended safeguarding training where as over 90% of nursing staff had attended level 2 safeguarding training. Out of nursing staff identified as requiring level three training four out of five nurses had attended this training.

Mandatory training

- All staff in surgery areas were aware of the need to attend mandatory training in issues such as moving and handling, and safeguarding. Ward managers kept good records of the training needs of staff, and were prompted by personnel department reports on performance.
- Staff training rates for the surgical area varied between 73% to 94% for nursing staff and 52% to 84% for medical staff. Infection control, basic life support, moving and handling and risk management training in medical staff were all less than 60% attendance. Nursing staff achieved above 80% attendance in these areas apart from basic life support which was 67% attendance.

Assessing and responding to patient risk

- There was comprehensive and accurate use of early warning scores on observation charts in the ward areas that we visited. We saw that raised scores were acted upon, and records made of actions in the patients case record by nursing staff. Ward managers reviewed the use of the scoring daily in the surgical admission ward, in view of the acute nature of patients being admitted.
- All theatre teams were using the World Health Organization's (WHO) 'safe surgery checklist', which is designed to prevent avoidable mistakes; this was an established process with the teams. Audits confirm that there is a 99% compliance with this procedure.
- Operating theatre teams undertook discussions as part of the WHO guidance, to discuss the operating list and allow all staff to be aware of the details of patient care and safety for each session.
- We spoke with staff in anaesthetic and recovery areas, and found that they were competent in recognising deteriorating patients. In addition to the early warning score observation chart and procedure, we saw that

there were pathways and protocols for different conditions or operations. Recovery pathways were used which were in line with guidance from the Association of Anaesthetists.
- During periods when many trauma cases were admitted to the hospital, there were transfers between wards, and from A&E into the elective orthopaedic ward, against the usual protocol for admission; this raised the risk level due to poor adherence to infection control screening

Nursing staffing

- We found that surgery wards and operating theatres usually had sufficient staff. Staff told us that there were clear staffing levels expected for the clinical areas, and that staff were recruited to maintain those levels. Additional staff were arranged when a specific need was identified, such as several patients at risk of fall, or acutely ill in one ward.
- On Deene C Ward there was additional bed capacity, which was used flexibly to manage high demand. In this area, staff told us that there were times when they considered there were insufficient staff to manage patients who were acutely ill. Staff were concerned that although agency staff were employed to supplement the team, there had been times in the few weeks prior to the inspection visit, when it was hard to maintain safe levels of care. Senior nurses told us that this was an area of continuous monitoring, given the flexibility required to manage patient demand. Nurses were concerned because patients with varied conditions were admitted, and staff were not always familiar with their specialist management. Records demonstrated the flexing of staff but we did not see any records of the identification of training needs for staff in this area to manage patients with specialist conditions. We saw that staff were using early warning score charts to monitor for deterioration of condition.
- We discussed handover of patient-specific information between shifts with staff and ward managers. There were different systems, such as communication books or information sheets in the wards, but all staff had access to relevant care plans and current information to enable safe care. There was a handover of patient care on the surgical admission ward at 7am for nursing teams including a nursing sister, and at 8am for medical teams. These handovers were detailed with information also held on all patients on a shared drive, and the process was replicated in the evening handover.
- We discussed the staffing of operating theatres and found safe staff levels. There were teams covering until 9pm daily, after which a standby team was available to cover emergencies. There were arrangements for extra staff to be called in, if required. Staff told us that there was good retention of staff in operating theatres, and this meant that agency staff were rarely used.
- Agency staff were used to support nursing teams, and these were approved by managers dependent on the needs of patients; for example, when there were several patients who were acutely ill, or at risk of falls in one ward. Ward staff told us that this was approved where there was a clear clinical need. Agency staff received and induction to the ward areas they were working on.

Surgical staffing

- The surgical doctor cover, overnight and at weekends, was described as minimal by staff in ward areas. To cover across surgical wards and orthopaedic wards there was one doctor for each speciality, with off-site support from registrars and consultants. This could also be dependent on emergency operations, and the needs of patients in accident and emergency. Staff told us that this meant that doctors sometimes did not have time to prescribe treatment, such as anti-embolism compression stockings before urgent operations. Nursing staff told us that having one doctor covering across surgical wards meant that they often had to wait for patient reviews and medication prescriptions; this was, in particular, when additional beds were open on Deene C Ward.
- We found that patients having gynaecology and obstetric procedures were accompanied to operating theatres by ward staff, clear handovers were given, and patients were returned safely to ward areas.
- Staff told us that there were consultant anaesthetic staff on site for emergencies, and there was good access to consultant surgical specialists for advice and support when required. Staff in ward areas told us that they had access to additional support of outreach specialists from intensive care if they had concerns about a deteriorating patient.
- In the surgical admission area, we saw that there was dedicated consultant support, and junior doctors were allocated for the week. We found that most patients were assessed directly by a specialist consultant within four to six hours of admission.

Surgery

Are surgery services effective?

Good

Staff described clear evidence-based practice in all areas of the surgery service. Guidelines and pathways were used extensively, so that best practice was used to manage patient's care. We found that patient outcomes were within expected performance levels, and there was good practice, for example, in pain management, and the monitoring of nutrition and hydration of patients in the perioperative period.

We found that most staff were well supported to maintain competency. There had been gaps in management which had meant that some nursing staff had not been provided with regular professional supervision.

Evidence-based care and treatment

- Specialist nurses and ward teams used pathways of care that were consistent with NICE guidelines, such as for managing patients with fractures of the hip.
- We saw that operating theatre staff used professional guidance, and that policies were coherent with accepted practices, such as those of the Association for Perioperative Practice.
- Patients with specific conditions, such as joint operations, or types of colorectal surgery, had their care managed using established enhanced recovery programmes to promote best outcomes.
- Management and care of elderly people with orthopaedic conditions was supported by specialist consultants for elderly care and orthopaedics. The specialists supported and reviewed in ward rounds through the week, and at multidisciplinary meetings, to check progress and plan discharge.
- All cases where a patient died from specific condition, such as a hip fracture, were reported in the governance arrangements and to commissioners. Audit was also made of any patient resuscitation. This meant that the trust checked that procedures were followed and learnt from clinical practice.

Pain relief

- We found that there was a dedicated pain team based in the main operating theatres, who supported pain management across the hospital. This was led by consultant anaesthetists, and used clear protocols and tools to plan pain management.
- In surgical wards, we saw that patients had clear post-operative or other protocols, or prescriptions for pain relief. We observed staff undertaking drug rounds, and saw that patients were asked about pain, and offered analgesia where needed. Patients told us that they had been offered effective pain relief when admitted from A&E, and also after operations.

Nutrition and hydration

- We examined case records in all areas, and saw that risk assessments had been completed to check if patients required extra support or monitoring for their nutrition and hydration. We found that fluid charts and food intake records were completed and summarised accurately.
- We saw that patients, other than those designated 'nil by mouth', had water available, with clean jugs and beakers. Staff told us that there had just been a 'focus week', which helped to raise the awareness of all staff of the importance to patients of good nutrition and hydration.

Patient outcomes

- We found that the surgery service reported information into national audits, and had reviews of service undertaken by professional bodies. In the fractured neck of femur audit the trust reported over 10 % of patients who developed a pressure sore following operation as opposed to the national rate of just over 3%. The trust has an improved pressure ulcer protocol in response to the audit.
- The length of stay of patients with orthopaedic conditions was being improved, by matching practices at other hospitals in the region, to improve recovery. Overall, the length of stay in the surgical service matches the average nationally.
- Hernia, hip and knee performance figures for patient reported outcome measures were below national average. Analysis of data showed that this was due to a poor return rate of surveys. The service had plans to improve the rate of response.

Surgery

Competent staff

- In ward areas, there were specialist staff to support the care and management of patients. In the orthopaedic ward, there were specialist trauma nurses, who facilitate admission and discharge of patients.
- Within the surgery teams, doctors new to the team undertook initial periods of shadowing an experienced team member, to learn local procedures and expected practice. In anaesthetics, registrar level staff supervised on-call staff to promote competence across the service.
- On Deene Ward areas, where there had been changes of ward manager, the nursing staff and health care assistants told us that they had gaps in the regularity of their appraisal, supervision and mentoring. Allied health professionals told us that they had clear and regular arrangements for professional supervision.
- The personnel department provided a summary each month for operating theatre staff, to show their adherence to mandatory training requirements.This was monitored by the theatre management team.
- Staff had their professional registration checked by the personnel department, and matrons were informed of the status of their staff on a monthly basis.

Multidisciplinary working

- In all surgery ward areas, staff told us that they had good support from pharmacy, dietetics, physiotherapy, occupational therapy and speech therapy staff. In acute wards, staff said that there was good access to radiology or imaging services when this was needed.
- We found that there was good team working across teams, such as the labour ward and obstetric operating theatres. There was good support given to operating theatres from the pharmacy department, including checks of medication safety. Operating theatres access to X-ray facilities was good, with dedicated radiography staffing or on-call support.

Seven-day services

- We found that surgery wards had access to consultants on-call out of hours. Staff told us that there was a nursing sister covering the surgical wards out of hours. For admission wards, there was good access to pathology, imaging and other services at all times.
- Trauma lists often commenced after the ward rounds, which meant a start time in operating theatres of around 10am, reducing overall utilisation of the facility.
- Staff told us that if there was an emergency operation already underway, when an emergency caesarean section birth was required, then on-call staff from home would be called to attend.

Are surgery services caring?

Good

We found that surgery services were caring. Patients told us that staff treated them in a caring way, and were flexible in their support to enable patients to access services.

There were isolated reports from patients and relatives about lack of information, or poor attitude, but most patients told us that they were cared for well and with compassion. Emotional support for patients living with dementia was lacking, according to some relatives.

We observed that children and parents, and elderly people, attending clinics, and for procedures, were cared for with understanding and compassion.

Compassionate care

- Patients in the surgical pre-assessment unit told us that they were not rushed; they felt like they were getting personalised support, and that staff made extra effort to ensure smooth arrangements and communications about admission procedures.
- Most patients in surgical and orthopaedic wards told us that staff were caring, understanding and supportive in ward areas. Three people told us that members of staff had been uncaring and showed annoyance of their request for support, but they said that they were isolated incidents.
- Patients attending the eye surgical unit told us that they felt extremely well supported by competent staff who understood their condition, and provided a flexible service for patients with sight and other disabilities.
- The Friends and Family Test scores for surgical areas were as for the national average, although there were some poor rates of response.

Patient understanding and involvement

- In the surgical admission ward, we spoke with two patients who said that they were aware of the tests or care planned for them, as they had been kept informed by nursing and medical staff.

- Most of the patients we spoke with in the orthopaedic wards did not know who the nurse was that was caring for them on the day. There were notices inside the bay of the nurse who was managing the group of patients, but this was not very clearly written, and could not be seen and read from all of the beds. Some patients, who had been in the ward for a week or more, told us that they came to be familiar with which staff were caring for them directly.
- Relatives told us that they often found it hard to understand who was in charge, and could advise them about how the patient was progressing.

Emotional support

- Relatives in orthopaedic wards told us that patients living with dementia were not always well supported, and this meant that their mood had deteriorated during the admission. We spoke with the ward manager, who said that they would discuss continuing care with the relative concerned, and review the support provided.
- We saw that in anaesthetic and recovery areas, parents of children having an operation were encouraged to be with the child when they awoke; we saw that this alleviated anxiety in both the child and parents.
- We observed a toddler being examined in the eye surgery department, and noted the personal care and flexibility of the staff, so that the child and parent were supported through the technical process of examination. We saw that the assessment was effective, due to the time allowed, and the encouragement of staff, in what could have been a stressful process.
- On the eye ward, we spoke with four patients who visited regularly, and found that they had high confidence in the team to manage delicate procedures, and provide accurate, safe care.

Are surgery services responsive?

Requires improvement

The surgical service required improvement, as there were various inefficiencies in working arrangements, which meant that some patients had their operations cancelled. However re-booking of operations were within the national target of 28 days. We saw that in some cases, staff had not provided good individual care for people who lived with dementia. The environment was not stimulating in many ward areas and this, combined with poor response of staff to patients' needs due to dementia, meant that confusion and mood could be negatively affected over long admissions.

Service planning and delivery to meet the needs of local people

- The trust was addressing and meeting 18 week referral to treatment times. This was being managed effectively, meaning that consideration was being given to increasing activity.
- Patients who required surgery for a fractured hip may need to wait, as there were limited sessions for this procedure over weekend periods. There were eight sessions over seven days. Emergency cases were managed within the expected time.

Access and flow

- The surgery service had a well organised pre-assessment department, which supported effective preparation of patients for their operations. Patients told us that they were very satisfied with the information provided before coming in for admission.
- In the surgical admission ward, staff were developing specific roles and processes to improve the efficiency and effectiveness of assessment of patients admitted and passing through the ward.
- We found that operation lists were cancelled each week in the treatment centre due to insufficient staff numbers. There were also cancellations simply because patient notes were not available. The final notes check was made after 4pm each day for the following day's list, which was too late to manage the operating list or reschedule the patient admission effectively, and therefore, could mean a cancellation. All patients who had their operations cancelled were invited back for their operation within four weeks.
- The current method of working by staff meant that it was necessary for all patients to arrive early in the day. Staff undertook safety checks with patients, including preoperative discussions with anaesthetists or surgeons prior to the commencement of the operating list session.
- Staff told us that patients with fractured neck of femur were seen within 36 hours, which was within the 48 hours expected nationally.
- Some wards required 15 to 20 minutes transfer time to operating theatres, but patients were called and held in suitable holding areas, so that the flow of activity in the

operating theatre could be maintained. Due to ward staffing levels, recovery staff told us that they were often escorting six or seven patients back to ward areas each day, which sometimes put pressure on recovery staff.
- In obstetrics and gynaecology operating theatres, there was effective flow of activity, with occasional delays only for emergency cases.
- There was 85% utilisation of operating theatres, which was monitored and reported weekly.
- Patients attending the eye ward for procedures were clear on their plan of care, and some told us that they attended regularly for treatment.
- We saw that multidisciplinary team (MDT) meetings in surgical wards were held to discuss discharge arrangements; this was a short meeting each day to check on progress, with an additional longer session once a week in orthopaedic wards.
- In some ward areas, the six bedded bays led to beds and lockers being closely aligned, meaning that it was difficult to move round the space, when using equipment such as hoists. The close proximity of beds also gave rise to difficulty in privacy for consultation at the bedside, and for therapy staff to provide support and guidance during rehabilitation.

Meeting people's individual needs

- Patients attending eye clinic were often elderly, and sometimes frail and living alone. Staff were aware of the need to provide a flexible service, and set appointment times to suit patient travel arrangements and offered support with transport booking.
- Two relatives told us about their experience of the care of patients living with confusion or dementia. They said that the wards had poor stimulation, and staff were not able to spend enough time to support people living with dementia. Personal items to aid memory and stimulation had been tidied away in the bedside lockers. We examined the case notes for the patient; there were some details of their personal preferences from discussion with the relative, but there was minimal care planning to support needs related to confusion and isolation.
- We saw that some ward areas had no televisions; staff told us that they understood this was due to aerial disconnection three years ago during building works. Patients, in particular those in side rooms, told us that this was a contributing factor to boredom during lengthy admissions.
- Ward managers and staff told us that some training about caring for patients living with dementia had been included in training for all staff about safeguarding of vulnerable adults. Some nurses had additional training about the needs of patients living with different types of dementia, and were starting to cascade awareness among other staff.
- We saw that a patient in one ward we visited did not have English as a first language; staff had arranged for an interpreter to be involved
- There were good facilities for welcoming children into the operating theatres, including a dedicated play room to help alleviate children's anxiety.
- The configuration of operating and theatre rooms in the treatment centre meant that patients had to wait to go straight into the operating room, rather than be prepared in the anaesthetic room. This led to delays and underutilisation of the facility.
- Staff told us that medical records were not effectively tracked through the hospital, which sometimes meant that appointments or patient care, including operations, had to be delayed.
- In the gynaecology and obstetrics operating theatres, one of the three operating rooms was not used. Staff told us that the ventilation system had not been upgraded, and that it was likely to fail if used. Staff advised that there was no requirement for the room to be used, in view of the activity level and availability of other operating rooms. A business case had been submitted for improving the facility.

Learning from complaints and concerns

- We saw that all wards had embedded lessons learnt from past serious incidents in the hospital.
- Staff in many wards told us that they were enthusiastic about providing safe and effective care, and they felt supported by initiatives that the trust had implemented, which had a clear focus on safety and good patient outcomes.
- Staff told us that there were regular complaints and comments from patients because they had to arrive early in the morning and would then have to wait many hours for their operation. This was to enable discussion and checks by surgeons and anaesthetists.

Are surgery services well-led?

Surgery

Good

We found that surgical services were well led. There was high awareness among staff of the values and expectations for patient care across the trust. There were pressures on some staff due to peaks of patient admissions and some ward management changes. Senior managers were aware of the issues, and were monitoring the additional pressure, but some staff felt that they had poor support during stressful periods. Staff told us that they were able to speak openly about issues and incidents, and felt this was positive for making improvements to the service. Staff told us they felt there was effective and supportive team working across professional groups in the surgical service.

Vision and strategy for this service

- Theatre staff told us that their new manager was very supportive, and they were clear on the three year plan to improve overall effectiveness of the operating theatre service.
- In the surgical admission unit, staff told us they had implemented significant change to ensure safe and effective care. Staff in different surgical areas told us that their improvements in patient care were supported by the trust. This was by means of a high profile campaign, working with staff, to establish clear expectations for patient care.

Governance, risk management and quality measurement

- In operating theatres, the staff took part in monthly meetings to review audit findings, complaints and incidents. Staff from operating theatres were joined by other staff, such as pharmacy and infection control specialist nurses.
- We saw that in each ward and department staff took part in or learnt from the auditing of nursing sensitive indicators. These included monitoring of pressure ulcers, falls, infection rates, and completion of the varied risk assessments and documentation of care.
- In the treatment centre, we found that important checks had not been completed. Two fridges that stored drugs had not been monitored for temperature. The staff and manager had not checked this for over a year.
- The risk register was up to date and included most of the issues we found on our inspection. However risks relating to medicine storage and infection control issues in theatre were not on the risk register.,

Leadership of service

- We saw that operating theatres and ward areas had clear management arrangements, with lead nurses covering across specialities, and matrons managing discrete clinical areas. Staff told us that they knew who the senior nurse was for their area, and the nurse director for the trust.
- There were good arrangements for support of staff in operating theatres. There was a full time nurse for supporting practice development. Staff were being supported to develop and improve personal portfolios of professional practice. Staff told us that weekly meetings were open and informative.
- On Deene C Ward, several staff told us that they did not always feel supported by senior managers. There had been a period of change of bed utilisation, and of ward manager arrangements, in the months prior to our inspection. When the escalation beds were opened staff felt less well supported.This was due to higher numbers of agency nurses who required supervision in a number of care tasks including the administration of medicines. Staff were asked to rotate quickly from night shift pattern to day shifts to cover the increased activity. Staff told us that managers had not been flexible in allowing adequate recovery. We found that managers were aware of staff concerns. There were action plans in place, with monitoring of bed utilisation and staffing, and measures to improve communication with staff.
- Operations in the treatment centre were cancelled each week due to staff vacancies. The vacancies had been frozen, but this had meant under utilisation of the facility. Staff in this unit felt that senior managers had not taken action to address this issue.

Culture within the service

- We found that staff in surgery areas were confident about raising any concerns, and reporting incidents. Staff felt able to discuss incidents with inspectors openly. They described a supportive response in the trust, where learning from incidents and staff issues was seen as important to improve safety and quality of patient care. Staff in operating theatres felt that there was an open culture, and they could speak with senior staff if they felt it necessary. At meetings to plan the

work of the day, all staff said they were able to speak if they required clarification on any issue. Staff told us that they had been able to express their views about reductions in staff numbers, and were confident this was being reviewed and managed appropriately.

- In the orthopaedic wards, staff told us that when they had required additional help to manage patients at risk of falls, managers had approved the extra staff resource.
- Allied health professionals told us that they felt able to raise any issues of concern with their manager or service leads. They said there was good multidisciplinary working in the different specialities they worked with.
- Staff felt that they were well supported in most areas of the surgery service. One member of staff, who had sustained an injury, was supported to take up a related professional role in the team. Health care assistants on surgical admission wards told us that they had been able to develop additional competencies to become assistant practitioners in that area.

Public and staff engagement

- In all areas of the surgery service, staff told us about the feedback they had from patients, either from the patient surveys, or general comments and letters received. We saw that there was discussion at ward meetings, and information was displayed on the feedback from patients and relatives or carers.
- We found that staff in all departments were enthusiastic about learning from past incidents, and had engaged with the culture improvement campaign within the trust.

Innovation, improvement and sustainability

- Staff described the multidisciplinary team as being very supportive of each other. Health professionals told us that they felt supported, and that their contribution to overall patient care was valued. Staff told us they worked hard as a team to ensure patient care was safe and effective.
- We saw that in the surgical admission ward staff were encouraged by improvements already made to develop new ideas, to make continuous improvement in the service provided. We saw that in all areas, staff had adopted national guidelines, and were aware of best practice for the conditions that their patients were admitted with.

Critical care

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

Information about the service

The intensive care unit (ICU) at Kettering General Hospital has 16 beds, with 12 commissioned and in use. The unit provides level 3 care, for patients requiring one-to-one support, such as those who are ventilated, and level 2 intensive care beds for high dependency care. The outreach team provides support with the care of critically ill patients who are on the wards. The critical care service has consultant cover 24 hours a day and seven days a week.

As part of our inspection we spoke with 26 staff and six patients and relatives. We spoke with a range of staff, including nursing staff, junior and senior doctors, a physiotherapist and managers. We observed care and the treatment patients were receiving, and viewed eight care records. We sought feedback from staff and patients at our focus groups and listening events.

Summary of findings

We found that significant and urgent improvements were required to ensure the safety of patients. Staffing levels were not always related to the dependency of patients as per national guidance, 'Core Standards for Intensive Care Units 2013' and were inadequate to meet the needs of patients. However, once alerted, the trust took action to address this issue. Improvements were required to ensure that lessons learned from incidents were shared with all nursing and medical staff. Infection control and medicines management systems were found to be safe.

The ICU was obtaining good quality outcomes, and patients received treatment that was based on national guidelines. Staff cared for patients in a compassionate manner, with dignity and respect. Both patients and their relatives were happy with the care provided.

Improvements were required to the leadership of the ICU, to ensure that the management responded to recommendations previously made on how to improve the service delivered.

Critical care

Are critical care services safe?

Requires improvement

There were serious safety concerns for patients, particularly in relation to levels of nurse staffing. Staffing levels were not related to the dependency of patients, and were not in line with national guidance. We observed some patients being left unsupervised for extended periods of time. However, once alerted, the trust took action to address this issue. Improvements were required to ensure that lessons learned from incidents were shared with all nursing and medical staff.

The environment was clean, and staff were following infection control procedures. There were good systems for monitoring the Safety Thermometer data and improving practice. Medicines, including controlled drugs, were safely and securely stored.

Incidents

- 'Never Events' are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers. The intensive care unit (ICU) had one 'Never Event' in August 2014. An investigation had commenced and new guidelines had been implemented to prevent the recurrence of this event. Nursing and medical staff we spoke with were aware of the new procedures.
- Medical and nursing staff were aware of how to report incidents. However, there were a low number of recorded incidents. There was a lack of feedback of lessons learned from incidents.
- Mortality and morbidity meetings had been planned to commence in September 2014, and take place quarterly.

Safety thermometer

- The NHS Safety Thermometer is a monthly snapshot audit of the prevalence of avoidable harms that includes new pressure ulcers, catheter-related urinary tract infections (UTI), venous thromboembolism (VTE), and falls.
- The NHS Safety Thermometer information for ICU was displayed on the entrance. Action plans were sent to the governance team where targets had not been achieved in a specific area. The unit had achieved 100% for venous thromboembolisms (VTE), urinary tract infections, and falls, for August.
- Risk assessments for patients for pressure ulcers and VTE were completed on admission, and prophylactic therapy initiated VTE prevention.

Cleanliness, infection control and hygiene

- The Intensive Care National Audit and Research Centre (ICNARC) data reported low levels of infection rates in ICU.
- Patients were cared for in a clean and hygienic environment.
- Staff followed the trust policy on infection control. The 'bare below the elbows' policy was adhered to. There were hand washing facilities at each bed space, and protective personal equipment (PPE), such as gloves and aprons, were available. We observed staff using gloves and aprons, and changing these between patients.
- There were effective arrangements for the safe disposal of sharps and contaminated items; these included dating of when the sharps box began to be used.
- The NHS infection control audit ('Saving Lives'), was carried out monthly. The service achieved 100% for August 2014.

Environment and equipment

- We found that equipment was clean and fit-for-purpose.
- Electrical safety checks had been carried out on the medical equipment used in ICU.
- The resuscitation equipment was checked daily, and a record of these checks maintained.
- The unit environment was bright and spacious. There was adequate space between each bed area.

Medicines

- Medicines, including controlled drugs, were safely and securely stored. The medication records of seven people we checked during our inspection were found to accurately reflect the prescribed and administered medicines for those patients.
- We saw records which showed that the pharmacist had audited the controlled drugs on a monthly basis.
- Fridge temperatures were monitored daily; these ensured that medicines were maintained at the recommended temperature, and the checks were signed by the individual undertaking these checks.

- There were arrangements for the effective access to medicines out of hours. ICU had its own allocated pharmacist, who visited the unit daily and reviewed all medical prescriptions to ensure sufficient stocks were available.

Records

- There was standardised nursing documentation kept at the end of each patient's bed. Observations were recorded clearly. The timing and frequency of observations were determined by the acuity of patients.
- All medical records were in paper form, and followed the same format.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff we spoke with were aware of the Mental Capacity Act 2005, and how this related to the patients they cared for.
- The medical admission documentation contained a specific section on mental capacity assessment, which ensured that this was assessed for each patient on admission to ICU.

Safeguarding

- Staff completed training on safeguarding vulnerable adults and children, as part of their mandatory training and updates.
- Staff demonstrated an understanding of safeguarding procedures and its reporting process. The nurse manager said that the safeguarding lead for the hospital was very supportive, and provided feedback and offered debriefing sessions following referrals that had been made.

Mandatory training

- The unit had a training plan for all nursing staff, to ensure they met their mandatory training targets. The nurse manager was informed monthly by the governance team as to which staff required specific training.
- Medical mandatory training averaged at 71% completion. There was a lack of systematic oversight to ensure that all doctors received their mandatory training.

Management of deteriorating patients

- There was an outreach team that provided support five days a week, from 8am to 8pm for the management of critically ill patients in the hospital. The hours of this service had recently been increased from 9am to 5pm.
- The national early warning score (NEWS) escalation process management of acutely unwell adult patients was used to identify patients that were becoming unwell. This ensured early, appropriate intervention from skilled staff.
- Patients were monitored using recognised observational tools and monitors. The frequency of observations was dependent on the acuity of the patient's illness. Alarms were set on monitoring equipment to alert staff to any changes in the patient's condition. This meant that deteriorating patients would be identified and action/escalation to the appropriate team initiated without delay.

Nursing staffing

- The staffing rota was planned, and staff worked on a rotational basis on days and nights. The nurse manager informed us that staff shortfalls were covered by internal bank staff. Occasionally, they used agency staff with ICU experience.
- We were informed that all level 3 patients were nursed one-to-one. The Intensive Care Society Core standards stipulate that one nurse must be allocated to each level 3 patient. However, we observed two level 3 patients being cared for by one nurse in two side rooms. When working in one side room, the nurse was not able to see or hear anything in the other side room, resulting in the patient being left unattended. There was generally a culture of leaving intubated patients unattended, even when a nurse was allocated to look after them. Nurses told us that one nurse frequently had to look after two ventilated patients, and they sometimes had to forego breaks in order to do this. We considered this to be unsafe practice.
- We highlighted this to the person in charge in the morning of our inspection; however, the same staffing arrangements were in place in the afternoon. We were informed that one nurse had gone off sick in the morning shift, but there had been no attempt to gain additional staff to cover the shift.
- We were concerned that during this period of understaffing, the unit was still open to admit a further level 3 patient. We checked staffing rotas and found that

staffing levels were similar to what they had been in the recent past, and were scheduled to be in the future, except for at nights, where there were two staff less on duty. It was not clear why there were less staff on duty at night than in the day.
- When we requested to look at dependency scores in the past few days, to check how many level 2 or level 3 patients were on the unit, staff were unable to provide us with this information. There was also no link between the dependency, staffing levels, and the number of patients being admitted.
- We raised our serious concerns regarding the staffing to the executive management team for the trust. The trust responded by providing assurances that they would rectify the staffing concerns to ensure the safety of patients. We visited the unit as part of our unannounced inspection and found that staffing levels were safe. However, long-term staffing plans were yet to be established.

Medical staffing

- Care in the ICU was consultant-led and delivered. Consultants provided cover seven days a week 8am to 8.30pm, and were available on-call at other times. They lived within 30 minutes of the hospital, and were readily available and easily contactable. Junior staff said that there were no problems contacting consultants, or getting them to come into the unit out of hours.
- All admissions to the unit were discussed and admitted under a consultant.
- Handovers were done twice a day. Details were noted in written format, and the handovers took place at each bed space, where patients were discussed for 15 to 20 minutes. Any patients that might require admission to ICU were discussed at handover, and recorded in a log book, so medical staff knew where the 'at risk' patients were within the hospital.
- There was a high use of locum doctors. However, they had a good induction to the unit and were well supported by the consultants.

Major incident awareness and training

- Major incident plans were in place, and staff were aware of where to access information.

Are critical care services effective?

Good

Patients received treatment and care according to most national guidelines. The ICU was obtaining good quality outcomes, as evidenced by their ICNARC data. However the implementation of care pathways for protective lung ventilation would increase the consistency of treatment for patients with this condition. We found that there was good multidisciplinary team working across the unit.

Evidence-based care and treatment

- The Intensive Care Society guidelines had been implemented to determine the treatment provided, to ensure good outcomes for patients. There were some gaps in the implementation of these guidelines, described below, however there was no evidence that patients were suffering as a result of the lack of these guidelines.
- There were care pathways and protocols in use. There was also a lack of clinical guidelines, such as a protocol for weaning.
- There was no evidence of consistent use of protective lung ventilation (PLV), which is utilised as best practice to reduce mortality. Staff knowledge of this practice, particularly amongst nursing staff, was patchy, and whether it was implemented depended on the consultant.
- There was no evidence of sedation gaps. These are done to reduce the risk of Ventilator Acquired Pneumonia, and to reduce the duration of stay on the ventilator.

Pain relief

- Patient's pain scores were assessed and documented. There were clear links between the pain scores and the level of analgesia administered.

Nutrition and hydration

- The unit used the Malnutrition Universal Screening Tool (MUST) to assess the nutritional needs of patients.
- In ICU, staff followed a protocol for hydration and nutrition for ventilated patients, and enteral tube nutrition was initiated. Dietician support was available Monday to Friday.

Patient outcomes

- There were low mortality rates on the unit, both generally, and for units of comparative size.

Critical care

- The ICNARC data outcomes compared well to national comparators.
- On review of patient data and clinical outcomes there was no direct correlation that the lack of these protocols around ventilator care had a negative impact on patient outcomes.

Competent staff

- All staff received one-to-one supervision and appraisals. These processes covered training and development needs and practices. Of the staff in this directorate, 94% had completed their appraisal.
- Over 50% of the nursing staff had the post registration award in critical care nursing. New staff to the unit had the opportunity of gaining this qualification after being in post for one year. All staff were working towards the national ICU competences, and were being assessed by a mentor at sister level.
- Medical staff had weekly half day education sessions. All junior medical staff were aligned to a mentor.
- The consultants covering the on-call work all had regular daytime sessions in ICU. There was a consultant rota that allowed continuity of care; the same consultant was on duty from Monday-Thursday.

Multidisciplinary working

- There was a multidisciplinary team (MDT) that supported patients and staff in the unit. For example, there was a dedicated critical care pharmacist, who provided advice and support to clinical staff in the unit. However, the multidisciplinary team and the lead nurse did not attend the doctor's ward rounds.
- There was adequate support and input from dietetics and physiotherapy. Microbiology did a daily ward round, and were available for advice at weekends.
- The unit had an outreach team that was fully integrated, and provided valuable support in the care of the critically ill patients.

Seven-day services

- There was consultant cover for patients in the unit during the day, 8am to 8.30pm, and an on-call service out of hours.
- There was 24 hour consultant cover. They carried out twice daily wards rounds, and were available for advice and support at other times.
- Pharmacy and dietetics were available Monday to Friday, and physiotherapy seven days a week

Are critical care services caring?

Good

Staff cared for patients in a compassionate manner, with dignity and respect. Both patients and their relatives were happy with the care provided.

Compassionate care

- We observed staff caring for patients in a kind and professional manner. Care was delivered in a compassionate manner to patients. We saw that the patients were treated with respect and dignity throughout their treatments. Nurses were attentive and had a good rapport with patients.
- We saw one example where nurses cared for an aggressive and verbally abusive patient, where the nurses remained calm, treated the patient sensitively, and calmed the patient.

Patient understanding and involvement

- Patients and relatives spoke very highly of the staff. Relatives told us that they felt they were kept informed, and were treated sensitively with understanding.
- One relative told us, "the nurses are very attentive, very lovely, very approachable and very polite".

Emotional support

- There was no specific bereavement service provided on the unit. The staff provided emotional support to all families in the event of bereavement.
- Two nurses were due to attend a counselling course to further their skills in this area.
- Relatives that we spoke with said that they had felt very well supported, and were always spoken to in a private room to maintain their privacy.

Are critical care services responsive?

Good

The unit was responsive to individual patients' needs. The staff also considered the needs of relatives and made efforts to reduce the anxiety caused by having a patient in critical care for relatives.

Critical care

Service planning and delivery to meet the needs of local people

- The unit had 12 open critical care beds. Between August 2013 to July 2014, the average bed occupancy rate for adult critical care beds in Kettering General Hospital was lower than that of all adult critical care beds in England.

Access and flow

- There was good access and capacity within the ICU. All elective surgical patients were booked in advance, and all new admissions were reviewed by a consultant within 12 hours of admission.
- The length of stay on the unit was below that for similar units, in comparison to the national average. Patients who were readmitted to the unit within 48 hours of discharge were similar to that of the England average.
- Out-of-hours discharge delays, which are patient discharges between 10pm and 7am, were below that for similar units in comparison to the England average.
- Patients frequently had their discharge from the intensive care unit delayed because of bed availability in the trust. We were informed that this had a direct impact on the service on most days. All discharge delays of over two days were reported as incidents. We were also informed that several patients were discharged home directly from ICU, because their discharge has been delayed so long.
- Non-clinical transfers out, which are patients discharged to a level 3 bed in an adult ICU in another acute hospital, were lower than that for similar units, compared to the national average.

Meeting people's individual needs

- The unit had access to translation services. Staff could contact the NHS interpretation service by telephone.
- Staff were aware of how to support people with learning disabilities. For example, staff told us how they would use people's learning disability passports within their plan of care. There was a lead nurse for learning disabilities and dementia, who provided support to staff on the unit.
- Staff used the 'butterfly' system to indicate which patients were living with dementia.
- There was a specific area that was used by relatives who wished to stay on the ward; facilities included a lounge, and two bedrooms with en-suite bathrooms. There was lots of storage space, no clutter, and locked doors for security.

Learning from complaints and concerns

- Outcomes and actions from complaints were disseminated to staff via a communication book. If a serious incident had occurred, staff were asked to sign to say that they had read the relevant information.

Are critical care services well-led?

Requires improvement

Critical care services required improvement as there appeared to be a lack of vision and strategy for the ICU. An action plan had not been produced to address recommendations following a peer review conducted in October 2013. Many of the issues raised were still present. However, staff felt well supported by their managers, and spoke of an open, supportive culture.

Vision and strategy for this service

- We spoke with the leads for the service, and found that there were no vision or specific plans for the unit.

Governance, risk management and quality measurement

- We were informed us that monthly governance meetings were taking place to discuss performance. There were plans to hold quarterly multidisciplinary team (MDT) meetings to discuss serious incidents, audits, quality issues, service development, policy review, and current/future challenges and developments for critical care. The first of these MDT meetings took place in August 2014, where ICNARC data and policy reviews were discussed.

Leadership of service

- Both medical and nursing staff told us that they felt well supported by their managers.
- Staff informed us that there had been more support from the executive team since the new management structures were put in place. We were told that the chief executive held monthly briefings, and was visible and had an interest in the ICU.
- There was a lack of planning staffing levels to patient need, and there appeared little ability to flex staffing levels up or down as patient need required. From our observation, the allocation of staff to patient was inappropriate, and there seemed to be a lack of leadership to escalate problems to a higher level. For

example, the lead nurse had not tried to obtain additional staff when someone went off sick. There was no plan in place to stop admissions to ICU until there were sufficient staff available to support patients. When we highlighted the problem in the morning, it had not been rectified by the afternoon; in fact, there seemed a lack of interest, concern and awareness that there was a serious problem.

Culture within the service

- Staff told us that there was a feeling of openness, where they felt able to report incidents without fear of a blame culture.
- Nursing staff told us that they felt valued, and were able to contribute to the development of the new ICU.

Public and staff engagement

- During our inspection, we saw a number of cards and letters from patients and their relatives, thanking staff for the care they had received.
- The unit had developed a feedback sheet for patients to complete following their stay. However, the unit had received little feedback via this method.

Innovation, improvement and sustainability

- The unit had received a peer review, conducted in October 2013. This review made a number of recommendations, including improving incident report feedback to staff; improving nursing staffing levels to ensure all level 3 patients had a staff ratio of one-to-one nursing; improving patient feedback to improve their service; and completion of a review of protocols and guidelines.
- There was no action plan developed following this review to address the recommendations. The same concerns were still present when we conducted this inspection. This demonstrated a lack of leadership and opportunity to improve the service.

Maternity and gynaecology

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

Information about the service

The maternity service at Kettering General Hospital includes births at home, and births at the hospital, offering both high risk (consultant-led) and low risk (midwifery-led) packages of care for women. The hospital managed 3,537 births last year.

During our inspection, we spoke with 32 staff and eight patients. We visited the antenatal & postnatal wards, foetal medicine, labour ward and outpatients maternity department. We received comments from our listening events, and from people who contacted us to tell us about their experiences. We used information provided by the organisation, and information that we requested, which included feedback from young people and women using the service about their experiences.

Summary of findings

The maternity service provided to women and babies by Kettering General Hospital required improvement. There was a lack of evidence to show that doctors were always actively involved in reviewing policies and practice changes, where performance was below the national targets, to reduce risks to patients. There was a lack of medical involvement in the development of some guidelines, and minimal evidence that national guidelines were being audited and followed.

The trust had provided adequate clinical staffing levels and skill mix, and had encouraged proactive teamwork to support a safe environment. However, we noted that the provider may wish to consider increasing consultant hours, to manage increased demands, and emergency support, in line with national guideline recommendations.

Concerns were identified and raised regarding the current poor fabric of the maternity building, and the facilities for breastfeeding and medicine management in parts of the maternity wards. We understand that the provider is currently taking action to improve these areas. Infection control standards required improvement.

Staff in all roles put significant effort into treating patients with dignity, and most patients felt well-cared for as a result. There were positive views from patients, and those close to them, about the care provided.

Maternity and gynaecology

The majority of maternity staff understood the corporate vision, and also the maternity strategy for developing the services at Kettering General Hospital. We saw that there were management systems in place, which enabled learning and improved performance, and which were continuously reviewed where required, although we found that there was a lack of corporate scrutiny regarding some of the maternity key performance indicators.

Are maternity and gynaecology services safe?

Good

The maternity service provided to women and babies by Kettering General Hospital was safe. The trust had provided adequate clinical staffing levels and skill mix, and had encouraged proactive teamwork to support a safe environment.There were arrangements in place to implement good practice, learning from any untoward incidents, and an open culture, to encourage a strong focus on patient safety and risk management practices. We raised concerns regarding the current poor fabric of the building, and the facilities for breastfeeding and medicine management in parts of the maternity wards. We understand that the provider is currently taking action to improve these areas this needs to be addressed in a timely manner to ensure that services are safe for women using the service.

Incidents

- We looked at incident reporting policies, a database which included maternity incidents raised by staff, and safety meeting minutes, and found that there were effective arrangements in place for reporting patient/ staff safety incidents and allegations of abuse, which were in line with national guidance.
- Staff were aware of clear lines of accountability for incident reporting, and all staff we spoke with stated that they were encouraged to report incidents. They usually received direct feedback from their ward manager, or through case reviews, directorate meetings, 'hot topics' at handover, or newsletters.

Safety thermometer

- There were dashboards clearly displayed for staff and visitors, which included key safety indicators, such as management of the deteriorating women, prevention of blood clots assessment practices, and infection control indicators. We saw that all indicators were compliant at the time of inspection, apart from one regarding medication incidents, which included actions being taken to improve the scores.
- We saw that 'hot topics' were raised at handovers to keep staff aware of current risks and practice changes, and this was noted as good practice.

Maternity and gynaecology

Cleanliness, infection control and hygiene

- We saw poor infection control standards, such as dusty shelving, a lack of keyboard covers, and missing 'I am clean' stickers on equipment being used in patient areas.
- Door ways and walls were chipped meaning that cleaning could not be effective to ensure that infection was controlled.
- We raised concerns regarding the fabric of the building in parts of the maternity wards, which included peeling wall areas, missing floor tiles, poor storage practices, inappropriate furniture and environment for breastfeeding, a lack of a clean area for intravenous drug preparation, and high shelving which made cleaning and infection control management difficult.

Environment and equipment

- Cramped facilities in the labour ward made equipment storage difficult. Staff told us that they wasted time looking for equipment, and we were told that one incubator in the storage room had not been used for over a year. Service stickers were not clearly displayed on some kit.
- The fabric of the building was poor and was not maintained. This did not appear to impact on the care of patients but impacted on the cleaning of the environment as described above.

Medicines

- Staff we spoke with were aware of medicine management policies. We saw that locks were installed on cupboards containing intravenous fluids, and monitoring systems were in place to pick up medication errors.
- Staff had raised concerns about a lack of a "clean area" for intravenous drug preparation, and that a drugs fridge was in an open area and not secure. Plans had been submitted for approval to create an appropriate environment. Whilst this did not appear to impact on the care delivered it was not in line with current guidance.

Records

- A new 'Medway' computer system was currently being installed to improve information and record management practices. Staff confirmed that training had been provided, and phase two of the system, scheduled for November 2014, would improve diagnostics and screening access, and the sharing of relevant information.
- Medical records were available to staff in the maternity unit and these were used in both in patient and community settings.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Review of mental capacity assessments were discussed at the safeguarding board meetings, and referrals made. Staff attend mandatory training on mental capacity awareness; the attendance was satisfactory.
- Staff were aware of issues around consent and mental capacity and took action to ensure that all women were aware of treatment options.

Safeguarding

- We found that the provider identified the things that were most important to protect women from abuse, and to promote safety. There were effective safeguarding policies and procedures, which were fully understood and implemented by staff.
- We saw that the named midwife for safeguarding children attended the safeguarding steering group, which included other agencies, such as the commissioning groups, so that people's protection plans were implemented effectively across the health sector.
- The training records showed that safeguarding training levels were: Level 1: 100%, Level 2: 88% and Level 3: 82%, which were within target.

Mandatory training

- Mandatory training was regularly monitored, with triggers in place to pick up non attendees. The current levels, ranging between 85% for information governance and 91% for mental capacity awareness, were satisfactory.

Management of deteriorating patients

- Staff confirmed training sessions, which included maternity early observation warning systems (MEOWS) to manage the deteriorating woman. There were escalation policies in place for the acutely ill patient, and monitoring systems to ensure that the scoring system was effective. We observed MEOWS in use and staff were able to describe escalation procedures.

Maternity and gynaecology

- The quality strategy dashboard for July 2014 showed that the women and children's directorate scored 100% compliance in the reducing unnecessary harm category.

Midwifery staffing

- Staff were confident that managers ensured, where able, that the right staffing levels and skill mix, across all clinical and non-clinical functions and disciplines, were sustained, at all times of day and days of the week, to support safe, effective and compassionate patient care, and levels of staff wellbeing. We saw staffing rotas which confirmed appropriate staff were on duty.
- The midwife to birth ratio was the same as the England average. Staff gave examples of increased staff numbers when demand was high, and said that managers were responsive to changing needs and circumstances, such as cover for long-term sick leave or study leave. There were no consultant midwives for the unit currently; consultant midwives are recommended by the safer childbirth guidelines 2007. There were on-call midwives for home births and emergency care each night, supported by the home birth leads.
- We saw that assessments of future workforce requirements, using established birth rate plus tools, were being completed yearly, to identify the number and experience of staff required to provide appropriate and safe cover in all maternity care settings at Kettering General Hospital. The trust used the safe staffing metric for ongoing monitoring, to ensure that safe staffing levels were maintained.
- Staff were willing to be flexible where needed, and told us that they liked the work, and patient safety was a priority. We saw staffing levels displayed for patient reference, which was good practice. Most patients we spoke with were very positive about the approach to safe care on the unit.

Medical staffing

- The trust has a higher proportion of junior and middle career staff than seen across England. The maternity unit has provision for 60 hours of consultant presence, including daytime on week days, and mornings at weekends; however, since there is no separate obstetric team to staff the elective caesarean section lists, this effectively reduces the consultant hours dedicated to cover the labour ward. There may also be a knock-on effect in reducing senior obstetric time for teaching and supervision of practical procedures on the labour ward, as we noted the relatively low instrumental birth rate compared to the higher section rate.
- Whilst staff noted a strong core medical team, the current medical provision was lean, and sometimes relied on goodwill to cover unexpected emergencies. One locum had been there for two years, and had numerous responsibilities, including being the audit lead, without the support of a permanent contract.
- We found that there was a lack of named lead consultants, such as for early pregnancy assessment, to support practice developments, such as the introduction of methotrexate for unruptured ectopic pregnancies, which was still waiting approval. Patients wanting this treatment currently have to go elsewhere.

Are maternity and gynaecology services effective?

Requires improvement

The effectiveness of services required improvement. There was a lack of medical input and scrutiny in the development of some guidelines, and minimal evidence that NICE guidance was being audited and followed. Where key performance indicators had been below target, we saw limited actions being taken to improve the effectiveness of service.

The number of staff receiving continual professional development, appraisals and clinical supervision was satisfactory. There were detailed and timely multidisciplinary team discussions and handovers, to ensure that patients' care and treatment was co-ordinated, and the expected outcomes were achieved.

We saw that the trust was currently investing in a new computer system, to facilitate better reporting practices, and link disciplines, to improve the effectiveness of communication and multidisciplinary working.

Evidence-based care and treatment

- The maternity service could demonstrate that there was a process for identifying relevant legislation, current and new best practice, and evidence-based guidelines and standards, which were reviewed and approved through the women and children clinical management team –

obstetric scrutiny committee. However, although doctors approved and signed off guidelines, staff told us that there was a lack of medical input and scrutiny in the development of some guidelines, and limited evidence that NICE guidance was being audited and followed. The compliance rate for NICE guidelines in the women and children's directorate was 67% in June 2014.

- We noted ongoing high rates of elective and emergency caesarean sections since February 2014. There was recognition around the need to review goals and targets at the delivery suite forum, and from the clinical staff we interviewed. However, we found that there was a lack of evidence to show involvement and engagement of medical staff, in plans to reduce the numbers of women having caesarean sections, to reduce risks to patients.

Pain relief

- Epidural and pain relief (entonox, pethidine, etc.) was available for women during labour if required

Nutrition and hydration

- Commissioners had noted an improvement over recent months in breastfeeding initiation, although rates remain low, at less than 70%. Breastfeeding initiation rates for women at Kettering General Hospital were lower than the national average.

Patient outcomes

- Where performance indicators had been below target, we saw limited actions taken to improve the effectiveness of service. Elective and emergency caesarean section rates were consistently higher since February 2014, and the average length of stay was longer than the national average. These indicators were not on the audit programme, considered in performance review meetings, or recognised on the risk register.
- Whilst midwives stated that they would challenge medical decisions, there was no clear medical plan on reducing the section rates, apart from 'medical staff to be encouraged to amend decision if clinical picture improves once theatre entered', which was included on the dashboard action plan, in July 2014. This approach was reactive, and did not give inspectors confidence that these indicators were being addressed effectively.
- Perinatal mortality meetings were held regularly, with lessons learnt highlighted, such as 'the pathway for referral of low blood count results has changed with increased consultant input to reduce delays'. Staff told us that they were invited to attend case reviews from a learning perspective, and we saw posters and attendance sheets which supported this.

Competent staff

- All permanent staff were appropriately qualified, and competent to carry out their roles safely and effectively, in line with best practice. Staff told us that there were effective induction programmes, not just focused on mandatory training, for all staff, including students. We saw educational audits supporting maternity student placements at Kettering General Hospital.
- Staff told us that their learning needs were identified, and training was put in place. We saw that there were opportunities, such as degree courses for professional development.
- The breastfeeding co-ordinator assessed each health care assistant (HCA) and midwife on their approach to breastfeeding support. Annual attendance at one of the breastfeeding study days organised by the breastfeeding co-ordinator was also mandatory.
- The provider had mechanisms in place to ensure appropriate levels of supervision and appraisal of all staff, and revalidation of doctors. The appraisal rate across the division for July 2014 was 88%.

Multidisciplinary working

- We found by observing ward areas, listening to focus groups, and individual doctors, midwives, support workers, community teams and administration staff, that there were detailed and timely multidisciplinary team discussions and handovers in place. Patients' care and treatment were co-ordinated, and the expected outcomes achieved both in the hospital and community setting. Care and treatment plans were recorded and communicated with all relevant parties, to ensure continuity of care. These findings were supported by a recent commissioner's team visit to the maternity unit, in August 2014.
- The lack of a maternity IT system had been recognised by the trust as a risk, and actions were currently underway to introduce the Medway system. Phase 2 was due to go live in November 2014, to facilitate better reporting practices, and link disciplines to improve communication and multidisciplinary working.
- We received a significant complaint regarding poor communication practices, between external specialist consultants providing services on site for foetal

anomalies, and the maternity teams. We checked the guidelines, and found that they had not been updated to reflect practice changes, which could have caused some of the confusion. This was raised for action with the service manager at the time, who confirmed that whilst all staff involved with the pathway were aware of provider service changes, and guidelines were updated, it took a significant time for new information to be replaced on the intranet for all staff members to read.

Seven-day services

- We were told that consultants were present for three hours on Saturday and Sunday mornings, and on-call from home at other times, coming in to assist and supervise when requested, providing an acceptable seven-day service.

Are maternity and gynaecology services caring?

Good

We found that the care given was good. Staff in all roles put effort into treating patients with dignity, and most patients felt well-cared for as a result. Patients, and those close to them, were encouraged to be involved in their care, treated as equal partners, listened to, and were involved in decision-making at all levels.

There were positive views from a breadth of patients, and those close to them, about the care provided, which were supported by the views of the staff, and also recognised by a recent commissioner's review, in August 2014. Care was person-centred, and parents sensitively supported where bereavement occurred.

Compassionate care

- We could see that staff in all roles put effort into treating patients with dignity, and most patients felt well-cared for as a result.
- The majority of patients told us that staff responded compassionately to discomfort and emotional distress in a timely and appropriate way. However, we did receive two significant complaints around an uncaring approach to pain management, and the lack of 24 hour facilities to support fathers as an integral part of the pregnancy process. We noted that 24 hour partner support during induction was being trialled as a response to patient feedback, although there were no facilities for the partners to stay in the postnatal period.
- We looked at the termination of pregnancy pathway, and early pregnancy assessment service, and found both to be well managed and caring regarding individual women's needs.

Patient understanding and involvement

- We observed, and commissioners had reported, that ward information boards were displayed at the delivery suite entrance. This included information on the Friends and Family Test (FFT), compliments and complaints, dashboard details, staff appraisals, nurse sensitive indicators, and sickness rates, in keeping with the trust expectations.
- The service scored 77 against the national average of 66 in respect of antenatal care and 82 against a national average of 76 in the birth score in the NHS Friends and Family Test. This is a positive sign that women were happy in these areas. However in postnatal care whilst the trust had previously scored around the national average the results for May2014 were well below the national average. This potential reflects the lack of responses received in this time frame.
- Patients told us that they were involved in decision-making, and understood the care and treatment they received. The vast majority were positive regarding the professionalism and support provided by the clinical and non-clinical staff.

Emotional support

- It was reported that the service had successfully applied for capital funding to upgrade elements of their delivery suite, helping to create an environment that is more personable and natural, and therefore supportive of breastfeeding. Commissioners reported in August 2014 that midwives were fully committed to encouraging breastfeeding, that they were following a variety of initiatives, and that the mothers (to be) they worked with felt properly supported.
- Staff provided a daily session called 'the 10 o'clock meeting'. This group for post-natal mothers provided support and discussion around mother and baby health, and feeding in a relaxed group setting. The midwives worked with the mothers on a one-to-one basis, if they chose not to attend the group meetings, and this was noted as good practice.

- There was a bereavement midwife in post, and a quiet room on the labour ward to support parents. Staff were familiar with bereavement protocols and counselling support opportunities for parents, where required.

Are maternity and gynaecology services responsive?

Good

The responsiveness of the maternity service was good. There were good mechanisms for information sharing with external commissioners and stakeholders, to provide co-ordinated and integrated pathways of care. Staff in the hospital and community were willing and flexible in working practices around responding to the needs of patients.

The provider was open and transparent about how it had dealt with complaints and concerns, and implemented practice changes based on patient feedback.

Service planning and delivery to meet the needs of local people

- We saw through the minutes of meetings and responses from focus groups that the provider had actively engaged with commissioners of services, local authorities, health visitors, school nurses, GPs, relevant groups, people who use services, and those close to them, to provide co-ordinated and integrated pathways of care that meet people's needs.
- Midwifery staff rotate on a six monthly schedule, to cover the wards, delivery suite and community services. This allows flexibility to support busy times; for example, community midwives may be called into the hospital during periods of high demand. Because of the positive attitude of the staff, the need for agency staff was minimal, which was noted as good practice.
- The maternity department was seeking approval to invest £2.9m (including VAT) in constructing two new obstetrics and gynaecology theatres in front of Rockingham Wing at Kettering General Hospital. The aim was to provide a fully compliant theatre ventilation system and a compliant theatre suite, recovery area, associated rooms and circulation to improve service delivery.
- The provider was aware that the current shower and toilet facilities in some of the maternity wards were not fit-for-purpose, or compliant with disability requirements. Plans were in place to replace these facilities, commencing in October 2014.

Access and flow

- The maternity unit has introduced some changes to improve patient flow. We were told that induction of labour was now undertaken on the foetal health unit rather than the ward. The admission times were also made later, in response to patient feedback, which was noted as good practice.
- Community support staff we spoke with told us that services provided in the community were flexible enough to fit in with people's lives, where possible, such as work and family commitments.

Meeting people's individual needs

- People who use the service were asked about their spiritual, ethnic and cultural needs, and their health goals, as well as their medical and nursing needs. Their care and treatment was planned and delivered to reflect these needs, as appropriate. Women were encouraged to reflect their wishes for birth in the birth plan. Evidence of completed birth plans was seen in medical records.
- Verbal, electronic and written information that enables patients to understand their care, was available to patients and their relatives in ways that met their communication needs. There were posters indicating different language options, and staff were aware of the provision of information in different accessible formats and interpreting services. All women booked into the unit had a named midwife.
- Privacy and dignity posters were displayed, and 'please do not enter' signs were observed, although the environment and cramped facilities made this difficult in some areas.

Learning from complaints and concerns

- People we spoke with knew how to raise concerns or make a complaint. Staff told us that they encouraged people who use services, those close to them, or their representatives, to provide feedback about their care. Complaints procedures and ways to give feedback were available.
- The provider was open and transparent about how they dealt with complaints and concerns. We saw examples

of practice changes in response to complaints or concerns raised, such as ladies requiring inductions being admitted to the foetal health unit with a one-to-one midwife; and couples now given better information and support at the start of the process. Also, partners were now allowed to stay during induction, and one bed had been removed from the bay in order to create more space for armchairs.

Are maternity and gynaecology services well-led?

Requires improvement

Whilst nursing staff were well led at a local level we found that there was a lack of corporate and medical scrutiny regarding some of the maternity key performance indicators, which were outside of national averages. This requires improvement so that all disciplines are working to ensure that the team are well led and achieving good outcomes for women using the services. The majority of maternity staff understood the corporate vision, and also the maternity strategy for developing the services at Kettering General Hospital. We saw that there were management systems in place which enabled learning and improved performance, and which were continuously reviewed, where required.

We found that the midwifery leadership model encouraged co-operative, supportive relationships among staff, and compassion towards people who use the service.

Vision and strategy for this service

- The senior executive team provided inspectors with a statement of vision and values encompassing key elements of the NHS constitution, such as compassion, dignity, respect and equality, with quality a key priority. The majority of maternity staff understood the vision and also the maternity strategy for developing the service.
- We saw through the minutes of meetings, and staff we spoke with confirmed, that they had been consulted with regarding service developments and design plans, such as the plans in constructing two new obstetrics and gynaecology theatres in front of the Rockingham Wing at Kettering General Hospital, and the refurbishment plans for parts of the maternity unit, to improve services to women and their partners.

Governance, risk management and quality measurement

- We looked at examples of board papers, governance meetings, risk registers, quality monitoring systems and incident reporting practices. These showed that there were management systems in place which enabled learning and improved performance, and were continuously reviewed, where required. We looked at minutes of the women and children's health governance meeting from July 2014, which showed monitoring and reporting of key performance indicators, audits, policy changes and risk management practices to improve care.
- We noted a lack of scrutiny regarding some of the maternity key performance indicators; there was no reference or actions noted in the performance reports in the integrated governance meetings regarding elective and emergency caesarean section rates, which were consistently higher than the national average since February 2014.
- The organisation directorates were going through changes, which staff felt were beneficial, as they said that there had been a lack of medical ownership of risk and governance, as this was currently led by the head of midwifery and nursing.

Leadership of service

- We found that the midwifery leadership model encouraged co-operative, supportive relationships among staff, and compassion towards people who use the service. Staff told us that they felt respected, valued and supported, and that leadership communicated effectively and was visible to community teams, as well as to hospital staff.
- There was a lack of medical leadership and scrutiny regarding performance indicators. It was not clear whether the trust had a set of expected standards and behaviours for its operational leaders.

Culture within the service

- Staff said that candour, openness, honesty and transparency were at a high level, and challenges to poor practice were the norm, but it was unclear if this actually resulted in changes to practice. It was good to see that staff were confident to challenge the chief executive about the poor environment in parts of the maternity service, with no fear of repercussions.

Maternity and gynaecology

Public and staff engagement

- Following the 2013 staff survey results for the trust, the trust board of directors had agreed to focus on the five domains which were components of the overall staff engagement score, and to focus on actions which it is hoped will improve the responses to these areas in 2014. There were clear action plans in place, which were reviewed regularly at senior management level.
- The maternity survey did not raise any significant concerns, and the Friends and Family Test (FFT) results indicated a satisfactory maternity service, apart from the postnatal ward. A working party was set up in response to this, and improvements had been noted, with scores increasing from 42% to 67%.

Innovation, improvement and sustainability

- We were informed that the new information system was supported through the midwifery staff obtaining £350,000 from the nurse innovation fund.

Services for children and young people

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

Information about the service

Kettering General Hospital paediatric clinical service provides acute clinical care to children and young people aged 0–16 years, requiring medical or surgical care. The children's ward (Skylark Ward) is located in the new Foundation Wing, which opened in May 2013, along with a purpose-built children's outpatient unit. There is also a paediatric assessment unit for children who may have been seen in A&E, or by their GP, and where it is felt that they need a longer period of observation and assessment before a decision is made about whether they should be admitted to the ward or sent home. There were 4,371 episodes of care provided to children at the hospital in the last year.

The special care baby unit has 18 cots altogether, with four designated to intensive care, six to high dependency and eight to special care. The hospital can admit babies from 26 weeks of age, and treat babies who are premature, or need special treatment for various conditions. There is also a parent's facility, including two bedrooms, a sitting room and bathroom, where parents can stay if their baby is really poorly, or if the mother is breastfeeding.

During our inspection; we spoke to 18 staff and five families. We visited the paediatric emergency department, inpatient ward, including the neonatal unit and assessment unit, and observed clinics.

Summary of findings

We found that the current service provided to children and young people by Kettering General Hospital was safe, effective, caring, responsive and well-led. The trust had provided good, flexible staffing levels, an adequate skill mix, and had encouraged proactive teamwork to support a safe environment.

There were arrangements in place to implement good practice, learning from any untoward incidents, and an open culture to encourage a strong focus on patient safety and risk management practices. Families told us that they felt safe in the hands of the staff, and staff said they felt supported by the trust in managing risk and keeping their patients safe. We saw good examples of care being provided, with a compassionate and dignified approach.

National guidance was being implemented, and monitoring systems to measure performance were in place. There was good collaborative working with partners and other agencies, and the number of staff receiving continual professional development and clinical supervision was satisfactory.

The children and young people's service understood the different needs of the communities it serves, and acted on these to plan and design services. The paediatric department encouraged children, their relatives, and those close to them, to provide feedback about their care, and were keen to learn from experience, concerns and complaints.

Services for children and young people

The paediatric departments could demonstrate that risks to the delivery of high quality care were identified, analysed and mitigated systematically, before they became issues which impacted on the quality of care. There was strong team-based working, characterised by a co-operative, inter-disciplinary, cross-boundary approach to delivering care, in which decisions were made by teams as well as leaders.

Are services for children and young people safe?

Good

The trust had provided good flexible staffing levels, an adequate skill mix, and had encouraged proactive teamwork to support a safe environment. There were arrangements in place to implement good practice, learning from any untoward incidents, and an open culture to encourage a strong focus on patient safety and risk management practices. Families told us that they felt safe in the hands of the staff, and staff said they felt supported by the trust in managing risk and keeping their patients safe.

Incidents

- We looked at incident reporting policies, a database which included paediatric incidents raised by staff, and safety meeting minutes, and found that there were effective arrangements in place for reporting patient/ staff safety incidents and allegations of abuse, which were in line with national guidance.
- Staff were aware of clear lines of accountability for incident reporting, and all staff we spoke to stated that they were encouraged to report incidents. They usually received direct feedback from their matron, or through case reviews, directorate meetings or newsletters. We noted that 90% of Datix incidents were reviewed within seven days.

Cleanliness, infection control and hygiene

- Staff were satisfied with the cleanliness levels throughout the department, and we observed staff being compliant with key trust policies, such as 'bare below the elbows'.
- Systems were in place to monitor the numbers of hospital-acquired infections. 'I am clean' stickers were displayed on all equipment, and parents noted that the wards looked clean. We saw staff regularly wash their hands between dealing with patients.

Environment and equipment

- The children's ward (Skylark Ward) is located in the new Foundation Wing, which opened in May 2013. Along with a purpose-built children's outpatient unit, it enabled the trust to provide modern facilities for children and their parents, or other carers.

- The environment was clean and tidy and there was sufficient equipment to meet the needs of patients in the unit.

Medicines

- Staff we spoke with were aware of medicine management policies. We saw that locks were installed on all cupboards containing intravenous fluids, and monitoring systems were in place to pick up medication errors.
- Regular medication audits were carried out. We saw full compliance with a controlled drugs audit for August 2014, which was a marked improvement on previous scores. Monitoring of medication errors was noted in the staff newsletter for additional information.

Records

- Recent documentation audits showed that patients had had a full nursing assessment accurately completed, and an appropriate individualised plan of care was in place. The records we reviewed were complete and personlised to the individual.

Consent

- We saw that staff were familiar with consent procedures. Staff were aware of the legislation around capacity to consent and took appropriate action when children were deemed to have capacity.

Safeguarding

- Staff were aware that the children's safeguarding team included a named nurse and named doctor for additional support.
- All staff we spoke with had received safeguarding vulnerable children training at the appropriate level. We looked at training records, and noted safeguarding training was currently below target for the department.
- Staff told us that they were involved in serious case reviews, and outcomes were shared to support learning.

Mandatory training

- Mandatory training was regularly monitored, reported, and with triggers in place to pick up non attendees. Levels of paediatric medical and nurse staffing attendance at mandatory training were below target at the time of inspection,at around 80%; however, actions were in place to address this.

Management of deteriorating patients

- The departments used the paediatric early warning scoring (PEWS) system. This system was introduced to standardise the assessment of acute illness severity. There were clear directions for escalation printed on the observation charts, which were available for staff reference. Staff knew how to activate escalation processes, which work well; for example, drafting in additional staff to cover increasing levels of demand, or responding to warning signs of rapid deterioration of patients.
- Audits showed 100% compliance with PEWS documentation, and there was evidence of appropriate action being taken, based on the PEWS and the escalation process. We saw that PEWS charts were not age-specific but were completed appropriately. This is recognised by the trust, who are considering moving to more age-specific charts.

Staffing

- We saw that annual audits were conducted using nationally-recognised tools, against activity regarding the number of staff and the skill mix required to ensure safe staffing levels in the paediatric units. Clinical and medical staff told us that the staffing levels were adequate, and the rotas submitted supported this.
- The British Association of Perinatal Medicine (BAPM) recommended staffing establishments are used at the hospital to benchmark neonatal nursing staff levels. The risk register acknowledged that the current staffing levels were below BAPM neonatal staffing guidelines for cot capacity of 18 cots (four ICU, six HDU & eight SCBU). We saw that contingency plans, such as staff flexibility and the rotation of staff and bank shifts were in place, for staffing and capacity shortfalls, in order to manage the service as effectively as possible.

Are services for children and young people effective?

Good

The effectiveness of services was good. National guidance was being implemented, and monitoring systems to measure performance were in place. There was good collaborative working with partners and other agencies, and the number of staff receiving continual professional development and clinical supervision was satisfactory.

Services for children and young people

There were detailed and timely multidisciplinary team discussions and handovers, to ensure patients' care and treatment was co-ordinated, and the expected outcomes were achieved.

Evidence-based care and treatment

- Doctors and nurses in the children's directorate used a combination of NICE and Royal College of Paediatrics and Child Health (RCPCH) guidelines to determine the treatment they provided. They showed us that local policies were written in line with this, and were updated regularly, or if national guidance changed. Staff were aware of the importance of adherence to local policies and procedures.
- Local audit activity was observed, such as infants and children admitted with bronchiolitis, which included verbal discussions on outcome. We noted that clear written action plans were not always in place to demonstrate plans for improvements following audits.
- Staff showed us newsletters updating them on local audits, such as correctly scored PEWS, fluid balance charts, blood pressure (BP) recordings and nursing assessments.
- We were informed that the unit is currently involved in five research studies, and has the support of a funded paediatric research nurse, which was noted as good practice.

Pain relief

- We saw good outcomes from pain audits, which showed that the patient's pain had been considered, assessed and appropriate action/care taken and documented. There were child-friendly pictures to help children assess their level of pain, and families spoken with were happy about pain management.

Nutrition and hydration

- Staff told us, and audit outcomes confirmed, that patients were weighed on admission and at agreed times during their stay. Eligible patients, such as children with complex care needs, had a completed paediatric nutrition assessment. Patients with a requirement for a food chart had one completed and an appropriate plan in place to support nutritional needs.

Patient outcomes

- Complete, accurate and timely performance information was readily available to staff, families and the public, through posters, meetings and board minutes. Staff told us that they understood the performance information they received.
- We saw that the trust was participating in national paediatric audits, such as the RCPCH National Neonatal Audit Programme (NNAP) and the National Paediatric Diabetes Audit (NPDA), with action plans in place where gaps were highlighted. Minutes of divisional meetings included reviews of national guidance, policy updates and national audits, to support improvements in patient outcomes.

Competent staff

- Staff told us that they had effective appraisals and continual professional development updates to maintain and improve their specialist skills. We saw training records which supported this, although some areas of core skills training were below target, such as basic life support (64%) and manual handling (66%) training.
- We saw educational audits regarding quality standards to monitor the placement learning opportunities for students, which were satisfactory.
- There were minutes of meetings which showed opportunities to reflect on practice and workloads. We spoke with numerous medical and nursing staff, who noted that good supervision, teamwork and peer support was provided to support them in their role.
- Staff did note that due to increasing dependencies and sicker children, more high dependency trained nurses would be needed in the future.

Multidisciplinary working

- There was collaboration amongst services to support children and young people's care and treatment, and action practice changes, where necessary, to ensure effectiveness of care delivery. Staff had contacts with social services, district nurses, health visitors and school nurses to ensure that appropriate support was available to children and families on discharge or transfer.
- We saw numerous examples of joint working, with clinical commissioning groups, safeguarding teams and NHS England, to develop a strong interface between the acute provision and community health provision for children and young people. We saw that in recent

divisional meetings it had been agreed to have a dedicated community section at each future meeting, to develop joined-up working practices and pathways to improve care.
- There were good training programmes to highlight staff awareness regarding transitioning children to adult services, and a user-friendly website available to support children during the process.
- We observed detailed and timely multidisciplinary team discussions and handovers, to ensure that patients' care and treatment were co-ordinated, and the expected outcomes were achieved. Care and treatment plans were recorded and communicated with all relevant parties, to ensure continuity of care.
- At Kettering General Hospital they have eight play specialists, who provide cover seven days a week. Eligible patients have an individual care plan to meet their specific play/recreation needs and patients whose length of stay is over 24 hours have daily access to a play specialist.

Seven-day services

- There were consultant ward rounds seven days a week, but there was not a full seven day working system.

Are services for children and young people caring?

Good

Services for children, young people and families were good and caring. We saw good examples of care being provided, with a compassionate and dignified approach. Patients and families were involved in planning their care, and making decisions about the choices available in their care and treatment. The vast majority of families and staff would recommend the service to family and friends. We found the play specialist support services outstanding.

Compassionate care

- Throughout our inspection we witnessed children and their parents being treated with compassion, dignity and respect.
- We observed that call bells were answered promptly, and parents we spoke to said that they would recommend the service to family and friends.
- We found that over 50% of the paediatric staff had signed up to be 'dignity champions'.

Patient understanding and involvement

- Children, young people and their families were appropriately involved in, and central to, making decisions about their care and the support needed. We found by looking at care plans, observing care, reviewing clinical guidelines and talking to families and staff that care was planned, to reach best practice as set down by national guidelines. Parents told us that the unit provided family-centred care, and that they were well informed regarding treatment. We also saw thank you letters and positive comments displayed, which supported this impression, and areas in the care plans for parents comments, to encourage their involvement.

Emotional support

- Feedback from families and staff show that this is an outstanding service. The play team recently won a hospital 'Smile award' for going the extra mile. The service also encourages pet and music therapy, and will support children's services including outpatients, where necessary, to ensure that children and families are supported.

Are services for children and young people responsive?

Good

The responsiveness of the service was good. The children and young people's service understood the different needs of the communities it serves, and acted on this to plan and design services. It was proactive in taking action to remove barriers that parents, children and young people may face in accessing or using the service. There were good mechanisms for information sharing, and willingness from staff for flexible working around responding to the needs of parents, children and young people. The paediatric department encouraged children, their relatives and those close to them to provide feedback about their care, and were keen to learn from experience, concerns and complaints.

Service planning and delivery to meet the needs of local people

- Skylark Ward is a 26 bedded unit, of which all beds are funded, Tuesday 7am to Friday 8pm. At all other times of the week the ward is funded for 18 beds. When operating at 26 beds, the normal staffing is for seven

trained staff in the day, and five trained staff at night, with healthcare support and play team support predominately for daytime work, which is adequate. A business case to support increasing demands and Winter planning to fund all beds 24/7 has been submitted for consideration for Winter 2014/15.

- We saw that there were minimal cancellations, both in the Skylark Ward and in the children's outpatient department. We saw good mechanisms for information sharing, and willingness from staff for flexible working around responding to the needs of parents and children.

Access and flow

- We saw guidelines and criteria which outline the paediatric rapid access 'hot' clinics, which are provided to support admission avoidance. The rapid access clinics are seen as an alternative to hospital/emergency admission for the management of unwell children, and are run at twice weekly clinics. A recent quarterly review showed good outcomes, including 24 children avoiding admission, and 14 facilitating early discharge.

Meeting people's individual needs

- We saw specific pathways of care being developed to support children and young people with mental health issues, such as self-harm. Staff reported adequate links and referral practices with the Child and Adolescent Mental Health Service (CAMHS) and social services. We saw minutes of the children's health and wellbeing board, which were developing workstreams to promote and improve emotional/physical and mental health wellbeing.
- Staff were aware of the use of health passports for patients with a learning disability to ensure that they were involved, and their needs were understood. The hospital intranet site included 'My future, my choice' – an easy-read website, designed in consultation with children with a learning disability. It included contact details for support from both the acute and community learning disability teams.
- We saw that verbal and written information that enables children, and to their relatives, to understand their care was available in ways that met their communication needs, including the provision of information in different accessible formats and via interpreting services. Smiley faces were used for questionnaires and pain scores, and age-appropriate accommodation for adolescents was in place. We found that the hospital maps and signage were not particularly welcoming or clear regarding children's services.
- The play areas and sensory room added to the welcoming environment. Equipment provided was age appropriate, including the resuscitation trolleys.
- We saw that some outpatient clinics, such as ophthalmology and the fracture clinic for children, were provided in adult areas, and were not always child-friendly.

Learning from complaints and concerns

- Child-friendly questionnaires were in place to encourage feedback. Staff said they were empowered to discuss complaints with the families where possible, and resolve issues in a timely manner. If this did not deal with their concern satisfactorily, they would be 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.
- Skylark Ward had received five complaints in the last year. Monitoring and practice reviews were discussed at the patient experience quarterly meetings. Staff were aware of complaint management practices, and received feedback through meetings and newsletters to improve practice.

Are services for children and young people well-led?

Good

The paediatric departments could demonstrate that risks to the delivery of high quality care were identified, analysed and mitigated systematically, before they became issues which impacted on the quality of care. There was strong team-based working, characterised by a co-operative, inter-disciplinary, cross-boundary approach to delivering care, in which decisions were made by teams as well as managers.

Vision and strategy for this service

- The senior executive team provided inspectors with a statement of vision and values, encompassing key elements of the NHS constitution, such as compassion, dignity, respect and equality, with quality as a key

priority. The majority of paediatric staff understood the vision and strategy for developing the paediatric services, although we did not see any details displayed for reference.

- From minutes of meetings, and staff we spoke with, it was confirmed that staff had been consulted with, regarding service developments and design plans, such as the move to the Foundation Wing in 2013, which was good practice. Staff were also aware of the business case to support winter planning to fund all paediatric beds 24/7, which had been submitted for consideration for Winter 2014/15.

Governance, risk management and quality measurement

- We looked at examples of board papers, governance meetings, risk registers, quality monitoring systems and incident reporting practices. These showed that there were management systems in place, which enabled learning and improved performance, and which were continuously reviewed where required. We looked at minutes of a women & children's health governance meeting in July 2014, which showed monitoring and reporting of key performance indicators, audits, policy changes and risk management practices to improve care.
- We saw that the performance and delivery of children's services was mapped efficiently on a dashboard, with audit outcomes, for staff and board members reference. This data was used at a strategic level to ensure that the board were kept aware of the timely delivery of service. These monitoring systems show that the board and senior managers were informed on quality issues, risk, and general performance regarding children and young people across the organisation. Staff we spoke with were aware of the key performance outcomes for the paediatric service.
- There was consistency between what front-line and senior staff said were the key challenges/problems facing the service. The risk register reflected what individuals said was on their worry list, such as the roof leak in Skylark Ward, neonatal staffing levels, and high temperatures in the kitchen.

Leadership of service

- We saw that the paediatric leaders and managers encouraged co-operative, supportive relationships among staff and teams, and compassion towards patients. Staff reported that the leadership of the departments ensured that they felt respected, valued, supported and cared for. Staff told us that there was visible leadership across the organisation to support the strategies, and senior managers were visible in the department for day-to-day operational management, although the paediatric clinical lead was currently not on site.

Culture within the service

- Staff within the directorate spoke positively about the service they provided for patients. Quality and patient experience was seen as a priority, and everyone's responsibility. Staff repeatedly spoke of approachable managers, and how they were encouraged to speak up if they saw something they were unhappy with regarding patient care.
- Staff worked well together, and there was obvious respect, not only between the specialities, but across disciplines. We saw in multidisciplinary team meetings that staff were actively engaged in quality improvement practices, and there was little evidence of professional isolation or management-clinician divides.

Public and staff engagement

- Web choices comments from families were regularly reviewed and responded to by the matron, to show that feedback was monitored and valued. We saw that positive comments had been noted about Skylark Ward.
- Following the 2013 staff survey results for the trust, the trust board of directors had agreed to focus on the five domains which were components of the overall staff engagement score, and to focus on actions which, it is hoped, will improve the responses to these areas in 2014.
- We found consistently positive views from a breadth of patients, families and those close to them, which were supported by the views of the staff. Child-friendly questionnaires were available to encourage feedback.

End of life care

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

Information about the service

Kettering General Hospital provides end of life care throughout the trust. Patients with palliative or end of life care needs are nursed on general wards in the hospital. The trust has a service level agreement with another trust for two and a half full-time specialist palliative care nurses. They are supported by one and a half whole time equivalent consultant posts from a local hospice, and a specialist registrar cover on site between two and four days a week.The team is led by the deputy director of quality at the trust. This team co-ordinate and plan care for patients at end of life on the wards, and are available Monday to Friday, 9am-5pm, excluding Bank holidays. Out-of-hours consultant support is provided via a telephone hotline to the local hospice.

We visited four wards where end of life care was provided, the bereavement centre, the multi-faith centre and the mortuary. During our inspection, we spoke with six patients, four relatives and 25 members of staff, including nurses, doctors, health care assistants, discharge co-ordinators, mortuary technicians and staff in the bereavement centre. We observed interactions between patients, their representatives and staff, considered the environment, and looked at care records. Before our inspection, we reviewed performance information from, and about, the hospital.

Summary of findings

We found that overall this service was inadequate due to the lack of leadership and effective outcomes for patients within the service. We found that access to services was poor and constrained by the agreement with the third party provider. We found that improvements were required to be made to safety and being responsive to people's needs.Care for patients at the end of their life was supported by a specialist palliative care team. Since the phasing out of the Liverpool Care Pathway, the trust did not follow a specific end of life care pathway.Ward staff were not appropriately trained in end of life care, and care was not always delivered appropriately, as staff did not always recognise when patients required specialist end of life care input. There was a failure to recognise patients as being at the end of their life until they were in the final stages of the process.

There were inconsistencies in the completion and review of 'do not attempt cardio-pulmonary resuscitation' (DNA CPR) forms. Some had not been signed by a consultant, and it was not always clear whether discussions with the patient and their representatives had taken place.

The caring and responsive approach to bereaved families by staff in the mortuary, including support with viewings, and support with funeral arrangements, was outstanding. Staff in this service went beyond the call of duty to support families, particularly those bereaved of children and babies during difficult times.

End of life care

Are end of life care services safe?

Requires Improvement

End of life care took place on general ward areas throughout the trust, and requires improvement. Most medicines were appropriately prescribed, but were not always administered when they should have been. Anticipatory medicines were prescribed for patients who required end of life care. 'Do not attempt cardio-pulmonary resuscitation' (DNA CPR) forms were completed, but had not always been appropriately signed in a timely manner by a consultant.There was no risk register specific to end of life care, and the specialist palliative care team told us that there were no risks in end of life care. However, we identified there was no medical leadership for end of life care in the trust, there was no formal strategy for end of life care, there was no end of life care pathway, and many staff throughout the hospital had not received any training in end of life care. However, the specialist palliative care team told us that end of life care training was now included as part of the induction programme for new staff.

Incidents

- Incidents were reported through the trust's electronic reporting system.
- There was no risk register specific to end of life care, and the specialist palliative care team told us there were no risks in end of life care. However, we identified that there was no clinical leadership for end of life care in the trust, there was no formal strategy for end of life care, there was no end of life care pathway, and many staff throughout the hospital had not received any training in end of life care.
- The specialist palliative care team told us that there were very few reported incidents relating to end of life care.

Cleanliness, infection control and hygiene

- The mortuary was clean when we visited. The environment was aged; however, staff ensured that appropriate cleaning protocols were adhered to.

Environment and equipment

- The environment within the mortuary had not been updated for some time. For example, the service did not have any permanent bariatric fridges for patients who would not be able to fit in a regular fridge. However, the service had purchased cooling blankets and utilised a room cooled down to an appropriate temperature to safely care for bariatric patients. The service had good links with the local undertakers, to ensure that the patients were moved to an appropriate facility as soon as possible.
- Staff reported that equipment required to care for patients at the end of their life was available when it was needed. The trust was still using ambulatory syringe drivers which are due to be phased out by March 2015, and replaced by ambulatory syringe drivers which meet the NHS Patient Safety guidance. Syringe drivers were not kept on the wards, but staff told us that they could be accessed from the equipment library as required

Medicines

- Staff told us, and we saw, that patients who required end of life care medicines were written up for anticipatory medicines (medication that they may need to take to make them more comfortable).
- The specialist palliative care team told us that medication could be accessed in a timely manner for patients who had expressed a preference to die at home.
- Staff told us that they were not aware that the trust had written guidelines relating to anticipatory prescribing.
- We checked six medication administration records and found that two out of the six records demonstrated that patients were not always receiving their medication when they should have done.

Records

- We looked at five DNA CPR forms, three of which had been completed in line with national guidance published by the GMC and Resuscitation Council UK. There were two DNA CPR forms that did not include a consultant's signature. There was also no evidence of discussion with the patient's relatives, and on one occasion, they had not been countersigned by a second doctor. These forms had been completed that morning. When we visited the trust unannounced we found a further DNA CPR form which had not been signed by a consultant five days after it had been completed.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Mental Capacity Act training was mandatory across the trust.

End of life care

- We saw that consent to treatment was obtained appropriately from patients who had the capacity to give consent.
- We saw one person who was being deprived of their liberty on one of the wards we inspected. We saw that this person had an appropriate deprivation of liberty assessment in place.

Safeguarding

- The trust had a safeguarding of vulnerable adults policy, which had expired in May 2014. This was under review at the time of our inspection, and the safeguarding lead told us that the policy would be ready for consultation by the safeguarding steering group by 12 September 2014.
- Safeguarding training was mandatory, and new staff received safeguarding awareness training on induction.
- All staff we spoke with confirmed that they had received training in safeguarding adults.
- The trust had a safeguarding lead, and staff we spoke with knew who the lead was.
- The staff we spoke with told us that they knew how to make a safeguarding referral, and were able to give examples of when they would make a safeguarding referral.

Mandatory training

- End of life/palliative care training was not included as part of the trust's mandatory training programme.However, the specialist palliative care team told us that as of January 2014, end of life care training was included as part of the induction programme for new staff. Since August 2014 the Palliative Care Team have also delivered training in terms of who the team are and how to refer to them at Junior Doctors induction. On the ward training is also delivered by the palliative care team to ward nurses.

Nursing staffing

- Patients requiring end of life care were nursed on general medical wards.
- Agency and bank nurses were used to fill gaps on staff rotas. Nursing staff told us that they were often left short staffed because staff were redeployed to other areas where the need for staff was greater.
- At the time of our inspection, there were no link nurses for end of life care on any of the wards we inspected. The lead for end of life care told us that they were in the process of identifying end of life care link nurses on each ward. None of the staff we spoke to knew about this.

Medical staffing

- The care of each patient was managed by the consultant who was most relevant to that patient's condition.
- There was no designated medical lead for end of life care based at Kettering General Hospital. Specialist medical support for people requiring end of life care was provided by two consultants who were based at Cransley Hospice. One of the consultants told us that they visited the hospital for four to five hours, four days a week and a minimum of two hours on the fifth day.
- Junior doctors told us that they were unaware of the referral process to the specialist palliative care team.
- Out of hours, advice about symptom control was provided by doctors based at Cransley Hospice.

Major incident awareness and training

- The mortuary were engaged in resilience for the trust, and were part of the major incident plan. The environment did not enable the isolation of high risk, infectious or contaminated patients; however, the staff were clear on how they would manage such an event.

Are end of life care services effective?

Inadequate

Services at the end of patients life was inadequate as there was no end of life care pathway in place, no training given to staff and no identification of patients who may not have been in the last days or hours of life but who would benefit from this service. In line with national guidance, the trust had withdrawn the use of the Liverpool Care Pathway. At the time of our inspection, there was no specific end of life care pathway in use at the trust, and staff were not clear about what guidance they should be following. We did not see a specific care plan relating to end of life care. The end of life care lead told us that the team were working on developing an end of life care pathway for use throughout the trust.

End of life care

The specialist palliative care team told us that they benchmarked end of life care throughout the trust; however, they had not benchmarked end of life care within the trust against national end of life care guidance since 2011. Staff we spoke with told us that they knew how to access the specialist palliative care team, but they were not always clear about identifying when a patient should be referred to the specialist palliative care team.

Evidence-based care and treatment

- Following the withdrawal of the Liverpool Care Pathway, the trust had not yet put an end of life care pathway in place. The lead for end of life care told us that the end of life care strategy group had been working on a replacement pathway, but as yet, this had not been implemented.
- We spoke with staff about what guidance was used with regard to caring for patients at the end of their life. Staff were unable to tell us about current guidance relating to end of life care.
- There were no local end of life care guidelines or policies in place that were based on NICE guidance.
- The specialist palliative care team had not benchmarked themselves against national end of life care guidance since 2011.
- The specialist palliative care team told us that there was a tool for identifying non-cancer patients, which had been in place for around nine months, but staff were not using it because it had been saved in the wrong area. They also told us that there was a treatment escalation plan, which was being well used. There were plans in place to move the identification tool to the same area as the treatment escalation tool so they could be linked.

Pain relief

- There was no prescribing guidance to ensure that anticipatory prescribing took place. This meant that pain relief may not be administered in a timely manner.
- Nursing and medical staff told us that they would contact the specialist palliative care team for advice about appropriate pain relief if required.
- The specialist palliative care team did not undertake local audits to assess the effectiveness of treating pain and pain management.

Nutrition and hydration

- The trust had participated in the National Care of the Dying Audit (May 2014). The results showed that the trust was identified as being significantly below the national average at reviewing nutrition and hydration at the end of life.
- Throughout the trust, a national assessment tool was used to assess patient's nutritional status, and identify what interventions were required.
- We observed that patients had access to drinks, and the majority of patients were able to reach their drinks. There were, however, some patients who would not be able to reach their drinks without support.

Patient outcomes

- Kettering General Hospital had taken part in the National Care of the Dying Audit. Four of the seven organisational indicators were worse than the England average, and all ten clinical indicators were worse than the national average.
- Staff we spoke with were not always clear about identifying when a patient should be referred to the specialist palliative care team.
- Patients and their representatives were complimentary of the care they received.

Competent staff

- New staff were provided with an induction programme where they undertook mandatory training.
- Staff told us that they received annual appraisals, and that they had regular supervisions within their ward areas.
- The specialist palliative care team told us that they were responsible for providing end of life care training for ward staff.
- Not all staff had received training in providing end of life care. Some staff told us that 'away' days had been arranged to attend end of life care training.
- The specialist palliative care team told us that training in end of life care was a 90 minute session, and was informal, as it allowed staff to discuss their concerns. We were also told that some staff were not interested in undertaking end of life care training.
- Staff told us that they could get support from the specialist palliative care team when they needed it.

End of life care

Multidisciplinary working

- The trust had participated in the National Care of the Dying Audit (May 2014). The results showed that the trust was identified as being significantly below the national average in relation to multidisciplinary recognition of when a patient is dying.
- The wards could access speech and language therapy services, and we saw that some people had been referred to dietetic services.
- There was a multidisciplinary team board round each morning, where each of the patients were discussed.
- The trust did not use the electronic palliative care co-ordination system to identify patients who were receiving end of life care.

Seven-day services

- The specialist palliative care team were available from 9am to 5pm, Monday to Friday, excluding Bank Holidays.
- Support out of hours, and at the weekend, was available from a local hospice.
- The chaplaincy service provided pastoral and spiritual support, and could be contacted out of hours.

Are end of life care services caring?

Good

End of life care services were caring. We saw that patients were treated with compassion, dignity and respect. Patients and their representatives spoke positively about their care, and told us that they felt included in their care planning. The caring approach by the mortuary and bereavement staff we observed was outstanding.

Compassionate care

- Throughout our inspection we observed patients being treated with compassion, dignity and respect.
- Patients told us that they were treated respectfully by staff.
- Patients told us that their privacy was respected, and staff respected their dignity.
- All of the staff we spoke with showed an awareness of the importance of treating patients and their representatives in a sensitive manner.
- One patient told us “the care is good, the nurses are attentive but they don’t have time to talk”. Another patient told us “you can’t fault the hospital they create a warm and caring ward”. Another patient said “it’s very nice and comfortable here, the staff are very good to me. I feel safe and well looked after. The staff sometimes are a bit rushed and I have to wait for my nurse call to be answered”.
- The mortuary service also housed temporary fridges for additional capacity; this temporary facility was within the mortuary facility and away from public view. This maintained the privacy and dignity of the patients.
- We observed the care provided by the mortuary staff to a bereaved family. The staff demonstrated that they cared passionately for their work and supporting families who were grieving. The caring approach by the mortuary and bereavement staff we observed was outstanding.

Patient understanding and involvement

- The trust had participated in the National Care of the Dying Audit (May 2014). The results showed that the trust was identified as being below the national average in relation to health professional’s discussions with both the patient and their relatives/friends regarding their recognition that the patient was dying. The survey also identified the trust as being significantly lower than the national average for communication regarding the patient’s plan of care for the dying phase.
- The specialist palliative care team told us that a recent audit showed that 95% of patients, who were identified as being at the end of life, had a DNA CPR in place; however, not all of these had been communicated to the patient and/or their representative.
- The patients and their representatives we spoke with told us that they felt included in their care planning.
- One patient told us “the doctors and nurses talk to me about my care and I feel listened to. Staff always treat me well and respect my confidentiality by talking quietly and pulling the curtains round”.

Emotional support

- The lead nurse in the emergency department informed us that when a patient died in the department, nurses placed a picture of a dove on the door to notify other staff. Relatives were able to spend as long as they wished with their loved one, although there was no designated room for this purpose. A vacant cubicle was used for this purpose. Tea and coffee was made available to relatives.

End of life care

- Ward level staff had not received any communication training to enable them to provide appropriate emotional support when caring for patients and their representatives requiring end of life care.
- The bereavement suites in the mortuary department were appropriately decorated, and comfortable for grieving relatives. The service could undertake viewings in three rooms, dependent on people's needs. The service ensured that they assessed each persons need prior to choosing a room to make the experience more personalised for the family.
- The bereavement staff supported families in need with planning of funeral arrangements through local services; they also supported with cremation and burial arrangements, as well as other tasks to support the bereaved.
- The bereavement staff explained their process for families who lose children or babies. The staff often went to the ward to support and retrieve patients, to ensure that they received the best care at the end of their life.
- The service provided viewing and funeral support for babies from 20 weeks old. Mothers and fathers were consulted on their wishes for their baby at every step of their end of life journey.

Are end of life care services responsive?

Requires Improvement

Patients who were referred to the specialist palliative care team were seen according to their needs. The specialist palliative care team were committed to ensuring that patients receiving end of life care services had a positive experience. The specialist palliative care team were available 9am to 5pm, Monday to Friday. Specialist support could be obtained from the hospice out of hours. The specialist palliative care team worked closely with patients who were at the end of their life, and their representatives, to ensure care was carried out in the patient's preferred place. Where patients were identified as being in the last eight weeks of their life, they engaged the support of an end of life care discharge link nurse, to facilitate a rapid discharge home where possible, for patients who identified a wish to be cared for in their own home.

There was a multi-faith prayer room, but it was set up for people practicing the Muslim faith, in that screens were available for separation of genders and six copies of the Koran were seen on a shelf. There was no evidence of a copy of the Holy Bible, and there was no cross present, either fixed or moveable for Christians. The specialist palliative care nurses did not express any concerns about the end of life care which patients received on the wards; however, they told us that at times, they felt patients who required end of life care were not always identified when they should have been. This meant that patients could be at risk of not receiving appropriate care to manage their symptoms from the specialist staff. The responsiveness to the needs of mothers, who had lost children or babies, by mortuary and bereavement staff, was outstanding practice.

Service planning and delivery to meet the needs of local people

- Since the withdrawal of the Liverpool care Pathway, the trust had no end of life care plan.
- The end of life care lead and the end of life forum had been working on an action plan to identify how they were going to respond to the results of the National Care of the Dying Audit.
- There were no specific consultation groups in place for patients and the public to contribute to the development of end of life care services in the trust.
- The trust had an agreement with the hospice to ensure end of life care support was available 24 hours a day.
- The specialist palliative care team worked closely with patients who were at the end of their life, and their representatives, to ensure care was carried out in the patient's preferred place. Where patients were identified as being in the last eight weeks of their life, they engaged the support of an end of life care discharge link nurse, to facilitate a rapid discharge home where possible, for patients who identified a wish to be cared for in their own home.

Access and flow

- Patients were referred to the specialist palliative care team if they had been identified as requiring end of life care.
- The specialist palliative care team told us that they met each morning to go through the patients that had been referred and the patients who required their input. They would then plan their caseloads accordingly.

End of life care

- Where possible, side rooms were prioritised for patients at the end of their life. This provided privacy for patients and their families.

Meeting people's individual needs

- Viewings of babies were undertaken in a discreet and personal way. Babies, if small, were placed in a Moses basket or bassinet, and brought into the comfortably dedicated family rooms, to enable to the mothers and fathers to view their baby in homely environment. This was responsive to their needs and the situation, and was outstanding practice.
- The service produced their own booklet on the end of life care services through bereavement, which detailed the support offered to families by this service. This was personalised and clear for people to understand, and was responsive to their bereavement needs.
- In A&E, we were informed that relatives could stay as long as they wished to after a patient's death. Drinks were provided, and patients were not moved until the relatives were ready.

Learning from complaints and concerns

- We visited the multi-faith prayer room. We saw that the room was set up for people practicing the Muslim faith, in that screens were available for separation of genders, and six copies of the Koran were seen on a shelf. There was no evidence of a copy of the Holy Bible, and there was no cross present, either fixed or moveable for Christians.
- Translation services could be accessed for patients who did not speak or understand the English language.
- Patients who had expressed a preference to die at home, or in their care home, and were thought to be in the last eight weeks of their life, were referred to an end of life primary care discharge link nurse, who was external to the trust.
- The specialist palliative care nurses did not express any concerns about the end of life care patients received on the wards. They told us that at times, they felt patients who required end of life care were not always identified when they should have been. This meant that patients could be at risk of not receiving appropriate care to manage their symptoms from the specialist staff.

Are end of life care services well-led?

Inadequate

Services for patients at the end of their lives were not well led within the trust as there was no medical lead for end of life care within the trust. Whilst the service was provided by a third party there was little ownership of the service at the trust. This meant that the service was not monitored and improvements were not owned by the trust. Most of the staff we spoke with on the wards were aware of the specialist palliative care team. However, some staff were unaware of who the end of life care lead was in the trust. The specialist palliative care team, including the discharge co-ordinator were not directly employed by the trust.

There was no clear vision or strategy for end of life care at Kettering General Hospital. Whilst all of the staff we spoke with were motivated to provide good care for patients, there was a lack of direction and co-ordination, with no documented end of life care priorities for 2014/15.There were very few audits and quality measures in place to monitor the effectiveness of end of life care throughout the trust. There were no end of life link nurses on any of the wards we inspected, and many staff throughout the trust had not received any training in relation to end of life care. Locally, the mortuary and bereavement service was well-led.

Vision and strategy for this service

- There was no clear vision or strategy for end of life care at Kettering General Hospital. Whilst all of the staff we spoke with were motivated to provide good care for patients, there was a lack of direction and co-ordination, with no documented end of life care priorities for 2014/15.
- The mortuary and bereavement service had a clear vision for the service they wanted to provide to patients. This linked with other support services; however, more involvement of mortuary and bereavement care was required in the end of life care strategy.

Governance, risk management and quality measurement

- There were very few audits and quality measures in place to monitor the effectiveness of end of life care throughout the trust.
- The palliative care consultant told us that the team had undertaken benchmarking exercises, to compare

current end of life care that was available at Kettering General Hospital, with end of life care quality markers. We looked at documentation in relation to the exercise, and found that this had been undertaken in 2011. The results demonstrated that the quality markers had not been met, or were only partially met.
- There was no evidence of a trust-wide audit programme to assess compliance with the Quality Standard for End of Life Care for Adults' (NICE, 2011; updated 2013) and other national guidance.
- There was no risk register for end of life care.

Leadership of service

- We were told that the medical director represented end of life care at board level, and the chairman was recently appointed as the non-executive representative.
- Most of the staff we spoke with on the wards were aware of the specialist palliative care team. However, some staff were unaware of who the end of life care lead was in the trust.

Culture within the service

- Staff within the specialist palliative care team spoke positively about the service they provided for patients.
- Staff within the trust spoke positively about the specialist palliative care team.
- Staff reported positive working relationships, and we observed that staff were respectful towards each other, not only in their specialities, but across all disciplines.
- The mortuary and bereavement staff culture was very positive and enthusiastic about the provision of care at the end of a person's life. This was demonstrated and evidenced through their approach to patient care.

Public and staff engagement

- There was a lack of effective engagement with staff in the trust on decisions about end of life care.
- Although staff knew how to refer to the specialist palliative care team, there was a general lack of knowledge amongst staff about end of life care issues.
- There were no end of life link nurses on any of the wards we inspected.
- We saw, from the meeting minutes of the end of life forum, that discussions had taken place to develop a bereavement follow-up service, inviting relatives to give feedback on the care that their loved one had received.

Innovation, improvement and sustainability

- The specialist palliative care team acknowledged that there was a lot of work to be done to improve end of life care services throughout the trust.
- The mortuary and bereavement service purchased items through their budget, and learnt to improve the service. Whilst this was not directly linked to the overall end of life strategy, the innovative ideas, including the design and areas of viewing rooms, leaflets and viewing accessories, were implemented to achieve excellence in care.

Outpatients and diagnostic imaging

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

Information about the service

The majority of clinics at Kettering General Hospital are provided from a central outpatients department. However, specialities such as endoscopy, ophthalmology, obstetrics and gynaecology, trauma and orthopaedics, diabetes, pain management and anticoagulation services, are provided from satellite departments on site. There are nurse-led outpatient clinics across a range of specialities, which are provided in the outpatients department. Outpatient clinics are held from Monday to Friday. In addition, the Trust provides outpatient services at 3 off-site locations in Corby (Diagnostic Centre), Irthlingborough (Nene Park) and Wellingborough (Isebrook Hospital).

We inspected neurology, urology, oncology, endoscopy, audiology, plastics, obstetrics and gynaecology clinics, as well as phlebotomy, the pre-screening unit, and nurse-led clinics, such as the respiratory clinic, dressings clinic and the heart failure clinic. Throughout our inspection, we spoke with 42 patients and relatives, and 19 members of staff, including nurses, health care assistants, receptionists, the service manager and medical staff. We observed interactions between patients and staff, considered the environment, and looked at care records. Before our inspection, we reviewed performance information from, and about the hospital.

Summary of findings

We found that improvements were required in the outpatients department. The physical environment at the hospital site was poorly maintained and clinical areas were small. Staff were caring, and treated patients with dignity and respect, and patients told us that they were happy with the care they had received while attending their appointments within the outpatients department.

The organisation of clinics was not responsive to the needs of patients. Many clinics frequently over-ran, and some patients were experiencing long delays in their appointment time. Clinics were sometimes cancelled at short notice. This led to patients having appointments cancelled and re-scheduled. We found that the leadership in the outpatients department required improvement as communication with staff was poor; the trust was already aware of the concerns within the outpatients department, and was taking steps to transform the service.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services safe?

Requires improvement

We found that safety in the outpatients department required improvement. The physical environment at the hospital site had limitations. The physical environment was poorly maintained and clinical areas were small. We found that staff were confident in reporting incidents, but didn't always receive feedback about incidents they had reported. We found out of date medicine in the department's medicine fridge, and fridge temperatures were not being consistently monitored on a daily basis. During our inspection of the urology outpatients clinic, we found that some catheters used to administer bladder chemotherapy had expired in September 2013. This meant that potentially unsafe catheters which could break could have been used on patients.

Incidents

- Incidents were reported via the trust's electronic reporting system.
- There had been one serious incident reported in outpatients.
- The staff we spoke with told us they knew how to report incidents. Staff were able to describe the types of incidents they would report. Staff told us that the most common incident they reported was missing patient notes.
- Staff told us they did not always receive feedback on the outcome of incidents they had reported.

Cleanliness, infection control and hygiene

- Staff followed the hospital's infection control policy. We observed staff regularly washing their hands, and using personal protective equipment, such as gloves and aprons, when required. Staff adhered to the trusts 'bare below the elbows' policy.
- We observed a nurse-led dressings clinic, and saw that staff adhered to a strict aseptic technique.
- Generally, there were adequate hand-washing facilities and soap dispensers, hand hygiene foam and paper towels for staff and the public to use. However, later in the afternoon we noticed that the foam dispensers at the entrance to outpatients were empty.
- We saw that where necessary, equipment was cleaned between patients.
- Clinical areas were visibly clean throughout the outpatients department.
- We saw that information on infection control data was displayed in outpatients, with results clearly visible. The cleaning audit displayed was 98%, uniform audit was 94%, and an audit of commodes was 50%.

Environment and equipment

- The environment in outpatients required improvement. The consultation rooms were very small . The consultation rooms in the main outpatients did not have emergency alarm bells. This could put staff and patients at risk, for example, in an emergency situation. This was identified on the risk register for the outpatients department, but there was no date for review attached to the risk.
- Resuscitation equipment was located in the department, and regularly checked. The equipment was safe and ready to use in the event of an emergency.
- Equipment in the department was regularly serviced, tested if electrical, and appropriately cleaned.
- Staff told us that they could access bariatric equipment if it was required.
- During an inspection of the urology clinic we identified some catheters which expired in September 2013. This meant if they were placed in a patient there is a risk that they could perish when used.
  Several of the nursing staff were questioned regarding the mechanisms in place to prevent these catheters from being inserted into a patient.The Matron and nurses explained the process for checking all equipment prior to use in a procedure; explaining that the expiry date forms part of this checking procedure. Any expired catheters would be identified, disposed of and replaced with another "in-date" product. We had escalated our concerns to the Matron who assured us that the catheters had been removed, and a full investigation with a root cause analysis regarding this issue would be completed.

Medicines

- Prescription pads were securely stored and appropriately managed.
- All medicine cupboards and fridges we checked were locked. However, fridge temperatures were not always

recorded. We found gaps in documentation where fridge temperatures should have been recorded. We also found some medication, which had expired in 2013, in the medicines fridge.
- At the time of our inspection, the medicines fridge temperature was reading within the normal range.

Records

- Some people told us that they had attended outpatient appointments and their medical records had not been available.
- The manager of outpatients told us that there had been issues with medical records not being available for clinics. This was due to ineffective tracking systems and filing backlogs, due to staff shortages. We were told that this had improved over the last few months as the filing backlog had been addressed, and medical records were now being tracked on an electronic tracking system. Staff told us that issues with medical records not being available had improved over the past few months. The lack of availability of medical records was not audited within the outpatients department.
- On the day of our visit, nursing staff told us that some medical records for clinics that day had not yet been made available.
- We saw that records in the clinic areas were kept securely, so that they could not be accessed by people who do not have the authority to do so.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- There were policies and procedures in place relating to consent, and the Deprivation of Liberty Safeguards (DoLS).
- Patients were asked to consent to procedures appropriately. Staff gave patients the information they needed to make informed decisions about treatment.
- Patients told us that staff always asked for their permission prior to undertaking any procedures.

Safeguarding

- Staff undertook both adult and children's safeguarding training, and had also undertaken conflict resolution training. Training figures demonstrated that 88% of all staff within the main outpatients department had attended level 2 adult safeguarding training, and 64% had attended level 2 children's safeguarding training.
- The patients we spoke with told us that they felt safe when attending outpatient appointments.
- The staff we spoke with told us that they knew how to raise safeguarding concerns.
- The trust had a safeguarding policy in place
- We saw that safeguarding was part of on-going mandatory training. This confirmed that staff were supported to receive regular safeguarding training.

Mandatory training

- Staff working in the outpatients department told us that they had access to mandatory training, and some staff undertook additional training when it was necessary for their role.
- Mandatory training uptake was reported and monitored across the directorate.

Management of deteriorating patients

- Approximately 92% of staff in the main outpatients department had undertaken basic life support training, and nursing staff were able to undertake vital signs checks if a patient's condition should begin to deteriorate.
- The staff we spoke with were able to give examples of occasions when they had had to respond to a deteriorating patient, and where the patient had to be transferred to A&E.
- Staff told us that management of patient's deterioration was on-going, with each patient's needs being individually assessed and dealt with during their clinic appointment.

Nursing staffing

- Outpatient staffing ratios at the off-site locations (Corby, Nene Park and Isebrook Hospital) run at a ratio of 33% registered nurses to 67% health care assistants. Within the central outpatient department at Kettering, the ratio is 48% registered nurses to 52% health care assistants.
- A senior nurse told us how staffing arrangements were planned in advance to meet the requirements of the clinics. The number of nursing staff and skill mix were determined by the nature of the clinic, to ensure that there were sufficient staff, with the appropriate level of skills, to run the clinic safely.
- There were no agreed national guidelines as to what constitutes 'safe' nursing staffing levels in outpatient departments. Throughout our inspection of the main outpatients department, staff told us that they were

short-staffed due to sickness. Nursing staff told us that they felt they were really short-staffed. the department currently carried a 3 wte vacancy. However the matron confirmed that they actually carried a 0.5 wte vacancy.
- Staff told us, and we saw from minutes of meetings, that there was no children's nurse in clinics where children were attending.

Medical staffing

- Medical and specialist consultants arranged outpatient clinics directly with the outpatients department to meet the needs of their speciality.
- Where appropriate, consultants were supported by junior colleagues in some clinics.
- Staff told us that there had been some problems with neurology clinics, due to the fact that two of the three consultants were on maternity leave. This had caused a delay in some patients being seen in outpatients. Maternity leave was presently being covered by locum doctors. The manager of outpatients told us that there were problems with locums not turning up for neurology clinics.

Major incident awareness and training

- There were business continuity plans in place to ensure that the delivery of services was maintained.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

Evidence-based care and treatment was practiced in the department, and staff told us that they worked in line with the National Institute for Health and Care Excellence (NICE) guidance. The new to follow-up ratios for Kettering General Hospital were worse than the England average.

Staff were competent to undertake their roles, but told us that there were not many opportunities to undertake further training and enhance their skills. Staff worked well together to meet people's needs.

The outpatients department clinics ran Monday to Friday, with morning and afternoon lists. Weekend and evening appointments were not available.

Evidence-based care and treatment

- The endoscopy facilities at Kettering General Hospital were Joint Advisory Group (JAG) accredited. JAG Accreditation is the formal recognition that an endoscopy service has demonstrated that it has the competence to deliver against the measures in the endoscopy global rating standards (GRS).
- Staff told us that they worked in line with the National Institute for Health and Care Excellence (NICE) guidance, and that they worked to local policies.
- Staff were aware of how to access policies and procedures within their departments.

Pain relief

- Staff in the hysteroscopy clinic told us that many of the women found hysteroscopy very painful. Women received a letter explaining the procedure, and offering a choice of local or general anaesthetic, however the uptake of having general anaesthetic was low.

Patient outcomes

- We saw that feedback was obtained from patients attending the clinic. A local outpatients survey indicated that nine out of ten patients would recommend outpatient services to their family and friends.
- New to follow-up patient ratios were benchmarked nationally, and indicated whether patients were being effectively managed, and if outpatient appointments were being used efficiently to reduce repeated attendance. The new to follow-up ratios for Kettering General Hospital were worse than the England average, placing the trust in the bottom 20% of trusts.

Competent staff

- Staff we spoke with told us that they received annual appraisals.
- We saw that 85% of staff in outpatients had received appraisals in August 2014.
- Although staff told us that they attended mandatory training, some staff told us there were not many opportunities for professional or specialist development, and health care assistants told us there were no systems in place for their competencies to be reassessed or checked.
- One of the matrons in the outpatients department told us that it was difficult for staff to attend training due to workloads. However, the matron had secured Friday afternoons to ensure staff could attend training.

Outpatients and diagnostic imaging

Multidisciplinary working

- There was evidence of multidisciplinary team working in the outpatients department.
- Specialist nurses ran nurse-led clinics, such as heart failure clinics and chest clinics. We spoke with one specialist nurse, who described how their clinics fitted into treatment pathways for people who had chronic obstructive pulmonary disease (COPD).

Seven-day services

- The outpatients department clinics ran Monday to Friday, with morning and afternoon lists.
- Weekend and evening appointments were not available.

Are outpatient and diagnostic imaging services caring?

Good

Outpatient services were delivered by hardworking, caring and compassionate staff. We saw numerous examples of patients being treated with dignity and respect, and given compassionate care. Patients told us that doctors, nurses and allied health professionals answered their questions, and kept them informed of their care and treatment. We saw that patients were given information about their treatment, and gave consent prior to any treatment.

The reception area was an open space, where people passed by to reach other services in the hospital. We observed that patients could be overheard when they were disclosing personal information. In addition, the clinical rooms were not soundproof, and so conversations could be heard by other people.

Compassionate care

- Throughout our inspection we witnessed patients being treated with dignity and respect.
- Chaperones were available to patients who requested them.
- We found that vulnerable patients, such as those who were living with dementia, were treated sensitively, and were seen as quickly as possible.
- All staff spoke with pride about their work, including those who were working in difficult circumstances.
- Nursing staff told us that patients were offered drinks in clinics, or when transport was running late, and patients had access to a water fountain if they required water.
- Patients generally spoke positively about the care provided by staff. One patient said "I feel well treated and respected by everyone in here. They're polite, gentle and caring". Another patient told us "the staff are helpful and caring".

Patient understanding and involvement

- We observed staff explaining procedures to patients to help them to understand and be involved in decisions concerning their treatment.
- In some clinic areas we observed that there was written information for patients to take away with them.
- Patients told us that they were given appropriate information in a way they could understand, and this helped them to be able to make decisions.
- Most of the patients we spoke with were aware of why they were visiting the outpatients department.

Emotional support

- The outpatients department had a private quiet room for patients who may have received difficult news, and staff were able to tell us about the support provided under those circumstances.
- The staff we spoke with were all sensitive to the potential for people to require emotional support while attending the outpatients department.
- Patients we spoke with were positive about the support they received from staff within the outpatients department.

Are outpatient and diagnostic imaging services responsive?

Requires improvement

The organisation of clinics was not responsive to the needs of patients. Many clinics frequently over-ran, and some patients were experiencing long delays in their appointment time. Clinics were sometimes cancelled at short notice. This led to patients having appointments cancelled and re-scheduled.

Patients who drove themselves to their appointment told us that they found car parking difficult, as the demand for spaces was high, and often required a long walk to the outpatients department. This made some patients feel anxious before they arrived for their appointment.

Outpatients and diagnostic imaging

Service planning and delivery to meet the needs of local people

- Staff told us that, due to staffing and availability of clinic rooms, it was not always possible to run additional clinics, particularly at short notice. Therefore, the demand for outpatient services was not always met.

Access and flow

- During our inspection, we saw some clinics running up to 90 minutes late. We saw that information regarding waiting times was displayed in the waiting room areas, and we saw staff informing patients of delays in some areas.
- Staff from the outpatients department told us that consultants and specialists running clinics in the department were required to inform the department of a cancellation of their clinic at least six weeks in advance. They told us that this did not always happen, and clinics were sometimes cancelled at short notice. This led to patients having appointments cancelled and re-scheduled. This was despite the trust reporting that no cancellations had taken place.
- Follow-up to new ratio was worse than the England average.
- Referral to treatment time for non-admitted and incomplete pathways was consistently better than the England average and national standard, being around 97%, compared with targets of 95% and 92% nationally.
- The percentage of patients waiting six weeks or more for diagnostic test results was significantly better than the England average at almost zero. whilst the national average ranges between 1 and 2 %.
- The patient 'did not attend' (DNA) rates for the trust were lower than the England average at around 4%, compared with the national average of around 7%.
- Throughout our inspection, we noted that one consultant arrived one and a half hours late for their clinic. This had a knock on effect on the afternoon clinic, which commenced approximately one and a half hours late.

Meeting people's individual needs

- One of the matrons told us that people who required additional support, such as people living with a learning disability or dementia, were flagged up to the department prior to their appointment. These people could be fast tracked through the system, in order to avoid unnecessary distress. However, when we looked at the minutes of the previous month's operations meeting, we saw that this had been discussed as an area of concern, stating that identifying patients with learning disabilities was a problem, as these patients were not always identified or flagged up prior to their appointment.
- Staff told us that translation services were available for people who required them.
- Wheelchairs were available in the hospital if these were required.
- Staff told us that they could access bariatric equipment if this was required.
- Chaperones could be provided if they were required, but staff told us that this would leave them short-staffed, as a health care assistant would provide this sort of support.

Learning from complaints and concerns

- Complaints were handled in line with trust policy.
- Staff we spoke with were aware of the local complaints procedure, and were confident in dealing with complaints if they arose.

Are outpatient and diagnostic imaging services well-led?

Requires improvement

We found that the leadership in the outpatients department required improvement as communication with staff was poor. Staff told us that they felt supported by their managers in the outpatients department, and they felt supported by senior management. Some staff did not feel supported by middle management, and felt that communication was often not filtered past the middle management within the outpatients department. Although we found concerns in the outpatients department, the trust was already aware of them. They had identified the concerns on their risk registers and were beginning to respond to them. There was a vision for the future of the outpatients department. There was a strategy for outpatient improvements, which set out a proposal for an outpatients transformation programme.

Vision and strategy for this service

- All staff we spoke with were aware of the trust's values.
- The service manager demonstrated a vision for the future of the outpatients department, and was aware of the challenges it faced.

Outpatients and diagnostic imaging

- We saw that there was a strategy for outpatient improvements, which had been submitted to the trust management committee for approval. The strategy set out a proposal for an outpatients transformation programme. There was a plan in place to relocate the outpatients department, but this was in the early stages of development. There was a plan that the medical records department would be relocated to a nearby unit by December 2014.

Governance, risk management and quality measurement

- There was a risk register for the outpatients department, and risks were being appropriately monitored.
- Incident reporting and analysis was taking place.
- Management team meetings took place on a monthly basis within the directorate, where risks and actions taken were discussed. We saw that risks were also discussed at the matron's forum meetings.

Leadership of service

- Staff told us that they felt supported by their managers in the outpatients department, and they felt supported by senior management. Some staff did not feel supported by middle management, and felt that communication was often not filtered past the middle management within the outpatients department.
- Most of the staff we spoke with were clear about the lines of management, and told us they felt well supported by their managers. However, one matron told us that they were not clear about who their line manager was at the time of our inspection.
- All staff spoke positively about the director of operations and the service manager for outpatients.
- One consultant we spoke with told us that they had faith in the new executive team, and felt they were listening.
- Staff confirmed that they received regular email communication from the board.
- Staff told us they never saw members of the board in the outpatients department, but open sessions were offered to meet with them.

Culture within the service

- Staff we spoke with were passionate about the service they provided for patients. However, staff morale varied, with some staff being positive, whilst others felt their views were not listened to. Staff were particularly proud of the way in which they worked together.
- We saw within the minutes of a matron's forum that the 'back to the floor' initiative was not happening in the outpatients department.

Public and staff engagement

- We observed interaction between patients, their representatives and staff. Staff were able to respond to the needs of patients visiting the outpatients department.
- People we spoke with voiced their concerns with regard to waiting times and parking facilities.
- Lower grade staff told us that they felt unable to voice their concerns, or contribute their ideas to influence wider decisions. These staff were unaware of the review that had taken place within outpatients.

Innovation, improvement and sustainability

- The environment within the outpatients department was not fit-for-purpose, clinical areas were small, clinical rooms were not soundproof, and the physical environment was poorly maintained. Senior management were aware of the problems in outpatients, had reviewed complaints from patients and GPs, and had listened to patient's stories, which demonstrated a far from satisfactory experience within the department. Themes that were identified included an inflexible appointment system, long waiting times, insufficient administration systems, poor environment and poor communication.

Outstanding practice and areas for improvement

Outstanding practice

- Excellent multidisciplinary working across the trust, to ensure that patients received appropriate and timely care.
- Staff described a supportive response in the trust, where learning from incidents and staff issues were seen as important to improve safety and quality of patient care. The practice in maternity of sharing 'hot' topics at handover to ensure that all staff were aware of these issues.
- The caring and responsive approach to bereaved families by staff in the mortuary, including support with viewings and support with funeral arrangements, was outstanding. Staff in this service went beyond the call of duty to support families, particularly those bereaved of children and babies during difficult times.

Areas for improvement

Action the hospital MUST take to improve

- Review staffing levels in the surgery and critical care units. This should include the use of junior doctors overnight.
- Review the environments in maternity and outpatients to ensure that infection control measures, and privacy and dignity issues, can be addressed.
- Review the safety of children waiting in and attending the A&E department.
- Ensure that best practice guidelines from 'The Safe and Secure Handling of Medicines: A Team Approach', published by the Royal Pharmaceutical Society, are implemented to improve the safety and efficacy of medications.
- Ensure 'do not attempt cardio-pulmonary resuscitation' (DNA CPR) forms are completed appropriately.

Action the hospital SHOULD take to improve

- Ensure that staff in the A&E department are aware of current risks and actions to be taken in relation to communicable diseases, such as Ebola.
- Ensure that the checking of resuscitation equipment in the A&E department occurs as per policy.
- Review the usage of storage facilities throughout the hospital, but especially in A&E and maternity.
- Ensure that patients' medical records are stored in a way that maintains patient confidentiality within the A&E department.
- Review the availability and uptake of training relating to caring for patients living with dementia.
- Ensure that staff receive appropriate appraisals in order that they remain competent to carry out their roles.
- Review the consent procedures for emergency patients.
- Review the end of life service to ensure that patients requiring this service receive care at an appropriate time.
- Improve record keeping throughout the trust, but especially in medical areas, to ensure that it reflects the needs of individual patients.

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 Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing People who use services and others were not protected against the risks associated, with not having sufficient numbers of suitably qualified staff in order to receive care in that There is insufficient staffing in the critical care unit that reflect national guidelines for this area. There is insufficient junior doctor cover out of hours and weekends was minimal across the surgery and orthopaedic wards, which meant some duties were delayed or not completed.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises People who use services and others were not protected against the risks associated with unsafe or unsuitable premises, because of inadequate maintenance in that: The design and layout of the outpatients department led to a lack of privacy and dignity. The maintenance and design of the maternity unit led to poor infection control prevention. There was a lack of monitoring of hot water temperatures on wards.

Regulated activity	Regulation

This section is primarily information for the provider

Compliance actions

Diagnostic and screening procedures

Maternity and midwifery services

Surgical procedures

Treatment of disease, disorder or injury

Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines

People who use services and others were not protected against the risks associated with unsafe administration or storage of medicines in that:

Recording and monitoring of fridge temperatures across the trust, but especially in MAU, ambulatory care and outpatients, were not always carried out, and high temperatures could reduce the efficacy of medications.

On one medical ward, six out of 41 medicines were past their expiry dates, including an antibiotic medicine. We also found in the same ward that one out of 11 items checked in the fridge was past its expiry date.

The safety of the keys to medicines cabinets was not maintained on Naseby Ward.

Medical wards reported 10% of patients had medicine doses omitted without a documented reason.

In outpatients, medication which had expired in 2013 remained in the medicines fridge.

There was a lack of clear documentation around controlled drugs medicines that patients were admitted with.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers People who use services and others were not protected against the risks associated with the assessing and monitoring of the end of life service in that: There is no medical lead for the service. There is no strategic direction or vision for the service. There is no monitoring of the outcomes and patient experience of the service. There is no service improvement identified.

This section is primarily information for the provider

Compliance actions

There was a lack of understanding amongst staff of the plans in place to manage patients at the end of their life.

There was little identification of patients for whom this service would be appropriate.