Care Quality Commission

Northampton General Hospital NHS Trust

Northampton General Hospital

Quality Report

Northampton General Hospital NHS Trust
Cliftonville
Northampton
NN1 5BD
Tel: 01604 634700
Website: www.northamptongeneral.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**
Accident and emergency	**Requires improvement**
Medical care	**Requires improvement**
Surgery	**Requires improvement**
Intensive/critical care	**Good**
Maternity and family planning	**Requires improvement**
Services for children & young people	**Good**
End of life care	**Inadequate**
Outpatients	**Requires improvement**

Summary of findings

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Overall summary

Northampton General Hospital NHS Trust (NGH) is an acute trust with 800 bedded acute hospitals. At the time of our inspection, it had an income of about £250 million and a workforce of 4,300 staff. It provided general acute services to a population of 380,000 and hyper acute stroke, vascular and renal services to people living throughout Northamptonshire, a population of 691,952. Between 2001 and 2012, there was a 9% growth in the population of Northampton, with significant increases in the 0 to 4 year and 60 to 64 year age groups (30% and 45% respectively). The trust's main hospital site is Northampton General Hospital (NGH). It also provides services at three community hospitals in Northamptonshire: Danetre Hospital in Daventry, Corby Community Hospital and Hazelwood Ward in Wellingborough.

Before visiting, we looked at a wide range of information we held about the trust and asked other organisations to share what they knew about it. We carried out an announced visit on 16 and 17 January 2014, and during that visit we held focus groups with different staff members from all areas of the hospital. We looked at the personal care or treatment records of patients, observed how staff were caring for people and talked with patients, carers, family members and staff. We reviewed information that we asked the trust to provide. We also held a public listening event where patients and members of the public shared their views and experiences of the trust and we continued to receive and review information from various sources during and after our inspection. We carried out a further unannounced inspection at night on 29 January 2014.

During our inspection, NGH appeared to be very clean throughout. In a national survey the trust was noted to have been performing well in relation to infection prevention and control.

The trust had a recent history of poor staffing levels on some wards. During our inspection, we saw that action had begun to address staffing issues. Staff told us that improvements in staffing levels were already having a positive impact on services. The trust was also experiencing a shortfall in consultant cover in the Accident and Emergency (A&E) department and the maternity labour ward. This was known by the trust and it had taken action in A&E. The trust had also responded to recent concerns around staffing and care on two medical wards and had taken action by increasing the staffing establishment to address those concerns.

Many of the executive post holders are either new to post or in interim positions. This had an impact on the trust's leadership as staff reported that senior leaders, with the exception of the chief executive, were rarely visible on wards. Staff were unaware of the positions and responsibilities of most executive post holders. There have been significant changes at the executive level of the trust for some time, and the chief executive was aware of the need for stability among this group in order to address the leadership concerns across the trust. A substantive post of director of finance had been appointed and was due to start imminently, and both the chief operating officer and medical director posts were being advertised around the time of the inspection.

Areas of poor governance, specifically in relation to the management and maintenance of equipment, and to the dispensing of medications to patients on discharge, were identified during our inspection. Both areas were taken up with the trust and the trust has actively responded since our inspection.

Our inspection revealed that end of life care was an area where the trust required more focus and commitment to improve.

Summary of findings

The five questions we ask about hospitals and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

We found that services at Northampton General Hospital NHS Trust were safe although some improvements were needed. We found that staffing levels were usually appropriate and that the trust's nationally measured Standard Hospital Mortality Index (SHMI), which measures the number of deaths occurring in hospital, were within the expected range.

We found that medical staffing in Accident and Emergency (A&E), on the labour ward and for the out-of-hours endoscopy rota was sometimes lower than expected. However we did not see evidence of unsafe care in those departments.

We found a lack of appropriate testing and maintenance of equipment across the trust during our inspection. The trust had started to address this, however, and this work was continuing.

There was a significant issue with bed capacity within the trust as there were delays in discharging patients appropriately. We found that patients' medications to take out (TTOs) were not always dispensed by the pharmacy in a timely manner, which meant some patients could not leave with them. TTOs were being transported to patients' homes in a taxi, later in the day or during the evening following discharge, but there was very limited governance supporting this process. When we brought this practice to the attention of the Chief Executive during our inspection, this activity was immediately stopped and the trust immediately undertook a review of its practice around discharge medication.

Are services effective?

Requires improvement

We found the services at Northampton General Hospital NHS Trust were effective but some improvements were needed.

We found that national and best practice guidelines to care for and treat patients were in use across the trust and the trust participated in all the clinical audits for which it was eligible.

The trust had recently made a significant investment in staffing.

There was an effective system in place to discuss a patient's care and treatment, and this included consultants, doctors and nurses and integrated multidisciplinary ward rounds.

We found that bed flow in the trust was not effective and resulted in patients not being cared for on appropriate wards, experiencing multiple moves within the trust and delayed discharge.

The emergency care pathway was not efficiently managed. The trust had data that suggested it has been struggling with an ineffective emergency care pathway since 2011. It had requested external reviews and collaborative

Summary of findings

forums to try and address this issue. During our inspection, we witnessed a very busy A&E department that was the bottleneck of the hospital. The trust did not have effective direct admissions wards. All patients, including those referred by GPs, were cared for in A&E. The area was not able to support the numbers of patients present, and therefore, the recommended wait times for 'true' A&E patients were being breached at their first assessment point.

We found that members of the palliative care team could not confirm the number of patients or identify any of the actual patients who required end of life care. Therefore, we were not confident about the team's ability to effectively manage those patients' needs.

Are services caring?

Good

We found the services in Northampton General Hospital NHS Trust to be caring.

We observed caring, compassionate staff in each of the service areas we visited. Patients and their relatives spoke very highly of the caring nature of the staff. Patient dignity was respected and upheld.

We found that the delays in the A&E department meant staff there often looked after patients for a considerable length of time. During our visit, we witnessed one patient in A&E for 11 hours. Patients were found beds and given food and drink by A&E staff, and the patients we spoke with felt their needs had been met.

We listened to staff and recognised an overwhelming sense of dedication and commitment from many employees of the trust. This was not the case in all departments, however, and a common phrase during our inspection was that staff attitudes varied 'depending on the middle managers'.

The trust had no risks or elevated risks identified in this domain. We looked at the Friends and Family Test results and found that the overall performance for the trust was in line with the England score with A&E being higher than the England score. On the NHS Choices website the trust has an overall rating of 3.5 out of 5 stars with the main positives identifies as excellent care, professional staff and being treated with dignity and respect. The trust performed in line with other trusts in the national inpatient survey.

Are services responsive to people's needs?

Requires improvement

We found that the services at Northampton General Hospital were effective but improvements were needed.

Care and treatment was planned to meet the individual needs of patients. Two medical wards had been adapted to care for patients with cognitive impairment. Additionally, pressure-relieving mattresses had been added to some wards and the trust had made an investment to ensure that this equipment was more widely available across all departments based on assessments of patients' needs.

Summary of findings

The Early Warning Score (EWS) system for monitoring deterioration in patients was seen to be in use across the trust and there was evidence of appropriate escalation by nursing staff.

Staff told us that the translation services within the trust worked well and there was still an opportunity to request a face-to-face interpreter, which staff valued.

An external review of the eye / ophthalmology clinic had been commissioned and a number of actions recommended as a result. We saw evidence that lessons had been learned from this review and that the recommended actions had been taken; patients and staff said had led to improvements at the clinic.

People's religious preferences were recognised. The hospital employed two Christian chaplains who were able to obtain the services of ministers from different faith groups if patients wished to see them. The chapel within the hospital held Christian and Muslim services on a weekly basis and was open to patients, relatives and staff of all faiths.

Treatment for children in A&E was not responsive to their needs. Northampton General Hospital could not guarantee that a qualified registered sick children's nurse (RSCN) would be on duty at all times. The A&E service did not have the staffing capacity or space to ensure that patients could be assessed and treated in a timely manner.

Are services well-led?

Requires improvement

We found that the services at Northampton General Hospital were not well-led. Robust leadership was not consistent at all levels across the trust. Governance was poor and this had an impact at every level of the organisation. We saw examples of good local leadership in some areas, but this was not consistent. Members of the executive team within the trust were not widely visible and did not demonstrate authority in a number of areas. The exception was the chief executive, previously the medical director, who was referred to very positively on numerous occasions. This gave us the impression that she was the only person who was effectively leading the trust.

The trust had identified issues relating to governance but had not effectively led the management of them. It had recognised the challenges within the emergency care pathway. However, there did not appear to be a co-ordinated process to address this which meant that the risk to patient safety and welfare had not been managed. During our inspection we revealed a number of risks which had not been identified through the trust's quality monitoring systems. These related to the supply of medications after patients were discharged, maintenance of equipment, inappropriate completion of the Do Not Attempt Cardio-Pulmonary Resuscitation (DNA CPR) form, the palliative care team's lack of knowledge of patients in that group and the regular occurrence of multiple patient moves within the trust.

Summary of findings

Staff who managed complaints were experienced and led a robust process of complaints management. However, there was no mechanism to ensure that recommended learning and actions resulting from complaints were achieved within an appropriate time frame. During our inspection, we observed that some actions relating to complaints had been outstanding for over three months.

There were significant delays in serious incident reporting and the resulting action plans were slow to be completed. At the time of our inspection, the trust had recently begun to use a simulation suite to re-create incidents in order to learn how to deal with them, so this was expected to improve. We saw examples of learning from incidents at a local level; for example, A&E staff identified a high-risk patient and flagged them on the department's IT system. However, learning from serious incidents was lacking across the trust which meant that improvements to the quality and safety of service provision was not embedded in the serious incident investigation process.

Throughout the hospital there was varied and, overall, poor compliance with both mandatory training (which had remained on the trust's risk register for three years with evidence of limited improvement) and completion of annual completion of personal development plans (PDPs). This meant that patients may have been at risk from staff who were not up to date with their training and / or had not had any performance concerns addressed.

Summary of findings

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

Accident and emergency

Requires improvement

The A&E department was unable to achieve the A&E performance targets for a number of reasons. The trust was aware of these reasons and had been trying to address them for some time without any noticeable improvements. The data shows that this trust's performance for the 30 days prior to our inspection met the 95% four-hour target on only six days. The trust recorded that it achieved the four-hour target in fewer than 75% of cases on five days and under 70% on one day.

We found that the department was safe, although consultant staffing levels were significantly lower than those recommended by the College of Emergency Medicine for an A&E department of its size. The consultant workforce had recently increased from four to seven, and the trust was carrying out additional recruitment activities to meet the recommendation. Patients frequently spent too long in the department before being admitted on to a ward.

Due to a lack of bed capacity across the hospital there were delays in patients being allocated beds. This created a bottleneck of patients in A&E and not only impacted those waiting for beds, but also other A&E patients whose assessments and treatment were delayed due to lack of staff and available cubicles. However, we observed that the patients in A&E received compassionate care from attentive staff, including the provision of beds when they were available, along with food and drink.

The A&E department was not responsive to the needs of children using the service; there were very limited separate facilities for children in the A&E department. We saw no evidence that the National Service Framework (NSF 2004) for children, or any best practice guidance which advises trusts on how to provide an appropriate environment for children, had been considered. Children were not prioritised on our inspection. Children who arrived at A&E booked in at reception with adults and were either referred to the triage nurse or to the 'minors' area for treatment. Seriously ill or injured children were taken directly to the 'majors' area in the same way as adults. The Royal College of Paediatrics and Child Health (RCPCH) Standards for Children and Young People in Emergency Care Settings (2012) identified that there should always be registered children's nurses in emergency departments and that all staff should, as a minimum, be trained in paediatric life support. Recently, staff had begun to highlight children on the department's IT system so that staff could see at a glance how many children were in the department and their position on their journey through the department. The same system was also used to highlight elderly patients. However, it was not clear how staff used the highlighted information. We did not find recommendations were being met at NGH, nor any evidence that the trust was working to achieve these.

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The A&E also recently introduced a 'red flag' system as a result of learning from a serious incident. This highlighted patients that were more vulnerable i.e. pregnant ladies or patients receiving chemotherapy. Patients highlighted by the red flag could then be prioritised within the department and the whole team would be aware of them to ensure they received the appropriate level of care within the appropriate time frame.

An interim service manager had been in place in the A&E for only a few months at the time of our inspection, and already appeared to have initiated improvements despite some resistance to proposed changes. Staffing levels had also been increased as part of the trust's winter plan. We spoke with driven, motivated and committed senior staff; however, the lack of resources had inhibited their abilities.

Medical care (including older people's care)

Requires improvement

We found that the medical division maintained a clean and hygienic environment in line with recognised Department of Health guidance, which helped protect patients from the risk of hospital-acquired infections. All medical wards maintained specialist equipment, and two of the wards had been refurbished to meet the unique needs of patients with dementia with bays and doors to bathroom facilities being painted in recognisable colours.

New staff were supported to integrate into their roles and teams through the creation of sub teams led by experienced staff, and suitable induction training programmes were in place. However, compliance with mandatory training was low on some wards, including the elderly care ward where falls management training is key for staff, but had not been attended by all. We observed that ward leadership was effective by the promotion of good practice and when leadership issues had been identified previously as a result of internal investigations. Staff told us they felt that the service managers were not sufficiently visible on the wards

We found that there was inconsistency record keeping, for example in completing required patient documentation, such as patients' BMI scores not being accurately calculated on the stroke ward.

We found evidence of patients being transferred between wards late at night with no assessment of their vulnerability or individual needs. We also found that some patients had been served out-of-date food replacements and supplements.

Patients told us that they felt well cared for and that staff treated them with respect. However, some patients were not able to access a choice at meal times if they had not been on the ward to make a selection from the menu.

There were significant delays in patient discharge from medical wards, which resulted in insufficient beds to accommodate all the patients within this service. This contributed to the bottleneck within the A&E department.

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Surgery

Requires improvement

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

Action plans were written as a result of reported incidents; however, these were not always monitored appropriately to ensure actions were implemented. The supply of equipment was insufficient at times, and we found that appropriate checks and maintenance of equipment was not consistently carried out.

Clinical management guidelines were reviewed and acted upon to ensure patients' needs were met. However, staff training and appraisals were not always carried out to ensure staff were competent and had best practice knowledge to effectively care for and treat patients.

Patients and their relatives told us that they felt they received good quality care, and that their privacy and dignity were respected by staff.

We found that staff were responsive to people's individual needs; however, staff told us that there were often delays in discharge from the surgery service. We also found that some patients were sent to another hospital for their operation because NGH could not accommodate then within the necessary timescales.

There was leadership at all levels within the surgical care service and staff felt well supported by their managers. A clinical governance framework was also in place.

Intensive/critical care

Good

Critical care services were provided in a clean environment and there were adequate infection prevention and control procedures in place to ensure the patient safety. We found that the staffing ratio was sufficient to meet the needs of critical care patients. Care delivery in this service was observed to be person-centred and compassionate.

Clinical management guidelines were reviewed and acted upon to ensure patients' needs were met. However, staff training and appraisals were not always carried out to ensure staff were competent and had best practice knowledge to effectively care for and treat patients.

There was a high number of discharge delays from the intensive therapy unit (ITU) and the high dependency unit (HDU), which added to the pressures on the critical care service. A nurse led follow-up clinic was provided for patients who had been discharged from either the ITU or HDU.

There was evidence of leadership at all levels within the critical care service and staff felt well supported by their managers. We were told that there was a culture of openness and acceptance to change. There was lack of clarity on some medical leadership, particularly anaesthetic support for the HDU. The trust were aware of this issue.

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Maternity and family planning

Requires improvement

The maternity service was found to have an adequate number of midwives. However, consultant cover on the labour ward was insufficient to meet professional recommendations.

Maternity services were provided in a clean environment in accordance with recognised guidance, and there had been 100% compliance with mandatory infection control training for the four months prior to our inspection. An audit of gynaecology and maternity services, undertaken by the infection control team, recorded no methicillin-resistant staphylococcus aureus (MRSA), methicillin-sensitive staphylococcus aureus (MSSA) or Clostridium difficile.

Staff told us that incidents that occurred in this service were reviewed by risk managers and matrons. Although staff were aware of the trust's incident reporting systems, they told us that did not always have time to report them. We reviewed two serious incident reports during our inspection, and found that both were thoroughly investigated and resulted in clear action plans to address the risk factors identified.

We found that one cardiotocography (CTG) monitor and one baby warmer had not been tested for electrical safety within the required timeframe. However, all other equipment had been properly tested.

Records showed that 74% of midwifery staff had completed mandatory safeguarding training, which is below the trust's target of 75%.

This service was commended for having the highest national home birth rate and its recent work to reduce the rate for caesarean sections, the latter of which represented a significant improvement for the trust.

Services for children & young people

Good

Children received safe and effective care in the paediatric unit. Staffing arrangements were flexible to meet the needs of children, and children's care and treatment followed best practice guidance.

Most parents told us that the staff who treated their children were caring and praised the inpatient wards, outpatient clinics and the neonatal unit. They also told us that staff engaged well with the children and treated them with dignity and respect. Children and their families told us that they were fully involved in making decisions about treatment and how it would be provided. Staff in the children's department told us that children were supported by play therapists who were highly visible on the wards and in outpatients. There was limited provision for sleeping arrangements for parents who wished to stay with their child on the wards.

Staff on the children's ward told us they felt supported. All staff we spoke with during our inspection had a good understanding of their role and responsibilities for monitoring service quality. They told us that action was taken in response to suggestions they made, and that they felt confident that they could raise any concerns that they had and that their concerns would be taken seriously.

Summary of findings

End of life care

Inadequate

For the wards we visited and other areas such as the mortuary, we found that appropriate guidance was followed for maintaining a clean environment and reducing the risk of infection. Staff were aware of how to report incidents and concerns, but gave us mixed views about the effectiveness of the trust's system of feedback so that the staff could learn from them.

There were inconsistencies in the record keeping in this area, with gaps in some patients' records relating to the daily nursing care that they had received. We also found a low level of compliance in completing 'do not attempt cardio-pulmonary resuscitation (DNACPR) forms.

Patients told us they received care that was caring and respectful and we saw this during our observations on the wards. However, there were concerns about the wards being noisy at night and the number of times that patients were moved between wards.

There had been a lack of clarity about the appropriate care pathway to use for patients at the end of their life. This meant that there were inconsistencies in practice across the hospital.

The trust had a dedicated specialist palliative care nursing team. However, although they have access to a palliative care consultant, there was no internal palliative care consultant, which had resulted in a lack of clear clinical leadership for end of life care across the trust. We also found that the availability of doctors at night and at weekends was lacking.

Outpatients

Requires improvement

The outpatients clinics that we visited were kept clean and staff followed good infection control practices. Staff were aware of the reporting procedures for incidents. We found that the main risk to patient safety was the number of occasions when patient records were not available at the time of their outpatients appointment.

Patients and their relatives told us that staff treated them with respect and dignity. They said the staff were caring and gave them the information they needed in relation to their visit, and we observed this during our inspection. The main concerns raised by patients related to parking and the current system for booking appointments.

There were breaches of the timescales for some follow-up appointments in some of the outpatient clinics and there were variations within clinics as to the percentage of patients who were seen for their initial appointment within the 18-week target set by the NHS.

Each outpatients clinic was under the leadership of the inpatient specialty that they were linked to. This meant there was a lack of clear leadership over the outpatients service as a separate entity. Records relating to staff training and appraisal were included within the wards' statistics, which meant it was difficult to ascertain levels of compliance in either mandatory training or appraisals.

Summary of findings

What people who use the hospital say

The Friends and Family tests had been introduced to give patients the opportunity to offer feedback on the quality of care they had received. The NGH scored 8% lower than the average for England for the inpatient component of the test, while its A&E score was 18% higher than the national average.

Analysis of data from the Adult Inpatient Survey, CQC, 2012, showed that in general, the trust had performed about the same as other similar trusts. However, it had performed worse than other trusts on patients being subjected to noise from staff and other patients.

During the summer of 2013, CQC sent out a maternity survey questionnaire about different aspects of care and treatment to all women who had given birth in January or February 2013 at an NHS trust in England. Each trust was given a score out of 10 for each question (the higher the score the better). Responses were received from 171 women who had used the services at NGH. NGH had performed about the same as most other trusts that took part in the survey; it scored 8.9 out of 10 for questions relating to labour and birth, 8.5 out of 10 for staff and 7.8 out 10 for care in hospital following birth.

Between June and October 2011, CQC sent a questionnaire to patients who had recently attended an outpatient appointment at an NHS trusts in England. Each trust was given a score out of 10 for each question. Responses were received from 468 patients who had attended an outpatient appointment at NGH. In most cases, NGH was found to be similar to other trusts. However, it scored better than other trusts on the questions about 'finding out test results', where it scored 8.9 out of 10, and 'explanation of test results', where it scored of 8 out of 10.

The Department of Health's national Cancer Patient Experience Survey, 2012, showed that NGH had improved across 64% of standards in comparison to its results for 2010.

There were 62 reviews of NGH on the NHS Choices website for the period between January and December 2013. Of these, there are 24 comments with five star ratings, which is the best review that can be achieved. Themes we identified among the positive comments include excellent A&E care, staff professionalism, waiting times, patients being treated with respect and dignity, and trust cleanliness. There were four negative comments which had one star ratings, which is the worst review that can be achieved. These related to poor communication, lack of care and treatment, waiting times and unprofessional staff.

The Patient Led Assessment of Care Environment (PLACE) audit for 2013 gave NGH a rating of 99.4% for cleanliness.

We held a public event in Northampton as part of our inspection, which was attended by over 70 members of the public. Feedback received during this event has been used to help write this report.

Areas for improvement

Action the hospital MUST take to improve

- Improve 'do not attempt cardio pulmonary resuscitation' (DNACPR), paperwork so it is clear and will no longer be incorrectly completed and used.
- Ensure that equipment is adequately tested and maintained.
- Ensure adequate supply and use of capnography machines in theatres.
- Put processes in place to ensure that medication is dispensed to patients before they have left hospital.
- Improve arrangements for children's care in the A&E department.
- Improve bed capacity and put processes in place to minimise or eliminate the movement of patients around the hospital, including a system to monitor patient movement on an on-going basis.
- Ensure that the door leading into the maternity unit labour ward is fully secured at all times.
- Ensure that staff attend mandatory training and receive performance appraisals in line with trust policy.

Summary of findings

- Address the throughput of patients from their attendance at A&E to their admissions onto the wards and finally their discharge. There were multiple examples of poor patient flow through the hospital resulting in paints staying in hospital longer than necessary.

Action the hospital SHOULD take to improve

- Build on the management of incidents in the area in which an incident occurred, to create a robust system for incident management across the trust which ensures that staff are trained to identify and report incidents in a timely way, and that action plans are monitored to ensure completion and share learning.
- Improve access to equipment across the trust.
- Improve response times to actions which are required when a complaint is investigate.
- Ensure records are accurately completed, reflect patient needs and are accessible when needed.
- Ensure that food supplements and nutritional drinks are monitored for consumption within expiry dates, and are disposed of where this is not the case.
- Ensure that that Body Mass Index (BMI) calculations are properly made and not guessed.
- Share feedback and learning with staff when they report incidents.

Good practice

Our inspection team highlighted the following areas of good practice:

- The A&E department was commended for its contribution to a trauma audit and research network.
- The maternity unit had one of the highest home birth rates nationally.
- The hospital had excellent facilities where simulation exercises take place to investigate the cause(s) of serious incidents.

Requires improvement

Northampton General Hospital

Detailed findings

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

Our inspection team

Our inspection team was led by:

Chair: Mr Edward Palfrey, Medical Director Frimley Park Hospital NHS Foundation Trust (2000-2014), Consultant Urologist

Head of Hospital Inspection: Siobhan Jordan, Care Quality Commission (CQC)

The team of 35 included CQC senior managers, inspectors and analysts, doctors, nurses, pharmacist, dietician, patients and public representatives, experts by experience and senior NHS managers.

Julie Walton, Head of Hospital Inspection led the team that visited the three off-site services with an experienced clinician.

Background to Northampton General Hospital

Northampton General Hospital NHS Trust (NGH) is an 800-bedded acute trust. At the time of our inspection, it had an income of about £250 million and a workforce of 4,300 staff. It provides general acute services to a population of 380,000 and hyper-acute stroke, vascular and renal services to people living throughout the whole of Northamptonshire, a population of 691,952. The trust's main hospital site was Northampton General Hospital.

During our inspection, we found the hospital to very clean throughout. The trust was noted to be performing well in relation to infection prevention and control.

The trust had a recent history of poor staffing levels on some wards. During our inspection, we saw that action had begun to address staffing issues. Staff told us that improvements in staffing levels were already having a positive impact on services. The trust was also experiencing a shortfall in consultant cover in the Accident and Emergency (A&E) department and the maternity labour ward. This was known by the trust and action had taken place in A&E. the trust had also responded to recent concerns around staffing and care on two medical wards and had taken action by increasing the staffing establishment to address those concerns.

Many of the executive post holders are either new to post or in interim positions. This had an impact on the trust's leadership as staff reported that senior leaders, with the exception of the chief executive were rarely visible on wards. Staff were unaware of the positions and responsibilities of most executive post holders. There have been significant changes at the executive level of the trust

for some time, and the chief executive was aware of the need for stability among this group in order to address the leadership concerns across the trust.A substantive director of finance post had been appointed and was due to start imminently, and both the chief operating officer and the medical director posts were being advertised around the time of the inspection.

During our last inspection of the trust in 2012, we found non-compliance with Regulation 13, Management of medicines and Regulation 22, Staffing. We found the trust compliant with both on inspection.

Why we carried out this inspection

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

How we carried out this inspection

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

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

The inspection team always inspects the following core services at each inspection:

- Accident and emergency
- Medical care (including older people's care)
- Surgery
- Intensive/critical care
- Maternity and family planning
- Services for children and young people
- End of life care
- Outpatients.

Before visiting, we reviewed a range of information we held about the hospital and asked other organisations to share what they knew about the hospital. This included the Clinical Commissioning Group (CCG), Area Team (AT), Trust Development Agency (TDA), Health Education England (HEE) and Healthwatch. We carried out announced visits on 16 and 17 January 2014. During the visit we held focus groups with a range of staff in the hospital: nurses, doctors, physiotherapists, occupational therapists, porters, domestic staff and pharmacists. We talked with patients and staff from all areas of trust including the wards, theatre, outpatients and A&E departments. We observed how people were being cared for, talked with carers and / or family members and reviewed patients' personal care and treatment records. We held a listening event on 15 January 2014 where patients and members of the public shared their views and experiences of the Northampton General Hospital site. We returned to the site unannounced on 29 January 2014 to collect additional information as part of the inspection.

Requires improvement

Accident and emergency

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

Information about the service

The Accident and Emergency department (A&E) provided a 24-hour service seven days a week, for a population of 380,000 people. The department has facilities for triage, minor and major injuries and a resuscitation area. There is also an Emergency Admissions Unit (EAU) which supports people being admitted to the hospital through A&E; it is referred to as EAU which cares for male patients and Benham ward which cares for female patients. The A&E department is led by a Consultant known as the clinical lead.

In the year from April 2012 to March 2013, the department had 96,180 attendances. In the nine months prior to our inspection (April to December 2013) 81,218 patients attended the A&E department, 19% (15,392) of which were children under 17 years of age.

The minors department is adjacent to the main A&E department and is staffed by Emergency Nurse Practitioners (ENPs). It provides a service seven days a week from 9am to midnight. This department only sees children over the age of one year.

The hospital is a designated Hyper Acute stroke unit and provides this service across Northampton. NGH is a trauma unit and Queens Medical Centre, Nottingham is the closest trauma centre.

All non-elective admissions to the hospital go via the A&E department as well as patients referred by their general practitioner (GP). There is a facility which supports children going directly to the children's department. Children accessing the A&E follow the same pathway as adults and have a small dedicated children's area within the major injuries department. This is accessed by walking through the adult's area. The receptionist team can stream children with adults to the triage nurse or directly to the minor injuries department. This is at discretion of receptionist staff. When streamed, the triage nurse can send patients to x-ray on route to the minor injuries department and give analgesia.

We spoke with 23 patients during our inspection and with 22 members of the trust's staff, including the department's clinical lead, the department's matron, the nurse consultant, senior nurses, junior doctors, nurses, health care assistant and a member of the integrated discharge team. We looked at 42 sets of patient records.

Requires improvement

Accident and emergency

Summary of findings

We deemed that the department was safe for patients, although consultant staffing levels within the department were significantly lower than those recommended by the College of Emergency Medicine for an A&E department of its size. The consultant workforce had recently increased from four to seven, but further appointments are required and the trust was carrying out additional recruitment activities to meet the recommendation.

The A&E also recently introduced a 'red flag' system as a result of learning from a serious incident. This highlighted patients that were more vulnerable i.e. pregnant ladies or patients receiving chemotherapy. Patients highlighted by the red flag could then be prioritised within the department and the whole team would be aware of them to ensure they received the appropriate level of care within appropriate time frame.

Throughout our inspection we observed that staff in the A&E department were caring, compassionate and attentive to the patients. They endeavoured to put patients in beds and to provide them with food and drink.

Patients frequently spent too long in the department before being admitted on to a ward and the department was not meeting the NHS A&E performance targets, often due to lack of available bed capacity across the hospital. This also meant that the department often breaches its own target for initial assessment due to lack of available staff and facilities such as cubicles.

The A&E department was not responsive to the specific needs of children despite 19% of attendances in the nine months prior to our inspection being under 17 years age. There was no evidence that the National Service Framework (NSF 2004) for children or any best practice guidance which advises trusts on how to provide an appropriate environment for children had been considered. Recently, staff had begun to highlight children on the department's IT system so that staff could see at a glance how many children were in the department and their position on their journey through the department. The system also highlighted elderly patients. However, it was not clear how staff used the highlighting system when delivering care and treatment.

An interim service manager in the department who had been in place only a few months prior to our inspection appeared to have already initiated improvements, although there had been some resistance to change. Staffing levels had also been increased as part of the trusts winter plan. We spoke with driven, motivated and committed senior staff, but, the lack of resources had inhibited their abilities.

Requires improvement

Accident and emergency

Are accident and emergency services safe?

Requires improvement

Safety and performance

A serious incident (SI) folder had recently been introduced. Staff were familiar with a recent SI in the department, and the required actions and learning which resulted from it. We saw that the SI had been thoroughly investigated, including external input from the Trauma Audit and Research Network, and there was clear evidence of departmental learning. However, it was not clear whether the learning had been shared across the organisation.

We were also informed about learning from another recent SI. Staff discussed how practice had changed as a result.

Staff told us that there were monthly meetings for nursing staff to ensure they were kept up to date with changes and improvements following the occurrence of SIs. We saw that this information was available in the staff room for all staff to read.

A clinical dashboard was prominently displayed in the area where clinicians completed patient records, which showed the department's performance against NHS A&E indicators, in real time. Many staff received daily emails which detailed the previous day's performance and giving a reason if patients were not seen within national the four hour target.

Systems, processes and practices

Staff were familiar with the incident reporting system in both A&E and the Emergency Assessment Unit (EAU). Medical and nursing staff were able to describe how to use the system and what it was for, although two junior doctors (Foundation Year One) had never received feedback about incidents they had reported. Completed incidents were reviewed by the A&E matron, who identified actions to resolve the issues. Information about incidents was shared with staff during staff meetings and by the display of information in the staff room.

We reviewed 17 sets of patient notes in paper copy which related to recent patients seen in the A&E department. We saw evidence in all sets of notes of nursing assessments where required and the correct use of forms in paediatric notes. Patients referred to specialties directly did not appear to have clinical notes attached to the casualty card. Our overall impression was that patient notes were being consistently completed to an acceptable standard.

Staffing

The College of Emergency Medicine has recommended a minimum of 10 whole time equivalent consultants for an emergency department of the size at NGH. We were told that three new consultants had joined the trust in the month prior to our inspection, which increased their number to seven. Of the seven consultants, six provided on-call cover. We were also informed that the three new consultants were previously trainees at the trust who had enjoyed working there and that all remaining training positions in A&E were full, which suggests a good staff experience in the department.

There was consultant cover in the department between 8am and 10pm. However, a high number of attendances that subsequently led to an emergency admission between 7pm and 7am meant that there was not sufficient consultant support during the time where up to a third of emergency patients were admitted. Consultants were available on call after 10pm and before 8am and we were told would always come in when required. There was no consultant identified as the lead for children's care.

Nursing staff in the A&E department at the time of our inspection was normally comprised of nine trained nurses and three healthcare assistants (HCAs). However, staffing levels were increased to support additional winter pressures. The matron told us that a business case for 11 trained staff and three HCAs had been developed. This was to be reviewed when a staffing tool was implemented, which was scheduled for February 2014. At the time of our inspection, staffing levels were not determined using any guidance. The director of Nursing could not assure us that an RSCN was on duty at all times, this is recommended in A&E departments of this size, to ensure children are seen by appropriately qualified staff at all times.

We were told that staffing numbers for the EAU met current requirements and there was a process to follow if additional staff were needed which ensured that staffing of that unit was maintained at a safe level.

Accident and emergency

Although we observed that staffing levels were safe in A&E, staff on the EAU and associated Benham ward told us that they had raised concerns regarding staffing levels, but that these concerns were not always acknowledged. They told us that they often received a corporate response that did not respond to the issues raised. They felt this had left these areas unsafe at times and resulted in delays in providing position changes for people for pressure area care, assistance with eating, treatment delays and people waiting longer than they should. One patient's notes indicated that they had been provided with one-to-one nursing care when it was required, but we observed that there were not enough staff to provide one-to-one care for a patient who was confused and at risk of injuring themselves.

Junior medical staff told us that they often stayed late or came in on their day off to ensure discharge letters and medications were written up. This was to reduce the list of tasks that needed to be completed during the week. They also told us that there was only one senior house officer, one junior doctor (Foundation Year 1) and one registrar for the whole of the medical directorate at weekends. We considered that this was likely to be a contributory factor to the delays seen throughout the hospital which were known to result from a bottleneck of patients in A&E. The executives advised that there is one specialist registrar, two senior house officers, and one junior doctor (Foundation Year 1). They also stated that there is one senior house officer for base wards, assessment unit and A&E.

Junior medical staff told us that they enjoyed working in A&E despite challenging shift patterns. One junior member of staff was considering a change of career to work with in emergency medicine on the basis of his experience in the department. However, teaching was highlighted as an area for potential improvement.

Monitoring safety and responding to risk

Auditing of infections was carried out trust wide. One example was urinary tract infections (UTI) following catheterisation. If a UTI developed, the infection prevention and control team completed a catheter audit and discussed the results at the Infection Prevention Committee. The matron for A&E attended this meeting because on occasion a catheter was inserted in A&E. This meant that A&E staff would be able to learn from these occurrences and improve practice to prevent infections in the future.

We spoke with two patients on EAU and Benham ward who told us that they felt safe. We checked information for nine patients to ensure that their wrist bands displayed accurate information, including their allergy status. We did not find any anomalies.

Risk assessments were started in A&E and completed in more detail in the EAU or on the admitting wards. Assessments included details around nutrition and hydration needs of patients. A senior nurse on EAU told us she felt that patients did not get enough to eat and drink while in the A&E department; one patient told us that they had not received anything to eat or drink for several hours in A&E and another patient told us they had received no assistance to eat or drink while in EAU. However, we saw on EAU that most patients had drinks and were able to access these and patients said that staff members had tried to help one patient to drink.

Environment

The NSF for Children published in 2003 includes specific details and references to A&E. It states "In A&E departments, surgery recovery areas, and outpatient clinics, there should be physical separation between children and adult patients, so that children are not exposed to potentially frightening behaviour; and equally, so that adults feeling ill are not disturbed by noisy children." NGH did not appear to have taken account of this guidance.

Anticipation and planning

Although a recognised tool was in use to forecast the number of patients expected to be admitted from A&E each day, we found no evidence of effective expansion in the hospital or intermediate care capacity to accommodate a higher demand for admission. A consultant told us that they had taken the lead to improve the emergency admissions pathway and had implemented some effective changes in clinical practice. However, we saw that additional action was still required as the trust could not accommodate admissions in a timely manner during our inspection.

Requires improvement

Accident and emergency

Are accident and emergency services effective?

(for example, treatment is effective)

Not sufficient evidence to rate

Using evidence-based care

We saw that standardised clinical pathways were in use in A&E. We reviewed the records for two patients who had recently been seen in A&E with chest pain and found that the acute cardiac syndrome clinical pathway had been followed in both cases. However, staff told us that there were also a significant number of forms for the pathways that were not yet being used. For example, paediatric head injuries were assessed and evaluated using a proforma, but there was no proforma for adult head injuries. One A&E consultant told us they thought that the use of the clinical pathways and proforma would improve once the new consultants were in post.

Multiple audits were carried out in A&E on a weekly and monthly basis. Examples of audits included patient care records, clinical quality indicators, infection control and mandatory training. We were told that one audit had identified that the evaluation of pain and the follow up pain scores were not always completed.

Two external reviews of the A&E service had been carried out, both of which focused on the use of the emergency care pathway since May 2013. The most recent review was completed during September and October 2013 by the Emergency Care Intensive Support team, which provided recommendations for the improvement of the A&E service. However, we found limited evidence of actions on-going or implemented following these recommendations.

Performance monitoring and improvement of outcomes

Patient records and test results were audited and reviewed in different ways. For example, errors in x-ray reporting by junior members of staff were detected by a review of films by more senior staff. Additionally, medical note keeping for all medical staff was audited on an on-going basis by their supervisors, using a College of Emergency Medicine proforma. Audits of head injury cases were done in retrospect through case-note analysis using the department's coding system to identify the relevant notes. Overall, we considered that the number of medical notes audited was small in relation to the size of the A&E department and the number of patients seen there.

During our inspection, we reviewed 21 sets of patient notes. These records were written respectfully and in a factual way, but did not contain the personal choices of patients or their relatives. We were told that nursing records were audited for the structure and format of the records, but not the content. There was also no feedback to nursing staff about the clinical outcomes for patients. This meant that there was not an effective governance structure in place to support medical and nursing staff comparably.

Staff, equipment and facilities

Although the appropriate equipment was available in suitable quantities in the A&E department, we found that it was not safety checked on an annual basis, which is required. Out of 16 pieces of equipment that we checked, 12 were not affixed with the stickers which are used to indicate the date of the last electrical safety test. One piece of equipment had a sticker but the date on it was illegible, while another sticker showed that the testing period had expired. Additionally, the staff we spoke with were not familiar with electrical safety checks for equipment. This meant we could not be assured that equipment was fit for use.

A staff member from the EAU told us that nursing staff had medical equipment training during their induction. However, if a particular piece of equipment was not regularly used, the nurses could lose their skills for using it. If staff needed to use equipment but weren't confident about their knowledge, they would ask a colleague for support.

Staff informed us that access to pressure relieving equipment was better now as the trust had invested in new mattresses.

The department was visibly clean and appeared to be well maintained, including toilet facilities. There was also sufficient access to food and drink. The reception staff had a clear view of the patients waiting to be triaged. The waiting room was shared with both adults and children; there were a few toys available for children who were waiting to be seen.

Requires improvement

Accident and emergency

There was a designated telephone for 111 and posters and messages to the public reminding them of the appropriate use of the A&E department. There was a sign on entry to the department which showed what the wait was to be seen, which was regularly updated during our announced inspection but during our unannounced inspection, we found it had not been updated for five hours meaning that patients had not been kept informed of how long they were likely to wait to be treated.

When the majors area within the A&E was busy, we observed that it was cluttered with trolleys in the corridors. This meant that equipment might be placed in front of the resuscitation trolley, which may mean that staff lost time when trying to access it in an emergency.

Hand sanitising gel and hand wash facilities were available throughout the A&E department and its associated wards, and hand hygiene information was displayed. Of the 16 pieces of equipment we checked, we saw that they had 'I am clean' stickers on them. 13 of these were dated between 14 and 16 January 2014 meaning that the majority had been checked in the week of our inspection.

Multi-disciplinary working and support

Staff within the A&E department told us that they would care for all patients who present to the department regardless of whether they were an expected admission. While this was supportive of specialist colleagues, it had an impact on the department's capacity and its ability to assess and treat patients who presented as an emergency.

Many of the delays experienced in the A&E were due to the lack of availability of beds within other areas of the hospital. We observed a delay for one patient going to a ward; the matron from A&E tried to address this but we did not see that it was resolved. The matron told us that they felt staff in other areas of the hospital understood the pressures on the A&E department.

Staff in A&E spoke positively about their relationship with the stroke team and their responsiveness to the arrival of possible stroke cases. It was acknowledged that patients who self-presented, had a slower response due to the fact that the ambulance called ahead and the stroke team could be waiting whilst self-presenters had to be triaged through A&E.

The trust was not achieving either the NHS one hour target to scan patients who had potentially had a stroke, or the target for all patients being admitted to be transferred to a ward within four hours. This issue is explored in the Medical section of this report.

The crisis intervention team was publicised on posters which indicated hours of availability and points of contact. We were told that Nene Healthcare Foundation Trust had an Integrated Care Team (of nurses, occupational therapists and physiotherapists), whose purpose was to work with Northampton General Hospital to review patients to see if they were suitable for care in the community.

Paramedics we spoke with were very positive of the staff in A&E and told us, "They do everything they can to help us." They told us that the building and the environment imposed limitations on the A&E capacity but said that staff worked with the paramedics to ensure patients were accepted by A&E staff within 10 minutes of arrival by ambulance.

One patient we spoke with in the EAU told us they felt as though the A&E and its associated wards operated in isolation from the rest of the hospital, and that inter-departmental sharing of information was not adequate. Another patient told us that there was poor communication within A&E, because they were told that they would be moved to a ward but instead were discharged.

We were also informed that Age UK was involved if there were minor social issues as a reason for the delay in discharge. Age UK volunteers also attended at times on a Thursday, Friday and Saturday to complete a tea round for over 55s.

Are accident and emergency services caring?

Good

Compassionate, dignity and empathy

The A&E department has a very comfortable well equipped room with refreshment facilities where relatives can wait for a person attending the A&E. This room has a dedicated toilet, baby change area and access to a garden area.

Requires improvement

Accident and emergency

A&E care is provided in individual cubicles with wall in between to ensure privacy and confidentiality for consultations. When the department reaches its capacity, however, patients are left waiting in corridors with little privacy and confidentiality.

We observed staff speaking to patients with kindness when they were waiting in the corridors, and staff assisted patients in returning to their cubicles. We also observed the matron assisting a patient to use the toilet. We saw an elderly gentleman trying to climb off trolley, and an A&E consultant was quick to respond.

Care was not centred on the needs of children in the A&E department. There was one children's waiting area, but this was accessed by going through the majors department, where unwell adults were waiting to be seen.

Patients gave us mixed views of the care being provided in the EAU. One patient said, "Brilliant service from nurses, explain everything they do. You can ask as many questions as you like", while another told us "No-one explained anything to me. I was moved around so I was very fed up by the end of the week". Another patient told us that they had presented with severe headaches at 8pm and waited one and half hours to see a nurse. They were not given pain relief until 12.10am, which was four hours after they had arrived, and until then had not been offered a drink. The patient was still waiting to see a doctor when we spoke with them.

Between April and mid December 2013, the A&E department received 37 complaints, many of which were about a lack of communication. Another theme among the complaints received was about the medical care provided. We were not told of specific actions to address.

Involvement in care and decision making

We spoke to eight patients during our inspection told us they felt that they were well informed while in the EAU, and were involved in the decision making about their care. They also told us that the care they received was very good and that staff were very attentive. One patient told us that while the care was good, nurses did not have time for them, and another said ''No one listened to me. They were too busy''.

Trust and communication

Review of a care record for a patient in the EAU clearly detailed contact with the patient's family and reflected daily discussions about deterioration in the patient's condition. The patient's decisions and wishes relating to their care were also recorded.

Between April and December 2013, 19% (seven out of 37) of the complaints received in the A&E were about attitudes of staff. We were not told of specific actions to address this, however we witnessed caring staff in the A&E department.

One patient told us about communications between the EAU and the wards about whether she was going to be moved to a ward. however she remained on EAU throughout our inspection.

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

(for example, to feedback?)

Requires improvement

Meeting people's needs

The NHS has a target to admit, transfer or discharge 95% of patients within four hours of their arrival in an A&E department. For the 30 days prior to our inspection (30 December 2013 to 28 January 2014), NGH met this target on only five days. The trust recorded performance of fewer than 75% on five days and under 70% on one day.

The total number of attendances varied between 342 on 20 January 2014, of whom 244 (71.3%) were seen within the 4 hour target to 163 on 25 December 2013, of whom 161 (98.8%) were seen within 4 hours.

There was no direct correlation between high numbers entering A&E and poor performance; 274 patients were seen on 12 January 2014, of whom 266 were seen within four hours (97.1%). In contrast, 224 patients were seen in A&E on 31 December 2013, of whom 167 (74.6%) were seen within four hours. The following day, 256 patients were seen in A&E yet the target was reached.

Within the four-hour target there are additional measures. For example, patients arriving in A&E should have a first assessment (also referred to as 'triage') by a nurse or doctor within 15 minutes of arrival, to determine their

needs. Additionally, patients in A&E should be assessed by a doctor or an Emergency Nurse Practitioner (ENP) within one hour of arrival. The A&E department at NGH struggled to achieve the one hour target because there was a backlog of patients in the department who were either waiting to be admitted to a ward or to be seen by specialist doctors. We observed this during our inspection, when all the cubicles were full and a number of patients had to wait on trolleys in the corridors. In total we saw 14 patients who had been waiting for more than four hours. This meant that patients had long waits in the department and their care and treatment was delayed, which may have put their safety at risk.

When activity in the department peaked the capacity issues became more apparent and as a result we witnessed patients waiting on trolleys and not enough cubicles for consultation purposes. The impact on not having the ability to assess people in a timely way meant that patients had long waits in this department and delays in receiving treatment.

We observed nine patients who had waited more than the four hours in A&E by 11am. There were also five patients the following day that had waited more than four hours, even though the department did not appear so busy on that day. We were told and observed that the first assessment to be seen by a doctor or ENP the target being within one hour was breached due to cubicles not being available.

Prior to our inspection it was brought to our attention that patients were “greyed out” on the department’s IT system. This suggested that they had left the department and the clock would stop measuring their length of time spent in the department. However, these patients had not actually left the department and were waiting further investigations. We confirmed this practice during our inspection and were given reasons for it. In response to our finding, the Clinical Commissioning Group (CCG) was addressing the practice formally with the trust.

In addition patients in the EAU were not being seen on time by the doctors. One patient in EAU said that they have been admitted via direct medical referral from their GP but there were still 15 patients waiting to be seen by the doctor before them. Another patient had waited four hours and then had been placed in a room and had to wait a further three hours to be seen by a doctor. The patient also added that while she was being admitted there were 12 ambulances waiting outside the hospital. This demonstrates the poor flow of patients through the hospital, the delays to patients being assessed and having their needs responded to and met in a timely manner.

Patients who were referred to medical and surgical consultants were also admitted via the A&E department. A&E staff told us that they always ensure that "no patient is left without care." This means that A&E staff were caring for patients who were not necessarily in need of emergency care, and could be cared for elsewhere while they waited for their appointment. We found that the surgical direct admissions unit was full not only with surgical patients, but it was also caring for medical patients, which meant it could not take any more of its patients from the A&E. It appeared on our inspection that A&E does not have enough staff or facilities to meet the needs of those who need specialist care and those needing emergency care at the same time and in the same department, this is resulting in poor A&E performance.

The trust has had several external reviews and had been provided with support to develop and improve the flow of patients through A&E and onwards to acceptable discharge timeframes. For example the NHS intensive support team, ECIST and an internal emergency care pathway review. Whist recommendations have been made and support has been provided the impact of this is yet to be seen. People are still waiting longer than they should in A&E and discharges are still delayed meaning that people are not receiving the response from the trust that they should expect.

Delays in discharging patients is also an issue for the trust, which added to the lack of availability of beds and contributed to the patient backlog in A&E. Junior doctors we spoke with told us that the backlog was linked to the lack of beds on some wards. This meant that patients were often placed on wards other than where they would be treated, and were subsequently moved around within wards and to different wards. Although the junior doctors felt that these patients tended to have less complex needs, We spoke with one patient with early dementia who told us that during their last visit to the EAU, they had moved beds in the unit three times in five days.

The trust was aware that the delays in discharge of patients was a major issue, and told us that it was being

addressed by the urgent care programme board. Improvements made by the Board meant that a proportion of discharges could be planned in advance each day, which was helping address the flow of patients through A&E. The trust also set itself a target to achieve most discharges by midday. However, at the time of our inspection, the trust was only meeting this target between 25% to 40% of the time.

The trust had implemented two coordinators on each shift, one for department safety and the other for patient flow, both of which assist with discharge. The trust has received positive feedback from staff about this initiative and it has been recognised internally as good practice.

An early warning tool was used throughout the hospital which was used to ensure staff responded promptly and appropriately to changes in patient needs. The tool assigned a score to patient which was calculated during the regular observations made by nursing staff. During our inspection, we saw the early warning score used in throughout A&E its associated wards. A junior doctor in the EAU told us that nursing staff contacted a doctor if the score was five or above, even if it would not result in a change to the patient's treatment.

A&E staff and the Emergency Nurse practitioners commented on how valuable play therapists would be in the minors' area and within the major department where children were cared for. This suggested that they do not currently provide this specialist resource, in an area and at a time that could have a significant outcome on the child and their families' whole experience.

Language translation services were available by telephone via the NHS Language Line, or a staff member who speaks the same language as the patient would be used. We found that information leaflets about injuries were only available in English, but staff told us that they could obtain the leaflets in other languages if they were needed. This meant that access to leaflets about injuries was delayed for people who needed it in languages other than English.

Vulnerable patients and capacity

The trust had safeguarding policies and procedures in place and staff knew how to follow them. The matron and nurse consultant were the adult safeguarding leads for the A&E, and a senior registered sick children's nurse (RSCN) led on child safeguarding. A nurse in the EAU was the safeguarding lead for that area, with one day per week dedicated to work relating to the safeguarding team.

At the time of our inspection, records showed that most A&E staff had received safeguarding training for both children and adults. However, staff were not necessarily trained to the nationally recommended level, and not all staff were trained. Junior doctors who had not received safeguarding training told us they would alert senior medical staff if they had any concerns. Together, the lack of training to the recommended level for children and the lack of RSCNs in the A&E department meant that there was a particular risk that children visiting the A&E may not have their abuse recognised by staff.

We were provided with evidence that as at 16 January 2014 all of the A&E staff were up to date with level 1 training in safeguarding children and young people, 72% of staff were up to date with level 1 training in safeguarding vulnerable adults. Training information also showed that all staff in EAU and Benham ward had received training in child and adult protection to level 1. However, we were unable to be sure of the compliance at level 3 for safeguarding children and young people as information provided to us did not identify A&E specifically. A&E staff are expected to be trained to level 3 to safeguarding children. This is a nationally recognised standard and given that children were seen and treated by all staff and not designated registered sick children's nurses (RSCNs) this is an important measure. The compliance rate at level 3 for all of general medicine was 52.05% if A&E is counted in this way; this is very poor compliance.

We spoke with one junior doctor about patients with limited mental capacity. They demonstrated a good understanding of the Mental Capacity Act (2005) and the process for deciding whether a patient has capacity to make their own decisions or to give consent for treatment. Ward areas had their own nursing lead for patients lacking capacity, who had also received training in dementia care.

We saw and staff advised of two-hourly safety checks in A&E with the consultant or consultant nurse on duty. They checked the status of each patient, their treatment and progress and changes were quickly made if required.

Accident and emergency

Staff in the A&E department spoke positively about their relationship with the trust's mental health team, which is available on-site during normal opening hours and are on call out of hours. They told us that there could be delays in accessing mental health support when team members were busy attending inpatient wards.

Children in A&E

We spoke with the matron for A&E to review the paediatric care pathway. There was no separate Children's Accident and Emergency Unit. Children who arrived at A&E were booked in at reception with adults and then either referred to the triage nurse or through to minors for assessment and treatment. Seriously ill or injured children were taken directly to the majors' area. Most admissions to the A&E were adult and all children go through the same pathway as adults. The number of children attending the department was 15,392 out of the 81,218 attendances (19%) in April-December 2013. NGH did not consider this a sufficient number to justify a dedicated children's service.

The Royal College of Paediatrics and Child Health (RCPCH) Standards for Children and Young People in Emergency Care Settings (2012) identified that there should be always be registered children's nurses in emergency departments, or trusts should be working towards this, and that staff should, as a minimum, be trained in paediatric life support. We confirmed with the lead consultant that the consultants were trained in advanced paediatric life support (APLs) she stated that most if not all were accredited trainers in this area. The department could not guarantee that a qualified RSCN children's nurse would be on duty all the time. Children were being cared for in adult areas and did not always have a children's nurse allocated to them. There was no children's nurse on duty when we asked on our inspection and no one shared with us plans towards this or any rotational opportunities with the children's in patients facilities. Children had to wait with adults and were not prioritised. Some children were waiting unnecessarily in the department because of delays in admission to the children's ward. We spoke to the staff on the ward who said the A&E pathway had an impact on the ward capacity.

One mother expressed a positive experience through the A&E route in the early hours where the child was triaged straight away and sent to the ward. However another parent at the listening event did not have a good experience through A&E.

Children who come through A&E who require high dependency care are stabilised in A&E firstly and then transferred either to the children's HDU and if necessary are transferred out to other hospitals and are collected by the retrieval teams. All the nurses working on the ward covering the HDU beds have the appropriate HDU accredited training. We were told there is always an HDU nurse allocated to each shift. The lead consultant in A&E informed us that all Consultants in A&E are trained in advanced paediatric life support.

There was no dedicated or decorated room for children with minor injuries and both the children's waiting area in A&E and the minor injuries waiting area had no toys visible when we inspected.

Access to services

The department's IT system showed the time that patients were waiting for their first assessment (triage), and this could be monitored by the trust. There were two triage rooms available once patients had booked in with reception, or they were instructed to go to the minors department. The A&E areas were not different for children and adults. Staff told us that they tried to prioritise children, but there was no formal process in place for this. by the receptionist. It was noted on our inspection there were no provisions for children who would use this waiting room and would wait to be triaged by the nurse. Those patients referred to minors can either go outside and across a road or walk internally to the minors department. Children remain part of the same process as adults and no differentiation was made. It was stated they do try to prioritise them however there was no specific process in place to do so. Children are not cared for separately, they have no separate dedicated waiting room. This model presents a risk as it means that patients can wait in the minors department for up to one hour before seeing a doctor or a nurse and no exception is made for children over one year old.

The minor's area was staffed by two or three ENPs. They have a variety of skills and backgrounds and are allocated shifts to complement each other's skills, the patients present with both minor injury and minor illness, they see all minor patients over one year old.

There is a combination of independent nurse prescribers (INP) and ENPs trained to use Patient Group Directions (PGDs). We were unable to see the PGD documents while on unannounced inspection as they were locked away. We were advised there was limited PGDs and if required prescribers would assist in ensuring the patient received the required medication. A framework was also in place for the prescription of a narrow range of drugs (undetermined) by ENPs according to predetermined criteria. Whilst aware of its existence, the staff members interviewed were unable to explain how the system worked. Staff were also unable to describe any audits of the use of PGDs.

On our unannounced inspection we observed patients waited less than 20 minutes to be seen and treated by the ENPs in the minors department.

A&E staff used the term "single front door" in recognition that all patients come through this route and there are no direct admissions for adult patients who are referred. In addition they said that "EAU/Benham ward does not have the capacity to do this for medical patients so A&E does it for them." This supports the findings that A&E is unable to deliver the national targets set for A&E departments and meet patients' needs in a timely way as it currently provides access to the whole hospital as well as providing care for extended periods when there is limited inpatient beds in the hospital.

Nursing staff told us about the positive relationship they have with local care homes and nursing home staff, and didn't identify any problems in discharging patients to these facilities after an A&E attendance. They also received support from the trust's intermediate care team if the patient needed support during transport following discharge.

Learning from experiences, concerns and complaints

We saw that comment boxes were located in A&E, but there were no comment cards for people to use. The families of patients in the EAU that we spoke with were aware of the complaints procedure and knew how to make a complaint. One patient in A&E we spoke with was not aware of the complaint procedure. We did not observe any information about the complaints procedure displayed in the department. A copy of an NHS complaints leaflet was available in A&E, but it was not clear whether this was the trust's complaints procedure or a national system.

In relation to the 37 complaints received by the A&E department between April and December 2013, a trust board paper stated that there were 34 actions that remained outstanding. Through the complaints process the trust had identified issues around communication and pain control in A&E. The matron advised that this has resulted in a patient safety round being undertaken every two hours. These rounds were undertaken by the most senior doctor and nurse

The A&E department had received 37 complaints between April and mid December 2013. However the trust board paper stated that there were 34 actions as a result of complaints in A&E that remained outstanding in actions being both identified and delivered. This suggests that there is some learning but clearly not enough and it is not timely. Comment boxes were available in A&E but no comment cards. The friends and family test showed 16% above the national average of patients that would recommend this service.

Feedback from the Family and Friends Test is displayed on a noticeboard in A&E and is visible to both staff and patients. The most recent results of the test showed that the number of patients who would recommend the service in the NGH A&E was 18% above the national average. Therefore, despite the issues that were identified in the department, patients continued to feel well cared for by staff.

The trust had introduced a programme for simulating serious incidents which had occurred. This gave staff the opportunity to see incidents re-enacted, which made it easier to identify what went wrong and for staff to learn from the incident.

Requires improvement

Accident and emergency

Are accident and emergency services well-led?

Requires improvement

Governance arrangements

At a local level A&E audits are generally completed by nursing staff. Actions were taken from these audits as well as the outcomes of incidents which had been reported through Datix.

Nurses also referred to actions following complaints and shared examples as detailed above however the board report suggests that between April to June 2013 the A&E department had 17 accounts where learning had been identified but evidence was outstanding and overdue and 4 accounts where an action plan had been received but evidence was still outstanding but expected within time frame.

There was a consultant lead for governance and safety and a lead for clinical audit. Consultants had identified and publicised a list of 'red flag' conditions, for example patients receiving chemotherapy, for which special vigilance was required. Part of the 'safety round' was to designate eligible patients with the appropriate 'red flags'.

Senior nurses in A&E felt that concerns around flow and the impact on safety in the emergency department was not being addressed in a systemic way by the rest of the trust. This was a well-recognised consistent challenge that on a daily basis there was a poor flow through the emergency department and a constant lack of availability of beds in the hospital.

We raised the issue of poorly completed and designed Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) documentation on the last day of our announced inspection. When we returned unannounced to A&E on 29 January we saw evidence that this document had been redesigned and was in use. The A&E consultant had been part of the multi-disciplinary team that reviewed the previous DNACPR form and contributed to the revised format.

Leadership and culture

The interim manager has worked in a number of emergency care settings and was able to bring fresh eyes to the department. There have also very recently been three new consultant appointments who had started work at the time of our inspection. The pre-existing consultant also worked on the air ambulance which suggested the workforce had the opportunity to consider practices in place in other settings which could have a positive impact if implemented in NGH.

The A&E department has had limited senior doctor cover for a number of years; this has impacted on its abilities. There was at the time of our inspection no lead for paediatrics and given that there were four consultants a department seeing patients that should have oversight by 11 consultants, the ability to be effective leaders had been challenging.

Several staff members said they had not seen a member of the senior management team specifically Directors and Non- executive directors on the unit to witness their challenges and talk to them about them. This was at the exception of the Chief Executive who was not only visible in the A&E department but also, (we were told) took the time to discuss the safety culture.

Learning improvement, innovation and sustainability

A junior doctor shared that he had a medical teaching day with talks on how pressure ulcers, falls and prescribing incidents affect patients and their hospital journey.

There was a very populated information board in the A&E staff room which sought involvement and input from colleagues on areas under development. It was not structured to be assured of feedback, which depended upon individual staff members seeking out the person responsible in order to provide respond. This could result in valuable feedback being lost due to a lack of structure.

Nursing staff were involved in the trust QuEST and audit results which were fed back during team meetings. Senior nurses were responsible for issues identified and resolving them with junior staff.

We were informed that there is a trust-wide Urgent Care Board with the following work streams: keeping patients safe in A&E; keeping patients safe under 10 days length of stay; keeping patients safe over 10 days length of stay, including community beds; keeping patients safe in the assessment units and flow, and seven-day services (previously called medical manpower work stream).

Requires improvement

Medical care (including older people's care)

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

Information about the service

We inspected medical care (including older people's care) at Northampton General Hospital where we visited nine acute medical inpatient wards that had a total of 227 beds. We inspected a range of specialty-based wards including stroke care (Eleanor and Holcot Wards), gastroenterology (Collingtree Ward) and elderly care (Brampton Ward), as well as general medical wards and the discharge lounge, Victoria Ward.

We spoke with 33 patients and their relatives over the course of the three day inspection and reviewed information from interviews, discussions and comment cards, as well as listening to patients' accounts during the listening event we held in the local community. We also reviewed 21 sets of patients' notes.

We spoke with a wide range of staff in different roles and grades across the medical wards. We observed care and treatment and looked at care records. We also reviewed the trust's performance data.

Summary of findings

We found that the Medical division maintained a generally clean environment to protect patients from the risk of hospital acquired infections. The medical wards responded to the changing needs of patients by ensuring the availability of specialist equipment.

New staff were supported to integrate into their roles/ teams and suitable induction training programmes were in place. However, compliance with mandatory training such as the management of falls, was low on some wards, including the Elderly Care ward. Ward leadership was seen to be effective where good practice was promoted, or where previously leadership issues had been identified. Overall, staff felt that the service managers (above ward sister level), were not sufficiently visible on the wards.

In relation to record keeping, there was inconsistency in completing required patient documentation. For example, we were concerned to find that patients' BMI scores were not accurately calculated on the Stroke ward.

From a safety perspective, we found evidence of people being transferred between wards late at night and were concerned to find that some patients had been served out of date food replacements and supplements.

Patients felt well-cared for and staff showed them respect. However, some patients were not able to access a choice at meal times, if they had not been on the ward to complete a menu selection.

Requires improvement

Medical care (including older people's care)

Within Medical Care there were significant delays in patient discharge, resulting in insufficient beds to accommodate all the medical patients within this service.

Are medical care services safe?

Requires improvement

Safety and performance

It is mandatory for NHS trusts to report all patient safety incidents. Information from the NHS Safety Thermometer report showed that during the period from September to November 2013 the proportion of patients over 70 with new pressure ulcers had risen sharply to more than double the national average. We did not have evidence that the trust had identified the reasons for this but the Medical equipment management report dated April 2013 stated that the trust intended to address the issue of the availability of alternating pressure mattresses, which are used to help prevent and treat pressure sores. The Medical Equipment Management Report dated October 2013 stated that the project to replace old and obsolete alternating pressure mattresses was nearing completion and that the objective was to improve equipment availability and significantly reduce costs. On our inspection, staff on the medical wards reported that the trust had purchased 200 new air mattresses. Ward staff told us these had a positive impact on pressure area care. However, the managers of two wards told us that the trust criteria for the provision of an air mattress had been revised and it had become more difficult to obtain mattresses, unless patients had either an existing pressure ulcer or a very elevated risk of acquiring one. Patient safety boards displayed outside four medical wards we visited indicated that there had been no new avoidable pressure ulcers reported in the month before we inspected the trust. This meant that the trust had taken action to reduce the number of pressure ulcers occurring whilst patients were in hospital.

The safety thermometer report also showed that, for most of the period November 2012 to 2013, the proportion of patients with a catheter who suffered from a urinary tract infection (UTI) was above the national average for all patients, with the trust scoring 0.95%, almost double the national average of 0.5%. There had been noticeable increases in January, March and September 2013. We saw in the minutes of the meeting of the trust's Integrated Healthcare Governance Committee held in October that this issue had been identified and the causes found to be inconsistent auditing and a need to update the policy for urinary catheterisation. When we spoke with staff on the

medical wards, we were told that there had been trust-wide retraining on cleanliness around taking samples. However, we reviewed trust policies and guidelines and found neither the male nor female policy had been reviewed since 2012. We also requested audits of urinary catheterisation for the period since the October Governance Committee meeting, but we could not determine whether improvements had actually been achieved.

Infection rates (August 2012 to July 2013) were within acceptable ranges for methicillin-resistant staphylococcus aureus (MRSA), methicillin-sensitive staphylococcus aureus (MSSA) and Clostridium difficile (C. difficile), for trusts of a similar size. During that 12-month period, the trust had reported one case of MRSA infection, 10 MSSA infections and 32 cases of C. difficile. We found that wards were generally clean and the environment well maintained, although we found dust at high levels such as curtain rails and TVs and below beds on three wards where we checked this. The Patient-Led Assessment of the Care Environment (PLACE) audit for 2013 scored the trust at 99.4% for cleanliness. We observed that hand washing facilities and hand hygiene gels were available in all areas and staff were observed using these. Personal protective clothing (such as gloves and aprons) was available in areas around wards for staff to access. We received evidence that cleaning audits had been completed on wards on a monthly basis. The medicine division was compliant for six of the nine months reported, with the non-compliance on two of those occasions being attributed to Victoria Ward.

Learning and improvement

On most wards we visited, staff told us they reported incidents using Datix, the appropriate incident recording tool. Most told us they received feedback on incidents and understood how the issues had been dealt with. We spoke with ward managers who told us that they usually shared learning from ward incidents with their staff. All the staff we asked knew how to report incidents and told us they had been trained by colleagues in how to do this. However, staff told us learning from incidents in other areas of the trust was not routinely shared with all divisions.

Learning from incidents was shared by ward managers but staff told us learning from incidents in other areas of the trust was not routinely shared with all divisions.

A member of staff on Collingtree Ward told us that an infection control incident on another ward led to a team from that ward delivering training across the medical division. This resulted in a change in practice in collecting samples. However, staff we spoke with were unaware of serious incidents that had occurred in other departments. Ward managers told us that learning from serious incidents and safeguarding investigations in other parts of the trust was not routinely shared. One ward manager told us, "You hear rumours about incidents but then no more." We were concerned that learning from this incident did not appear to have been shared across the trust.

We reviewed a serious incident investigation report about a patient who had fallen on Allebone Ward and broken their hip in August 2013. The report indicated that the family of the patient were immediately informed of the incident and resulting surgery performed on the patient. The investigation identified that the patient had not received a falls risk assessment after being transferred to that ward, although it was the trust's expectation that assessments would be repeated following transfer to another ward. The patient had been admitted through A&E on 24 August and stayed on Benham Ward until 9.17 pm on 27 August when they were transferred to Allebone Ward. The exact time when the patient arrived on Allebone Ward was not recorded. The fall occurred the following morning. The report also showed that the care plan had not been completed correctly and that 60% of staff working on the ward at the time of the incident were either bank or agency staff. Of the five permanent staff on the ward, only three were up to date for training in slips, trips and falls. Compliance with mandatory training (including slips, trips and falls) had been identified as a risk on the medicine risk register since 2011 and we were concerned that compliance was still low on the ward when the serious incident occurred.

During our inspection we spoke with the ward manager who told us that an appropriate number of permanent staff had now been recruited and they had received their mandatory training. Information provided by the trust showed that, at the time of our inspection, over 72% of staff on that ward had met the requirement for falls training compared with the medicine division's overall performance of 54.37%. Data from the NHS Safety Thermometer showed that, while there had been a higher than usual number of falls with harm amongst those over 70 reported for September and October 2013, there were none in November and December.

Medical care (including older people's care)

Systems, processes and practices

Equipment

We had received information that there were not enough walking frames to help mobilise patients on Knightley Ward. We spoke with a member of the therapy team whom we had observed using a walking frame to assist a patient on the ward with walking. They told us that frames were wiped down after use and were then available for the next patient. However, we observed that the frame used with that patient was not wiped down before being replaced for its next user.

Medicines management

At our last inspection, we had identified that storage and recording of medicines were not compliant with the Health and Social Care Act's regulation for management of medicines. On this latest inspection, a pharmacist who was part of the inspection team reviewed the storage facilities on a number of medical wards and found that they were now compliant with the regulations under the Health and Social Care Act 2008 around storage and recording of medicines. We checked fridge temperatures and storage of medicines. We found that patients who had pre-existing conditions such as Crohns disease or diabetes were helped to manage their own medicines, although the storage cabinets beside their beds were locked and the keys held by nursing staff to protect patient safety. This was in accordance with the trust's self- administration policy for medicines, which is due for review in October 2016. We observed a drugs round on Collingtree Ward and noted that the nurse dispensing medication to patients wore the red 'Drugs Round – Do Not Disturb' tunic, and that this was generally respected by staff. The nurse introduced herself to each patient and explained what she was going to do. She checked the patients' wristbands and in one case identified that a patient was wearing the wrong wristband. The nurse arranged for a new wristband, which was applied by the ward sister after checking with the nurse that it was the correct patient. The patient was originally admitted on 7 January 2014 through A&E and the nurse explained that they had not produced the wristband in accordance with trust policy. The patient had been on Collingtree Ward since 8 January 2014 but this had not been picked up until our inspection on 16 January.

Safeguarding

The trust's safeguarding vulnerable adults policy was last reviewed in October 2011. It was next due for review in October 2014. Staff told us they were aware of the policy and knew how to raise a concern if they suspected abuse of a vulnerable adult. Staff on the medical wards had attended mandatory training and compliance varied between 82% and 100%.

Monitoring safety and responding to risk

On all but one ward where we checked the resuscitation trolley, we found records of daily checks having taken place. On Collingtree Ward, we found that there were no records available for the period 25 December 2013 to 13 January 2014. We asked for these to be located but did not receive them during the course of our inspection. This meant that hospital could not be assured that the trolley had been appropriately equipped during that period.

In August 2013, Allebone Ward had been the subject of an internal investigation after concerns about low numbers of staffing on the ward being raised with the CQC by a member of trust staff and a previous patient. The trust's action plan stated that a significant uplift to the staffing establishment both at trust level and on Allebone Ward would be completed by January 2014. At the time of our inspection, we did not receive any information about staffing on wards being below establishment levels by more than one, and the staffing information on patient safety boards confirmed the numbers of staff we saw on the wards. We were told by a member of staff on Eleanor Ward that there was no hostess at night to serve drinks to patients on a number of medical wards; this service was provided by a healthcare assistant on those wards. When we visited Eleanor and Allebone Wards at night, we found that the healthcare assistants combined offering this service with providing their hourly care rounds. They told us that they did not find it difficult to do this.

The trust practice of carrying out hourly patient care rounds to check on patients' comfort and wellbeing was seen to be in practice and was evidenced in the care plans we looked at. A leaflet explaining this practice was provided to patients on admission. Patients were monitored using the trust's early warning score (EWS) system to ensure that deteriorating patients were escalated to be seen immediately by a doctor. On Collingtree Ward, we noted that a patient whose EWS was raised to a level of concern experienced a two-hour delay before a doctor attended them, even though the phone call requesting a doctor's attendance was made in a timely way. This meant that, while ward staff followed the protocol for escalating the

deteriorating patient, they were not supported by the doctor to ensure the patient received the appropriate care at the right time. However, staff told us there was not usually a delay in receiving a response. We looked at 21 sets of patients' records and found that the EWS system was used appropriately. This meant that staff were appropriately monitoring patients for deterioration.

We spoke with staff on wards caring for patients living with dementia. They confirmed that they had received dementia training and were aware of the trust's dementia strategy. A ward receptionist told us that she thought all staff on the ward, not just the nursing staff, should receive dementia training because they interacted with the patients on a daily basis.

We noted that patients knew which staff to call when they needed help and were aware of who was looking after them. Above each patient's bed was a board that displayed the name of the member of staff responsible for that person's care, as well as the name of the consultant.

We looked at staff sickness rates for the medical division and compared them with the trust. We noted that, in the year ending December 2013, seven of the medical wards had sickness rates significantly higher than the trust average of 4.15%, and two wards, Eleanor and Knightley, had more than double the trust average at 9.32% and 9.84% respectively.

Anticipation and planning

Patient assessments were not consistently completed; we looked at 21 of them. In two records, body maps were not completed for patients who could be considered to be at risk of developing pressure ulcers, although the Waterlow score had been calculated. In one other record, there was no falls assessment for an elderly patient. On Collingtree Ward, we noticed that one patient who had been admitted for treatment for symptoms of alcohol withdrawal had no other aspects of their health considered, and none of the assessments had been completed. On Creaton Ward, we discussed this issue with the junior sister who told us that the absence of completion of notes by the emergency assessment unit (EAU) had been picked up on her ward and staff had been advised to complete assessments where there were none. This practice had not been adopted across the rest of the medical wards we visited. We spoke with a member of the night staff who told us that the nursing assessment form had been introduced a few months before and that they had not been offered any training around its completion. Food and fluid charts were completed for patients judged to be at risk, and patients were escalated to the speech and language therapists (SALTs) if their intake deteriorated. On Eleanor Ward, the stroke service rapid assessment had been completed in detail for each patient whose notes we reviewed. We also spoke with a member of the night staff about how and when Mental Capacity Act (MCA) assessments were carried out. We were told that doctors carried out MCA assessments but that these were not completed for patients who had already been diagnosed with dementia. Because patients' capacity could fluctuate, we were concerned that it was not regularly reviewed.

There was no consistency around the organisation of patients' notes. We looked at patients' notes and assessments on all the wards we visited. We observed that each ward organised these differently so that they could be held in between one and three files per patient. When handover sheets had been completed, these were either kept in a separate file for the whole ward or in patients' files. Staff on the wards knew the systems in place for records but, if staff came from other wards to work there (as they had done to cover absences), this could cause confusion around the whereabouts of particular records. We were also concerned that a set of patient's notes we looked at on Collingtree Ward in fact belonged to a patient on Benham Ward, the EAU. This meant that the patient's records were not available to the staff caring for him on Benham Ward. We brought this to the attention of a member of staff who immediately returned the notes to the correct ward.

There were no clear monitoring systems in place around food and meal replacements given to patients on the wards. We spoke with patients during our observations of lunch time on Eleanor and Brampton Wards. We also spoke with patients on other wards about how their nutrition needs were being met. We were concerned that on Eleanor Ward the food replacements and supplements were out of date. The drink given to a patient on 17 January 2014 had expired on 19 December 2013, while the feed and supplement had expired on 11 and 12 January 2014 respectively. We spoke with a member of the ward staff who told us this had happened because neither the environmental nor drug audits carried out on the ward included these items. This meant that there was no control over the expiration of the feed and supplements and they could be either ineffective or harmful to patients receiving

them. On Collingtree Ward, a patient told us they had received out-of-date milk on more than one occasion. This meant that there had been no check made by either the kitchen or the ward to ensure that the milk was safe for that person to drink.

Are medical care services effective?
(for example, treatment is effective)

Requires improvement

Using evidence-based guidance

On Creaton Ward, body maps were updated weekly with extra copies added to the nursing assessment in order to document the monitoring of skin integrity, the skin health in detail. However, on Eleanor Ward, we were concerned to find that for two patients the nutrition scoring had been incorrectly completed and this error had prevented referrals to a dietician. We reported our concerns to the ward sister. Another patient's nutrition score had been completed correctly and a moderate risk established, but the protocol for a low-risk score was followed because staff told us they did not believe that the result had been correct for the patient. Our inspectors discussed this with the ward sister. Also on Eleanor Ward, a member of staff told us that the height and weight of patients had been guessed and the BMI calculation done on Google. These errors and departures from protocol had not been identified through ward or matron audits, and they posed a risk in that patients' care was not based on accurate evidence.

Performance, monitoring and improvement of outcomes

The trust participated in all the clinical audits for which it was eligible. The service was using national and best practice guidelines to care for and treat patients. For example, the trust fell within expectations in the national audit of managing heart attack and similar to other trusts in the national audit of falls and bone health. Local clinical audit was undertaken. An example of this was on Collingtree Ward where patients with gastroenterological and hepatological conditions were treated. The trust had been identified as being a raised risk in this specialty due to a higher than average number of in-hospital deaths. A consultant on the ward told us that an audit of 10 deaths had been carried out; the results concluded that three of the deaths had been incorrectly coded and the remainder had resulted from metastatic disease. This meant it was likely that the number of deaths attributed to the department was not accurately recorded. Whilst we did not see the audit results we were provided with the resulting action which continued to monitor the situation, and to show that the trust had identified and responded to this information.

The Sentinel Stroke National Audit Programme (SSNAP) was a programme of work that aimed to improve the quality of stroke care by auditing stroke services against evidence-based standards. The data for the trust showed that between April and June 2013 only 52% of patients were taken to the stroke unit within four hours of admission. The target was 90%. We spoke with staff in Eleanor Ward (for hyper acute stroke) who told us they had identified that delays in getting patients into the hospital and through Accident and Emergency (A&E) had had an impact on the numbers of patients arriving at the unit within four hours of having a stroke.

They had communicated to the A&E team that assessments must be speeded up in order to get stroke patients to the right place for their treatment with the minimum of delay. However, during our evening inspection, we spoke with a specialist stroke nurse. They described how they met the ambulance when they had been notified a patient with a suspected stroke was due to arrive. They told us about the various stages of assessment they carried out and how after midnight they experienced significant difficult with the radiology department accepting stroke patients for a CT head scan unless the patient was in need of thrombolysis. The nurse expressed concern at having to negotiate with members of the radiology department, and the registrar identified other patients who needed scans and the impact this had on the target of scanning patients within one hour of arrival in A&E. This view was corroborated by the A&E staff leader.

The SSNAP audit identified that 36.5% of patients were scanned within an hour with an average waiting time of 82 minutes. The stroke nurse told us that three years earlier she had written a protocol around the referral of patients for CT scans, but that the implementation of this had been delayed because the radiology department could not agree the stroke care pathway with the stroke care team. She had been told that this had now finally been agreed and the protocol would be referred to the radiology governance meeting for consideration. We were concerned that there

had been such a delay in reaching an agreement on the radiology department's role in the stroke care pathway. To date, the average length of stay data for 2013–2014 showed that elective patients stayed on the Holcot stroke unit for an average of 42 days while the average stay for non-elective patients was 32.8 days. The staff acknowledged that there was a need for more multidisciplinary staff, such as SALTs, physiotherapists and occupational therapists, in order to ensure that patients were supported before discharge and to achieve the best outcomes in the shortest period. However, they did not provide evidence that this had been taken up with the trust leadership, so there was no evidence of an action plan to reduce length of stay for patients who had suffered a stroke or to address the issues just described.

We found evidence on wards of matrons' audits in areas such as C. difficile, wound care, cannula insertion and catheters. These were shown to us on request for information on these audits on Allebone Ward, but staff on other medical wards did not bring any to our attention. The trust had recently introduced a performance management system that linked with salary grade progression. Non-attendance at mandatory and role-specific training was linked to this and ward managers told us they believed this would help to improve the levels of compliance with training. However, data provided by the trust during our inspection showed that less than a third of staff across the trust had an up-to-date performance development profile (PDP). On two medical wards, Allebone and Brampton, no staff had a PDP and no medical ward had more than 60% of staff with a plan in place. This meant there was a risk that not all staff were receiving adequate support and supervision to ensure that their performance was of an acceptable standard.

Staff

The trust had recently made a significant investment in staffing. On each ward we visited in the medical division, we found an appropriate skill mix of nurses and healthcare assistants. Ward managers reported that recruitment was on-going and that levels of staff had risen steadily. On Creaton Ward, three newly appointed staff had found they were not suited to working with patients with dementia. Those staff had been redeployed elsewhere and the vacancies filled. On both Creaton and Allebone Wards, we found that inexperienced staff were divided into teams led by at least one experienced member of staff. This was to ensure that teamwork developed and that staff were supported in increasing their knowledge. However, we spoke with a member of staff on Knightley Ward, which is not a designated dementia ward but received patients with that diagnosis. That staff member told us they found it difficult to get additional staff if a patient with dementia needed one-to-one care. They usually had to deploy a healthcare assistant to that role, which put pressure on other staff on the ward.

We spoke with junior doctors during both the day and night inspections. Some felt that on-call duties were 'brutally busy' although others felt that shifts were generally steady with occasional peaks. They told us that at night there are five junior doctors of varying levels of experience covering the whole medical division. Additional cover was provided by one junior doctor specialising in orthopaedics, another in surgery and two night practitioners. At the weekend there were two further junior doctors.

Ward managers told us that there was a good preceptorship programme in place so that new members of staff received induction and mandatory training within the first few weeks of taking up their role. The trust then applied a 'cluster' approach to updating that training so that staff did all their updates at the same time each year. A dietician on the stroke unit told us that the induction they had received at the trust was the best they had ever had. Compliance with mandatory and role-specific training was monitored through the trust's learning and development team, who sent the latest information to ward managers on a monthly basis. It was then the responsibility of line managers to follow up those staff who had not attended training. The training data the trust gave our inspection team during our inspections showed that medical wards achieved 80% and above compliance with level 1 training in both safeguarding vulnerable adults and equality and diversity, with 80% and above compliance in manual handling training. However, compliance with other mandatory training was significantly lower on some medical wards. On four medical wards, health and safety training (including risk management of slips, trips and falls) was below 60%.

On Brampton Ward, which provided short-term care for elderly people, less than 23% of staff were up to date with this training. This was of particular concern given the vulnerability and high-risk nature of the patients on that ward. The medical division's risk register had recorded the risk of non-compliance with mandatory training since 4

Requires improvement

Medical care (including older people's care)

March 2011. A recent review of how this was to be monitored had only recently been implemented at the time of our inspection, so it was not possible to test the efficiency of the measures. However, the measures of monthly checks by ward managers had been in place for almost three years and there were still concerns about the compliance with mandatory training at the time of our inspection.

Multidisciplinary working and support

We observed that the trust had reorganised the therapy teams so that they were largely ward based. This meant that patients were treated by therapists who they could get to know as well as the ward staff. The therapists worked as a team with the nursing staff. However, at a focus group for allied health professionals, some of the staff commented that they could feel isolated from a professional peer support viewpoint. This was particularly the case if they were employed by the department in which they were based rather than the Therapies department. Comment was also received that setting up wider peer support groups had been tried in the past but had been unsuccessful because of lack of engagement by all directorates.

Before our inspection, we had received concerns from relatives that patients were transferred within the hospital without their knowledge. On Knightley Ward, we asked to track the number of internal transfers a patient had experienced. The ward staff showed us how this information was captured on an easily accessible online system. However, we found no consistent practice to hand over information when patients were transferred between wards. The nursing assessment notes contained a page on which to record this information but we checked 21 sets of patients' notes and did not see this section used in any of them. We asked ward staff what the practices were on their wards; on Collingtree Ward, the ward sister showed us a pro forma she had designed to capture handover information for patients coming onto the ward. The pro forma was comprehensive but it did not include the time the patient arrived on the ward. We saw evidence that the information was used by ward staff on a regular basis. On Creaton Ward, a different pro forma was in use and another on Knightley Ward. However, staff on some other wards we visited did not know how this information was captured. This meant that patient information may not have been accurately transferred between wards and different departments in the hospital, which could pose a risk to the continuity of care for individual patients.

There was co-operation with other providers. For example, clinical staff had direct online access to patients' summary care records, which were taken from their GP records. A junior doctor demonstrated this facility and showed us that a legitimate relationship between the trust and the patient needed to be created in order to access the records.

Are medical care services caring?

Good

Compassion, dignity and empathy

Patients received care that was centred on them and they were treated with dignity and respect.

Wards were divided into single-sex bays in order to protect people's dignity. We observed staff interactions on the wards and around the hospital. In corridors, we noted that staff were friendly and helpful to people visiting the hospital, and took time to ensure that visitors and outpatients were able to find their way. On the wards, all the interactions we observed between staff and patients were very positive.

Involvement in care and decision making

Both nursing staff and doctors used people's names, spoke with them politely and patiently and explained the care they were delivering. They always sought consent verbally and ensured that people had time to complete tasks without hurrying them. On Creaton Ward, we saw the ward receptionist go to the aid of an elderly patient, gently encouraging them to sit down because they were unable to be mobile independently. The receptionist was very kind and calm with the patient and stayed to chat with him while he settled back down. Call bells were in reach of patients, and staff also responded to patients when they called out. On most wards, there were no significant delays in responding to call bells, although we noted two delays of eight minutes to respond to a call bell while we were on Becket Ward.

Trust and communication

On each of the wards, we saw that patients' privacy and dignity were respected by the appropriate use of curtains

during delivery of personal care or examinations. Patients' individual preferences and cultural needs were documented in care plans. We heard one member of staff on Knightley Ward refer to one patient as "that guy" and another as "the bloke who came in last night" when speaking with other staff. However, this was in marked contrast to the way in which that member of staff spoke with patients because she used the patients' names and was respectful towards them.

Patients on Eleanor Ward described the staff as good and one patient told us "this is the best place for me". Before lunch was served on that ward, we spoke with patients about their views of the food. They described the food as "OK" or "very nice". We observed that some patients on the ward had not been able to place an order for lunch during the morning. They experienced a 40-minute delay for their meals and were not offered a choice. Another patient on the same ward did not like the pureed meal they were served but was not offered an alternative. Staff told us that snack boxes were generally available but these often ran out. This meant that not all patients received meals of their choosing.

Emotional support

The views of 25 patients and eight relatives were that staff were very caring and responsive to their needs. Patients told us that they were kept informed about their care and treatment and that they were involved in making decisions. The families of patients also felt well informed about their relatives' treatment and were updated when they visited the wards.

Are medical care services responsive to people's needs?

(for example, to feedback?)

Requires improvement

Meeting people's needs

We visited nine acute medical wards. We did not see people having to wait for attention from staff; there were sufficient staff on the wards to meet the needs of patients at all times. We observed lunch being served on Brampton and Eleanor Wards. On both wards, people received their meals in good time and those patients who needed assistance with eating were supported by staff to ensure their meals could be eaten while still warm. On Collingtree Ward, we observed a patient having difficulty choosing food to accommodate their food intolerance. The patient was not helped by staff on the ward to make a choice and there was no dietician present to support them.

The trust's response to the changing needs of its patients was noted in the Medical equipment management report, April 2013, within its bed replacement programme, whereby six bariatric beds with bariatric alternating pressure mattresses and over 30 low profiling beds (to prevent patient falls) had been acquired. During the period November 2012 to November 2013, the proportions of patients suffering falls with harm were below the average for England. For most of the period, the same report in October 2013 confirmed that the two-year electrical profiling beds' replacement project was now complete with all old hydraulic and mechanical beds presenting significant risks to patients and users having been replaced.

We received information before the inspection that patients were often transferred between wards late at night. There were no records of actual times of transfer available on the wards. Discussions with portering staff responsible for moving patients confirmed that on average they moved five patients a night who were often elderly. One member of staff described moving those people during the night as "not fair". When we returned for an unannounced inspection, night staff told us that elderly patients had been transferred as late as 3 am. On the night of 29 January, nine patients moved between midnight and 3am. They described the patients as being disorientated by this and needing higher levels of care that put additional pressure on the ward staff.

Vulnerable patients and capacity

The trust had undertaken a redecoration programme on Creaton and Brampton Wards to assist people with a diagnosis of dementia remain orientated. The bays for use by patients with dementia were each painted a different colour to help patients who were mobile find their way back to the correct bay. In addition, doors to toilets were painted orange and patients reminded of this so they knew which doors to use to access those facilities.

Access to services

Leaflets advising on how to get help with giving up smoking and alcohol and following a healthy diet were freely available on wards. We saw it documented in patients

notes where they had been given these leaflets and additional advice. One patient who was receiving treatment for alcohol withdrawal had received advice on getting support to deal with their addiction.

Leaving hospital

We identified that medical patients were often not discharged when medically fit. We attended the morning bed meeting on two wards, Creaton and Eleanor, and a lunchtime meeting on Brampton Ward. On each ward, we found that they were well attended by a multidisciplinary team who discussed every patient. However, the centralised bed management team were not able to attend the morning meetings because they had a 9 am operations meeting each day. There was not a bed manager in attendance at the lunch time meeting on Brampton Ward. A sister on one of the wards we visited told us that this meant that discharges were always delayed by at least a day because decisions could not be made without the involvement of that team. It was determined at the Creaton bed meeting that six of the 28 patients on the ward were medically fit for discharge. However, it was estimated that none would be discharged that day because plans could not be put in place in time. We were told that there were medical outliers (patients without a bed on medical wards) in both the stroke and cardiology units. In the cardiology unit, this had had an impact on elective patients and we were told that elective procedures were "down to a trickle" due to the unavailability of beds. Medical outliers were managed by the medical consultant leading their treatment and we were told by staff and patients that they received ward rounds from those consultants about twice a week.

We spoke with staff (including therapists) on a number of wards who told us that there was a delay in putting care packages in place. We heard that social care professionals sometimes failed to attend meetings to set up care packages. On one ward, we were told that these delays could mean patients' discharge was delayed by up to two weeks. The risk of an inconsistent inpatient flow due to delays in the discharge process was recorded on the medicine and A&E risk register. It had originally been entered in September 2011. One of the measures introduced was 'robust tracking' of patients with a length of stay of 10 or more days. Ward staff told us that in practice this meant they received frequent calls from the bed management team to ask what was being done to discharge patients on their ward. Without exception, the staff we spoke with felt that a recent decision by the trust to remove the bed managers from the wards and establish them as a central team had meant the relationship between them and the wards was less effective, particularly as the bed managers no longer attended the daily bed meetings on the ward.

The trust had secured a number of beds at Cliftonville Care Home, which was close to the hospital site. The beds were intended for patients who were awaiting discharge. The trust website stated that a care plan would be arranged and agreed with patients and their relatives or carers to assist with safe discharge to an appropriate place, and those patients should stay on the ward for a limited period of time before their discharge. However, the delays in discharge to a suitable place were also evident in the care home because the average length of stay for elective patients was 37.8 days and 43.4 days for non-elective patients. This meant that the flow of patients through medical wards was further affected by long stays at one of its discharge facilities.

Families were usually involved in patient discharge but this was not consistent across the medical wards. We found evidence of good practice of family involvement in which a relative of a patient being discharged from Creaton Ward was invited to travel in the ambulance with the patient to help them orientate. However, we also saw an example of a patient with vascular dementia having been discharged to a new care facility in the morning and the family not having been told. The family arrived on Collingtree Ward to find their relative's bed empty, and became very distressed. They were told that their relative had been discharged to a local home and, because they were from outside the area, they were given a map so they could find it. Ward staff told us that a bed had suddenly become available and they had had to move quickly.

We were told by patients that discharge was often delayed as a result of medication being unavailable. When this was the case, patients may have been moved to the Victoria discharge lounge where they would wait for their medication along with other patients who may have been waiting for transport to take them home. This lounge did not have any beds and patients were not accommodated there overnight. The environment was unwelcoming, although there was a television for people to watch while they were waiting. Staff on Victoria told us that, while patients were in the lounge, they remained under the care

of the consultant on the ward from which they were being discharged, although there was a junior doctor linked to the discharge lounge and Victoria Ward. We checked the log book for the discharge lounge and noted that patients' stay on the ward was on average no more than two to three hours.

Two patients we spoke with during our inspection told us they had been discharged without their medication and that it had been sent to their homes in a taxi. One elderly person told us they had been frightened by a taxi driver knocking on their door at 10 pm and insisting they open the door because he had to hand the medication to them in person. We also noted on the patient safety board on Allebone Ward that patient feedback had criticised the use of taxis to deliver medication. When we returned for the unannounced inspection, we had already been informed that the practice had been discontinued. Staff told us that the practice of planning discharge for people who could go home at the same time trust-wide put significant pressure on the pharmacy. A recent trust initiative meant that the ordering of medicines from the pharmacy was now done online. At the time of our first inspection, we received a number of reports of people being discharged without their medication, so we were unable to establish whether the online ordering system had had an impact on people going home in a more timely way.

Learning from experiences, concerns and complaints

In the Adult Inpatient Survey, CQC, 2012, the trust scored worse than other trusts on the questions relating to patients being disturbed by noise at night. We noted that doors on Creaton Ward had been adapted to ensure that they closed softly so that they did not disturb patients. On Knightley Ward, there were three beds close to the ward office and entrance. Similarly, Eleanor Ward, which cared for patients who had had a stroke, had a layout that meant that patient beds were immediately behind the doors at the entrance to the ward. When we visited Knightley Ward during an unannounced inspection at night, staff confirmed that patients may be disturbed by the doors and by people speaking in the ward office. This meant that the issue identified by inpatients in 2012 had not been resolved in all of the medical wards.

As part of the discharge process, patients were given the Friends and Family test to complete. On the medical wards we visited, we saw both positive and negative comments summarised so that staff could read them, and learning objectives were discussed at ward meetings and displayed for staff as a reminder. In the Friends and Family Test Creaton Ward scored the least of all wards with 18% of people questioned likely to recommend the ward. This equated to 2 of 11 responses received on the ward. We spoke with the junior sister who told us that the key issue had been that those patients were unaware of their consultant's name. The ward now ensured that the names of all the people directly responsible for the care of each patient were displayed on a white board above the patient's bed. We noted that this was the case for every patient on the ward.

Comment, compliment and complaint sheets were given to patients so that they could provide feedback on their care during their stay. Creaton Ward patients were given the forms to complete on a weekly basis.

We saw evidence of learning and actions from comments and complaints, as well as compliments being visible to ensure that staff were also aware of patients positive experiences.

Are medical care services well-led?

Requires improvement

Vision, strategy and risks

Leadership from the senior management team was not clear to staff on the wards. Many ward staff we spoke with told us that the senior management of the trust was not visible on the wards. Most did not know the names of the members of the trust board and did not recall seeing them on the wards other than the CEO. Staff also said that they felt matrons and ward sisters were expected to attend too many meetings and that this took too much time away from their management of the wards. They also expressed their confusion at all the trust initiatives and were unsure how they linked to improvements in the trust. Staff spoke very positively about the Chief Executive and said she was both approachable and visible.

Risks were monitored at ward level through review of the safety thermometer data and the trust had recently introduced a new internal quarterly ward auditing process,

Medical care (including older people's care)

QUEST (Quality Effectiveness Safety Team Review). Staff were beginning to have ownership of the risks and were aware of the measures the ward team were taking to mitigate them.

Quality, performance and problems

On Creaton Ward we saw effective auditing of nursing assessments and shared good practice within the team. Staffs were kept well informed of the latest information relating to patient feedback and patient safety boards were updated.

Most staff told us they knew how to report incidents through Datix and that they were encouraged to do so by their colleagues and managers.

Leadership and culture

The leadership at ward level was generally viewed by staff as positive and effective. The staff we spoke with on the medical wards were very positive about the teams they worked in and how well they were led. We saw examples of strong leadership with experienced staff being made responsible for supporting and leading the large numbers of new staff who have recently been appointed. The sister on Creaton Ward had trained her junior sister to ensure succession planning. On Allebone Ward a change of leadership had been implemented as a result of a safeguarding investigation into a concern raised last summer. We spoke with the acting ward sister who told us that there had been challenges in terms of staffing levels and pulling the staff together as a team but that this was now beginning to take effect. There had been a significant uplift in staffing levels in order to address the issues raised within the safeguarding concern which meant that the team building was on-going. She had introduced short daily meetings with the staff (known as 'huddles') where issues could be raised and information passed on. Smaller teams had been created within the larger ward team to support the development of the working relationship between nurses and healthcare assistants as well as building the confidence and competence of newly appointed staff. The acting sister had also identified that Band 6 nurses were in need of more professional development and was supporting them to address this. When we returned for the unannounced inspection we spoke with night staff who told us that they felt they were less well-informed as they regularly worked nights and had little face to face contact with matrons and senior staff.

Although the ward discharge meetings we observed were efficiently managed by the multidisciplinary team, the absence of the discharge co-ordinators meant that the outcome of the meetings was not effective since patients were not discharged in a timely way. We were told that communication of information from the bed managers operations meeting was often poor. We did not see evidence that the medical colleagues had an active approach to resolving the issues related to delayed discharge both within and beyond the trust. Also, the lead nurse in medicine did not place it within her top four risks in the medical division. Staff on the wards were not aware of any current initiatives designed to address this significant issue. Whilst this issue does not rest solely with medicine alone we would have expected to see evidence that the leadership of the division were proactively working on helping to resolve some of the issues in order to ease the pressure on wards and reduce the impact on patients. In addition the levels of compliance with numbers of staff having an up to date PDP is significant. On two medical wards, Allebone and Brampton, no staff had a PDP and no medical ward had above 60% of staff with a PDP in place. This meant that there was a risk that not all staff were receiving adequate support and supervision to ensure that their performance was of an acceptable standard.

Requires improvement

Surgery

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

Information about the service

The surgical division consisted of seven surgical wards, a surgical admissions unit (SAU) and 17 operating theatres in five separate suites, including one at Danetre Hospital. The hospital provided a range of surgery including trauma, orthopaedic, ophthalmic, urology, gynaecology and general surgery. The emergency and ophthalmic theatres provided a 24-hour service.

We visited six surgical wards, including the trauma and orthopaedic (T&O) wards, the SAU, four operating theatres and six anaesthetic recovery areas. We talked with 24 patients, two relatives and 55 staff, including nurses, healthcare assistants, doctors, consultants, support staff and senior managers. We observed care and treatment and looked at 12 care records. We received comments from people at our listening events, and from people who contacted us to tell us about their experiences. Before our inspection, we reviewed performance information from, and about, the trust.

Summary of findings

Surgical services were provided in a clean environment and there were good safety checks in place. Action plans were written as a result of incidents; however, these were not always monitored appropriately to ensure actions were implemented. Sometimes the supply of equipment was insufficient and checks on the equipment were not carried out.

Clinical management guidelines were reviewed and acted upon to ensure patients' needs were met. However, staff training and appraisals were not always carried out to ensure staff were competent and had best practice knowledge to effectively care for and treat patients.

Patients and their relatives informed us that they received good-quality care, and that their privacy and dignity were respected.

We found that staff were responsive to people's individual needs. However, we were told that there were often delays in discharge. We also found that some patients were sent to another hospital for their operation as they were unable to receive their treatment at Northampton General Hospital within the given timescales.

There was good leadership at all levels within the surgical care service and staff felt well supported by their managers. A clinical governance framework was in place. However inspectors found that the actions were not always monitored to ensure that they had been implemented.

Requires improvement

Surgery

Are surgery services safe?

Requires improvement

Safety and performance

Patient safety boards displayed in the various surgical wards and operating suites we visited showed the figures for the previous month on specific areas, such as the number of pressure ulcers, the number of falls and if any patients had had any omissions in their medication. This demonstrated to all patients the safety of the ward or theatre area.

We observed good use of the paper-based system of surgical safety checklists in place in the operating theatres we visited. This included the use of the World Health Organization (WHO) surgical safety checklist, which is designed to prevent avoidable errors. We reviewed 12 patient records specifically to review the completeness of the WHO checklist and noted that in eight of the records it was not present in the files. However, it was confirmed that an audit of the checklists was on-going in the operating theatres at the time of our visit. A staff member within the main theatres confirmed that the WHO checklist was sent to the post-anaesthetic recovery area and then filed; however, a copy was not put in the patient records.

Audits were completed on a monthly basis to ensure theatre sessions included a team brief and a WHO surgical safety checklist completed for the patient; these demonstrated a high level of compliance across the trust. The latest spot check audit results across all operating theatres, including Danetre Hospital, found that 99% (102/103) of operation checklists had been completed. The trust had not had a 'Never Event' (which is a nationally defined largely preventable patient safety incident) since 2012.

Learning and improvement

Staff we spoke with confirmed that they had access to the trust's electronic incident reporting system and understood their responsibilities to report incidents. One ward sister recognised that there was a backlog of incidents that were to be investigated. They went on to explain that the incidents had been divided between three senior nursing staff to ensure they were fully investigated and action taken. Written notes from the Surgical Care Group Governance meeting in December 2013 highlighted a backlog in reviewing incidents reported.

Written notes from ward meetings demonstrated that learning from incidents and complaints was discussed; this included, but was not limited to, the management and prevention of pressure sores. One staff member told us that they also received direct feedback from the tissue viability nurse after reporting a pressure sore. We noted that staff members were required to sign the written notes of the meetings to confirm that they had read them. Learning within each specialty took place at ward level and also at surgical specialty meetings; this information was then shared at the Surgical Care Group governance meetings.

A significant serious incident occurred on one of the surgical wards in August 2013, which related to staffing levels and the lack of care provided to vulnerable patients. We reviewed the action plan that the trust had implemented as a result of the incident and noted that some actions were still on-going. The Surgical Care Group governance meeting in September 2013 highlighted that some of the themes would be trust-wide. A trust-wide action was for all wards to have a nominated lead consultant to liaise with the ward manager to discuss any concerns or changes that were required on the ward, this had not happened yet on every ward we visited.

This was confirmed by the lead nurse for the Surgical Care Group. The Surgical Care Group governance meeting in December 2013 also highlighted that some of the members of the group were uncertain as to what exactly had taken place on the ward. A staff member on Cedar ward also told us, "Nobody is sure what the initial issue was." The trust recognised a lapse in the monitoring of some action plans and ensuring actions had been implemented, and that this was a necessary area of development; this was reflected in the trust board papers.

Systems, processes and practices

Equipment

One staff member told us that the availability of equipment on the wards was compromised by a new booking system. The Medical Equipment Library procedure for the trust highlighted that the services were available between 8.30 am and 4 pm; additional services outside of these hours were available through the portering service.

Another staff member informed us that at times it was difficult to get an air mattress when a patient was at high risk of developing a pressure ulcer. When we visited one of the surgical wards, we were told that a training session had

been running for the day for a new pressure-relieving air mattress; this meant staff could attend the ward to receive an approximate 10-minute training session. The company representative informed us that over 300 staff members had been trained since December 2013 and the delivery of the new mattresses. This meant that the trust was taking action to give patients the equipment appropriate to their individual needs.

Pre-planned maintenance (on-going maintenance checks at regular intervals to prevent the failure of equipment before it actually occurred) for equipment were not always completed. We identified equipment in the operating theatres and anaesthetic recovery areas that was out of date, specifically two air cylinders. This was raised immediately with staff who reassured us that they would be replaced. Staff we spoke with explained that equipment was checked before its use; however, there was no evidence that some equipment had received pre-planned maintenance.

We found a further seven pieces of equipment that were in use but two had passed their re-test dates in May 2013 and October 2013, and the others gave no indication that pre-planned maintenance had taken place. A staff member an operating department practitioner (ODP) from theatres confirmed that one make of anaesthetic machines was maintained by the manufacturer; however, they were unsure who maintained the second make used which was in use in theatres. We saw that three anaesthetic machines had no evidence of a pre-planned maintenance check having been carried out.

Pre-planned maintenance (PPM) checks and pre-verification testing (PVT) for the trust were below an acceptable level. We requested to see the trust's figures for PPM and PVT checks. The 'quarterly PPM PVT key performance indicators (KPI) figures 2013 2014' document for September 2013 stated that 76.8% of PPM had been completed against a minimum standard of 90% and 54.5% of PVT had been completed against a minimum standard of 60%.

The non-compliance with maintaining the trust's own standards internally was raised as an incident in September 2013 this was to highlight the concern of medical equipment maintenance, as a result a trust-wide maintenance plan was implemented due for completion at the end of March 2014.

Trust data (September 2013) highlighted that 23% of medical equipment identified within a high-risk category had not been maintained. This included only 31% of the defibrillators identified on the list, but 90% of the ventilators had been checked. This data also demonstrated that 45% of the pre-verification testing that were required to be completed for medical equipment identified within a medium-risk category had not been completed. This meant that patients could not be assured that all equipment used was fit for purpose.

During our unannounced inspection on 29 January 2014, we saw that equipment in theatres had received electrical safety testing since our announced visit. A review titled "Medical Equipment Maintenance at NGH status report to CQC" detailed that out of 308 pieces of equipment, 47 had either no label to indicate that it was safe to use or the date for re-testing had passed. We received this report on 25 January it detailed the actions the trust had taken to address the concern we had raised with them on 17 January.

Within the anaesthetic recovery areas, we were informed by a consultant anaesthetist that there was an inadequate supply of equipment: for example, a capnography machine (a machine that monitors a patient's carbon dioxide level in respiratory gases). The availability of these machines ensures compliance with post-anaesthetic recovery safety guidelines as clearly defined by the Royal College of Anaesthetist (RCoA) as part of their minimal monitoring standards. On our unannounced visit a consultant anaesthetist confirmed that a capnography machine was available in the main theatre suite, but not within the ophthalmology theatre suite. The trust confirmed that they had a total of 24 capnography machines; it is therefore recommended that the trust must have an appropriate process in place to ensure the distribution and availability of this equipment.

A review of the risk registers for general surgery, head and neck, and T&O identified a total of five pieces of equipment as a risk and needing to be replaced, although this did not include the equipment that had been highlighted to us as being in inadequate supply. In some cases, it was identified at the time of our visit that the equipment had either been ordered or was to be part of the capital bid for the financial year starting in April 2014. It was proactive to see

replacement equipment being ordered however we had concerns that the list of what was required was in complete. This could have resulted in equipment either not being available of not being fit for use.

Environment

We found that some surgical wards and theatres had limited storage capacity, so at times appeared to be cluttered. We noted that bay areas within each of the wards were single sex only and had access to single-sex toilets and washing facilities. This ensured that the patients' privacy and dignity were respected at all times.

On two surgical ward areas, we noted that staff were required to dispose of dirty linen by using the fire exit doors. On one of these wards, we found the fire exit door open. We brought this to the attention of the nurse in charge who took immediate action.

There were no emergency call alarms in the anaesthetic rooms or operating theatres in the main theatre suite, which does not comply with the NHS Estates Health Building Note 26 (HBN 26). Theatre staff informed us that if there was an emergency in theatre, "There are enough staff around to go for help." This could lead to a delay in treatment for the patient because it would mean someone leaving to find help rather than pressing an alarm to summon help while treating the patient.

In the Manfield theatres, there were emergency alarms that we were told were in the process of being replaced because they were badly placed and regularly pressed accidentally, causing many false alarm

Medicines

During our inspection visit, we did a random sample on four of the surgical wards to ensure medication was stored securely. We noted that, on two of the wards visited, rooms where medication was stored were left unlocked; however, the medication trolleys and cupboards within the rooms on all four wards were locked. We also observed a medication round and noted that medication trolleys were locked when left unattended.

Medications stored within theatres were not always consistent with trust policy, "controlled drug procedure for operating Theatres". We saw that some of the areas visited within theatres stocked low-strength midazolam; however, its storage in anaesthetic rooms was inconsistent. We noted that it was ordered as a controlled drug (a medication that has specific legal controls), and it was stored in a controlled drug cupboard in the Manfield post-anaesthetic recovery area. However, the trust policy indicated that midazolam was not required to be stored as controlled drug. A staff member an OPD confirmed that it was low-strength midazolam and as such should not be stored as a controlled drug.

Infection prevention and control

Infection rates (April–November 2013) were similar to those of other trusts for methicillin-resistant staphylococcus aureus (MRSA) and Clostridium difficile, although the number of C. difficile infections was above the trust's own target to date. As of November 2013, the trust had 24 incidents of C. difficile against a target of 20; six of these incidents related specifically to surgery and T&O. Staff were using protective equipment and clothing, such as aprons and gloves. Hand hygiene gel was available at the entrances to surgical wards and units, and staff were observed using these. However, we noted that there was a lack of provision of hand hygiene gel on entry to operating theatres and that one medical staff member was not adhering to the 'bare below the elbow' policy. The most recent hand hygiene results covering all theatre suites found that there was 98.5% compliance. The areas of non-compliance were found in the main theatres and Manfield theatres. There were regular hand hygiene and infection control audits across the surgical areas. The results were discussed at staff meetings and showed good practice.

All elective patients who attended the pre-operative assessment area before their operation were screened for MRSA. This meant that a patient could be given appropriate treatment if their MRSA screening was found to be positive. Information leaflets were also available for patients. Trust data as of September 2013 showed that 99.9% of elective patients and 96.4% of non-elective patients within general surgery, T&O, and head and neck had MRSA screening.

One patient we spoke with told us, "This is a clean place, the ward is clean, toilets are clean and they are always cleaning."

Patient records

We reviewed 12 patient records across four wards and noted that appropriate assessments had been completed accurately, such as venous thromboembolism (VTE) risk

assessments, pressure ulcer risk assessments, and nutrition and fluid assessments. One record in particular also detailed a patient's particular nutritional needs and the level of support they needed to eat and drink.

Staffing

We reviewed the staffing establishment of the ward areas we visited and noted that the funded establishments met the needs of the service in line with best practice guidance. The ward sister explained that they worked with colleagues on other wards to move staff to ensure staffing establishments did not compromise safe patient care and treatment. Another ward sister told us that, although staffing levels had improved, they still remained a concern because of sickness and vacancies.

The sickness absence rate in December 2013 for surgical areas, excluding theatres, was 4.82%. Across general surgery, T&O, head and neck and theatres, there was a total of 35.64 whole time equivalents as vacancies; 16.88 of these vacancies related to qualified staff.

One patient told us, "The staff are so dedicated and wonderful, but there is not enough staff."

Monitoring safety and responding to risk

Safeguarding

Nursing staff we spoke with were able to show us a good understanding and awareness of the trust's safeguarding systems and processes, and how they would report any concerns. Training data showed that for staff working within general surgery, T&O, and head and neck, 92.82% of staff had received training in safeguarding vulnerable adults. One staff member explained that they had a special interest in safeguarding and had sought additional training, which included spending time with social services. This information was then shared with the rest of the staff on the particular ward. Patients and relatives told us that they felt safe in the trust.

Are surgery services effective?
(for example, treatment is effective)

Requires improvement

Using evidence-based guidance

National clinical audits were completed, such as the fractured neck of femur audit (data was from April 2012 to March 2013) and national bowel cancer audit. Information on patient-reported outcome measures (PROMs) was gathered from patients who had had groin hernia surgery, vascular vein surgery, or a hip or knee replacement.

We noted that in April 2013,, following the fractured neck of femur audit, an action plan was implemented with 11 recommendations, including the recruitment of an ortho-geriatrician (a doctor who works in close co-operation with orthopaedics and has a focus on care of the elderly and rehabilitation). We noted that the trust had implemented a clear pathway for all patients admitted with a fractured neck of femur. We were also informed that an ortho-geriatrician had been appointed, which meant that such patients had access to specific co-ordinated care and treatment. Trust data for October 2013 showed that only 86% of those patients who were fit for surgery within 36 hours actually received surgery during that time. However this was an improvement on September 2013, where only 68% of eligible patients were treated within 36 hours.

A staff member was able to describe the pathway for emergency surgical admissions from the A&E department with continuity of care from the surgical team into the surgical admissions unit (SAU). They went on to explain that due to the pressures in A&E medical outliers were often admitted to the SAU; however, the clinical and support teams worked well together. During our inspection, we noted that there were medical outliers in the SAU.

Patient mortality

Surgical specialty groups met on a monthly basis to monitor mortality rates and actions taken to address any issues that arose. Written notes of meetings confirmed this. We were also made aware that joint mortality and morbidity reviews started in October 2013 between the surgical specialties and the intensive therapy unit (ITU) to ensure there was cohesive learning. Mortality rates relating to fractured neck of femur in 2012/13 were higher than expected. As a result of this, a review of the clinical processes was undertaken and a decrease in the mortality rate had been seen in 2013. The specific hospital standardised mortality ratio (HSMR) is an indicator of the quality of care and compares deaths in hospital for specific conditions and procedures. The trust's overall HSMR was within the expected range, which was consistent with the previous year.

Pain management

Staff we spoke with confirmed that they had received training in patient-controlled analgesia (PCA). One patient told us that they were offered pain relief; however, they chose not to accept this and their decision was respected. Patient records showed that pain scores were calculated and pain relief provided appropriately to patients, including the use of PCA.

Consent to treatment

Medical staff were able to give a detailed account of the consenting process and the people who were involved in it. This included doing a further check before an operation that valid consent had been obtained. Staff on the surgical wards and in operating theatres told us they understood the requirements of the Mental Capacity Act 2005 to ensure treatment was provided in the patient's best interests. We were told any decisions would be made with the input of people who could speak on behalf of the patient if the patient did not have capacity to make their own decision.

We saw various information leaflets that were available for patients in the surgical ward areas, which included information about consent. During our review of six records, we noted that consent forms had been completed appropriately. However, the forms reviewed were all dated the day of the surgery and there was no indication if first part consent had been obtained during an outpatient appointment or pre-operative assessment.

Staff, equipment and facilities

Ward sisters we spoke to explained to us that statutory and mandatory training were provided to ward staff and that this information was recorded centrally and distributed to ward sisters on a monthly basis. We were also told that this data was often inaccurate and needed to be cross-referenced to the electronic rostering system; a local record was held containing the correct data. Training data demonstrated that there were various levels of compliance for the general surgery, T&O, and head and neck staff, with a total of only 77.21% attending all mandatory training. The lowest attendance rates were within health and safety (37.57%) and information governance (51.72%), whereas the highest attendance rates were within safeguarding children and young people (99.64%) and attending the trust induction (97.20%).

Ward staff also told us that a new appraisal system was being implemented. The trust appraisal rate for general surgery, head and neck, and T&O was 38.14%, which meant not all staff were receiving appropriate support and development through the use of the appraisal system.

We spoke with two junior doctors regarding their induction to the trust and their local induction to the specific area they worked within. They told us that the trust induction covered the basic topics including health and safety and fire awareness, and that they were given passwords and identification badges either before their start date in the trust or on their first day. They went on to tell us that their local departmental induction had been very beneficial and also provided information about what the expectations were within their role.

Multidisciplinary working and support

During our observations on the ward, we noted that that there was an effective system in place to discuss a patient's care and treatment, and that this included consultants, doctors and nurses and integrated multidisciplinary ward rounds. We were shown a newly implemented electronic system, which was designed to track patients while they were in hospital. However, at the time of our inspection visit, only ward clerks were able to use the system because other staff had not received training. This meant that the system could not effectively be updated at all times.

We also observed integrated handovers, which included 'huddles' at the patient's bedside. This ensured that patients were involved when their care and treatment was being discussed and handed over to the next shift. On some wards, we saw that additional 'huddles' were carried out at the ward board, highlighting patients at risk and ensuring all staff were aware of the ward safety status, including falls and pressure sores. This was observed on the SAU, and Cedar and Willow Wards.

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

Requires improvement

Surgery

Are surgery services caring?

Good

Patient experience and feedback

Patient and public involvement were sought from the trust through various meetings and patient forums We were informed that the T&O team held very successful meetings that included the public and they were involved in the development of the orthopaedic services.

Patients, and their relatives, as appropriate, told us that they felt involved in the decision making for their treatment. One patient told us that their treatment was explained to them, even though they often did not fully understand. They went on to explain that they trusted and had confidence in the doctors and nurses, and were given information leaflets relevant to their care and treatment.

We also saw completed records of Family and Friends tests, discharge surveys and care round records that showed patients felt that they were involved in their care and treatment planning, although two relatives told us that they found it difficult to find out what was happening in terms of their relative's management plan and discharge arrangements.

We spoke with a number of people at the listening event and they had positive views about surgical care at the hospital. One person told us, "I was asked if I wanted to hear everything about my condition." Another said, "Everything was seamless." A man described having surgery for necrotising fasciitis involving nine operations in two months, and extensive periods in the intensive therapy unit (ITU) and on the wards. He stated, "I can honestly say that the care and treatment that I and my family have received has been exceptional."

We saw on one of the wards evidence that a person had been smoking outside the ward area between two sets of fire exit doors. We raised this with the nurse in charge who informed us that they discouraged patients from smoking while they were an inpatient; however, they were unsure who was responsible on this particular occasion.

Two patients told us that the fire exit doors were often used to dispose of bags that were full and that this was sometimes disturbing at night time. We were told at the listen event that staff smoked outside of the doors.

Patient centred care

During our time spent on the surgical wards, we observed positive interactions and caring behaviours between staff members and patients. Patients were complimentary around the level of care they had received. One patient told us that, while they had only been on the ward a short time, staff had offered them food and drink to ensure they were kept comfortable. Other patients informed us that staff were caring but had little time to talk, and that they did not "want to trouble the nurses as they had too much to do".

Privacy and dignity

During our inspection visit on the surgical wards, we observed care that was delivered with dignity and respect. One patient we spoke with told us that they had been treated with dignity and respect by the nursing staff.

A consultant anaesthetist explained that on the occasions when an ITU patient had been cared for in the post-anaesthetic recovery area, an area was cornered off to protect the person's privacy and dignity. This also meant that relatives were able to visit the patient's bedside.

Are surgery services responsive to people's needs?

(for example, to feedback?)

Requires improvement

Access and waiting times

The trust was meeting the national 18-week maximum waiting time for patients to have planned surgery and for patients to receive an operation within 28 days following cancellation. However, the trust was performing worse than expected for those patients who were on an incomplete pathway for longer than 26 weeks, specifically for elective surgery in T&O, general surgery, urology and oral surgery.

In the pre-operative assessment department, drop-in clinics were run and minimal numbers of patients booked an appointment. A staff member informed us that there was a process in place that meant that, if a patient's operation was cancelled, they could re-attend the clinic to have further blood tests taken and a shorter appointment time was allocated for the repeat blood test.

We were told that roughly 100 patients had been referred elsewhere in December for T&O, but that this number

subsequently reduced to between 20-30 per month. This was due to a higher demand than it was possible to meet. The risk register also identified an on-going risk as a T&O ward had moved in December 2012, resulting in a reduction of 14 elective inpatient beds. Theatre staff confirmed that waiting list initiatives were not in use by the trust.

We were informed by staff on one ward that medical outliers had a dedicated clinical team for the ward. We spoke with a medical patient on the SAU who told us that they had been admitted to one ward for a short period of time before moved to the SAU at 8pm. We spoke with them at 10.30am the following day and they told us they were still waiting to see a doctor.

Patient support

Nursing staff we spoke with were able to demonstrate an awareness of the Mental Capacity Act 2005 and were knowledgeable about Deprivation of Liberty Safeguards. We also found Mental Capacity Act checklists in patients' records that had been completed appropriately, and action taken to ensure decisions were made in patients' best interest. Nursing staff we spoke with were able to confirm that mental capacity assessments were completed by a doctor.

We tracked a patient's pathway when they were admitted as an emergency and noted that within the records the early warning system demonstrated that the ward staff on the SAU had contacted a doctor to review the patient and this had been completed within 15 minutes. Other patient records showed that the early warning charts had been completed accurately.

The trust used a telephone interpretation service and we saw that this was easily accessible in the pre-operative assessment department and the day surgery unit. Staff explained that this was a good service to use; however, they still requested, if possible, an interpreter to attend an appointment because communication was easier when an interpreter was present.

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

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

Vulnerable patients

Nursing staff on the various surgical wards explained that medical staff completed a dementia screening assessment for patients over the age of 75, and that this process was audited. The trust figures demonstrated that, although improvements had been made on a monthly basis for the initial assessment, the trust was not on track to meet its own target of 90% for referral for specialist diagnosis 66.6% in December 2013. Nursing staff on one ward told us they often had to remind doctors to complete the screening assessment.

If a patient was identified as having a type of dementia, there was an alert system in place to highlight that the patient may need additional support, it is called the 'butterfly system'. This meant that all relevant healthcare professionals were aware that the patient was living with a type of dementia and could therefore provide appropriate care and treatment if and when required.

A staff member told us about the process they undertook when a patient who had been identified by the butterfly system was admitted for an operation and they had concerns about their care and welfare. We saw that the staff member escalated this to the safeguarding team and a decision was made before the operation went ahead that it was in the person's best interest.

We also spoke with parents of a patient who had learning disabilities, who gave very positive feedback regarding the nursing staff's knowledge, care and treatment specific to the patient's needs, including providing appropriate support to eat and drink at meal times.

Discharge planning

We saw that discharge planning was supported by discharge co-ordinators; we were informed by hospital staff that delays in discharge were often due to the unavailability of out-of-hospital care provision or social services support. Social services confirmed that referrals to them were assessed within 24 hours. A delay in out-of-hospital care provision had a particular impact on patients who needed rehabilitation support.

Complaints

Staff we spoke with explained that patient and relative feedback, particularly around complaints and concerns, were readily encouraged and we saw documented evidence of this. Written notes of ward meetings showed us that patient histories were discussed, as well as learning

from complaints received. We also saw that local issues were resolved in real time using a specific proforma where patients could highlight any complaints, compliments or concerns.

One staff member explained that one issue raised with the ward related to the catering department. This was resolved locally when a staff member from the catering department came to the ward and spoke with the patient personally.

Are surgery services well-led?

Requires improvement

Leadership and vision

We were informed by some staff that they felt the culture within the trust had started to change and that opportunities were arising for staff to go on courses for personal development; however, there were some staff who felt that progression in job roles remained difficult.

Some nursing staff told us that they were confident in raising concerns to their direct line manager or to a medical staff member if it concerned a patient. One staff member told us they felt supported by their matron. Staff informed us that matrons visited the wards on a daily basis and that consultants were very approachable.

One person told us that they were "still struggling with local ownership". This was because they felt they were told what actions to implement and they were not involved in the process of decision making.

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

Management of risk

Some staff told us that they felt the hospital had a reactive culture. One person said, "It seems as though everything is really very reactive." On a different ward, a person told us they were "still doing too often quick fixes".

The trust had a system in place to identify and escalate identified risks onto the appropriate surgical risk register. However, we noted that at the time of our inspection there were various risks that were originally placed onto the risk register in 2011 or before then. Poor mandatory training attendance rates and poor appraisal rates were identified risks for general surgery, T&O and theatres, potentially jeopardising both staff and patient safety.

The Capital Committee highlighted that equipment needing to be replaced in the financial year beginning April 2014 was linked to associated risks as identified on the trust risk register. We noted that this included the five pieces of equipment identified on the general surgery, T&O, and head and neck risk register. However, this did not include identified equipment in theatres to ensure there was an adequate supply of equipment for the correct treatment and care of patients.

Good

Intensive/critical care

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

Information about the service

The trust's critical care service included the intensive therapy unit (ITU) and the high dependency unit (HDU). These were co-located and had 16 beds. A critical care outreach team operated 24 hours a day, seven days a week and assisted with the care of critically ill patients who were on other wards throughout the hospital.

We spoke with 11 staff; these included nursing staff, a pharmacist trainee, doctors and consultants. We observed care and treatment and looked at eight care records. We also received comments from people at our listening events. Before our inspection, we reviewed performance information from, and about the trust.

Summary of findings

Critical care services were provided in a clean environment and there were adequate infection prevention and control procedures in place to ensure the safety of the patients. The staffing ratio was sufficient to meet the needs of critical care patients. Care delivery within the unit, was observed to be person-centred and compassionate.

Clinical management guidelines were reviewed and acted upon to ensure patients' needs were met. However, staff training and appraisals were not always carried out to ensure staff were competent and had best practice knowledge to effectively care for and treat patients.

Care was provided in a person-centred and compassionate manner.

There was an unacceptable level of delayed discharges from the intensive therapy unit (ITU) and the high dependency unit (HDU), which added to the pressures on the critical care service. The service provided a follow-up clinic to patients who had been discharged from the ITU or HDU.

There was leadership at all levels within the critical care service and staff felt well supported by their managers. It was felt by staff that there was an open culture to change.

Good

Intensive/critical care

Are intensive/critical services safe?

Requires improvement

Safety in the past

Before our inspection, we reviewed some of the trust's safety performance information and noted that ITU had had four grade 3 pressure ulcers (an injury that breaks down the skin and underlying tissue) between August and November 2013. We spoke with a staff member who informed us that detailed analyses had been completed and actions had taken place. We reviewed some of the analyses undertaken and noted that for one patient, although the pressure sore was unavoidable because of other clinical risk factors, there was a delay in reporting the incident and therefore a delay in seeking further professional advice from the tissue viability nurse. At the time of our inspection visit, we noticed that it had been 30 days since the unit had had a patient with a pressure ulcer.

Learning from incidents

Staff we spoke with on ITU and HDU confirmed that they knew how to report an incident using the electronic incident reporting system, Datix. One staff member told us that they received feedback regularly at ward meetings. They also said that they had a feedback box within the relatives' room and that suggestions for improvement were implemented. For example, relatives provided feedback that an overnight room would be beneficial and that the relatives' room could be improved. We saw that the relatives' room had been re-decorated, providing a comfortable area for relatives, and that a small overnight space was available if needed.

Equipment

A daily checklist was completed by an operating department practitioner (ODP), which included checks on emergency equipment and fridges where medication was stored. The checklist also included various tasks that were to be completed on a weekly basis. At the time of our inspection, we noted that most of the daily checks had been completed but the checks that were not yet complete could have been completed throughout the rest of that given day.

Environment

The trust's ITU and HDU were co-located; both consisted of eight beds each. We were informed that depending on the needs of the patients, the bed configuration was altered to meet changing priorities. This meant that, if there were more patients who needed an ITU bed than beds available, the patient would be nursed on HDU and another bed on HDU would be closed to ensure the patient had the correct level of nursing support. At the time of our inspection, there was a higher need for beds in ITU and we observed a decision made to transfer a patient from ITU to HDU so that another patient from an adult inpatient ward could be admitted to ITU.

There was a centralised desk area in both ITU and HDU, which meant the staff team could observe patients in the main area. We saw that there were single rooms in HDU to respect a person's privacy and dignity.

Infection prevention and control

On arrival to ITU and HDU we observed that all staff and visitors were requested to use the hand washing facilities and hand hygiene gel. We noted the environment to be visibly clean. Monthly audits confirmed that ITU and HDU were meeting the required standards for cleaning the environment and for cleaning and decontaminating equipment.

We saw that a recent audit was undertaken of eight staff members to assess whether they were adhering to the uniform and dress code policy. It was found that one person was not wearing trust identification. We noted that the audit was completed at a later stage in the day and the person was then wearing trust identification.

Other audits undertaken within the critical care service included observations around hand hygiene, which was noted to be at 100% from April to December 2013. The trust also carried out various high-impact intervention audits within the critical care service that demonstrated compliance with the management of surgical sites, and on-going management of urinary catheters and ventilation to ensure patients were protected from the risk of acquiring an infection. Audit results showed that 100% compliance was achieved in these audits between April and December 2013.

Patient records

We reviewed eight patient records that contained comprehensive information on the assessment and

monitoring of the patients. One set of records reviewed also contained well-documented evidence of communication with the patient's relatives during the time of the patient's stay on ITU.

One staff member informed us that 'do not attempt cardio-pulmonary resuscitation' (DNA CPR) forms were not used in HDU. If a patient was not to receive resuscitation, this was highlighted on the front of the patient's records. During our unannounced inspection on 29 January 2014, we saw that new DNA CPR forms were now in use and filed in patients' records when it was relevant. One staff member informed us that they had been told to use the new forms but that "No one has actually said what it is and this is what you do with it."

Staffing

The critical care service had a good system in place for the middle grades on call and consultant to discuss each patient and handover when shifts changed. There was an outreach team for the hospital led by two intensive therapy unit (ITU) nurses and consisting of 11 nurses who in total worked the equivalent of five whole-time staff members. We were informed that the outreach team provided a service 24 hours a day, seven days a week and that there was one person from the outreach team who worked during the night. However, we were told by staff that, if there was staff absence or low staffing on ITU, the staff member providing the outreach service would support ITU and the outreach service would not be covered. This was confirmed by A&E staff also. We were told that the outreach team was "busiest at night". The trust had implemented the national early warning score (EWS) for patients, which was a system to standardise the assessment of acute illness severity, and indicate when senior staff should be contacted.

We reviewed the staffing establishment on ITU and HDU and were informed that there were three vacancies that were to be advertised for recruitment. The matron confirmed that new staff members to the unit would work six weeks supernumerary, unless they already had experience working in an ITU. Staffing levels were confirmed as one nurse to one patient in ITU and one nurse to two patients in HDU. This ensured patients received the appropriate care and treatment by sufficient staffing levels in line with recommended guidance. One staff member told us that there was a good skill mix on the unit.

The matron confirmed that, if a shift was not fully staffed, rotas were reviewed to accommodate any gaps. If shortfalls in staffing could not be addressed in this way, shifts would be covered using nursing staff from a specialist bank of staff. If agency staff were needed, the agency staff member would work in HDU under supervision and a staff member from HDU would be moved to meet the patient's needs in ITU. The anaesthetic and critical care risk registers had highlighted staffing as a risk since December 2011.

Staffing within the critical care service also included operating department practitioners (ODPs), healthcare assistants, clerical staff, housekeepers, a critical care activity co-ordinator, a pharmacist, a physiotherapist and a dietician. A staff member confirmed that support from housekeepers out of hours was requested through the switchboard or the nurse on call.

There was sufficient medical staffing cover for ITU with a dedicated ITU consultant team. We spoke with doctors who confirmed that there had been a recent increase in the junior doctor cover at night and that they felt well supported. However, we were informed that there was no ITU consultant cover for patients in HDU because they remained under the care of the responsible consultant from the medical or surgical team.

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

Good

Evidence-based care

We were informed that a patient's admission to ITU was agreed on a consultant-to-consultant referral basis. Referrals for admission could also be made by contacting the outreach team. The EWS was used to refer a patient to the critical care outreach team.

The lead ITU consultant had recently reviewed the Intensive Care Society's Core standards for intensive care units, published in November 2013, and had completed an analysis of any areas that required improvement to meet those standards. We reviewed the analysis that identified gaps against the standards. However, we did not see any evidence of actions that were going to take place as a result

of the standards being published. A staff member we spoke with was unsure what the standards were and if there were any plans in place to address the identified areas that required improvement.

The Intensive Care National Audit and Research Centre (ICNARC) report published data from all the NHS trusts taking part in the audit (95% of eligible units). Following the ICNARC report published in July 2013, the trust had completed an analysis of the data and suggested recommendations. The data demonstrated that the mortality rates for elective and emergency surgical admissions were above the average compared with other units. We noted that a joint surgical and anaesthetic mortality and morbidity meeting had been held in October 2013 to review the findings from an independent review of the patients' records. Three actions were agreed as a result of the review, which included a review of the surgical escalation policy and improvements in record keeping, especially by junior doctors. We asked to see a copy of the surgical escalation policy and noted that the policy in use was dated December 2012. Therefore this action had not yet been completed; we did not see evidence in relation to the improved record keeping action. The importance of having joint meetings was also acknowledged at the meeting, and it was agreed to continue these to ensure there was learning across specialties.

Staff training and support

We were informed that all nursing staff in ITU and HDU had the same competency assessments carried out to ensure they could work in both areas. Training data demonstrated that 97% of staff had received all required mandatory training. The lowest attendance rates were for health and safety (56.7%) and information governance and record keeping (75.26%). During our observations on ITU and HDU, we noticed that at times computers were left unattended and had not been locked to prevent unauthorised access. The highest attendance rates were for safeguarding children and young people (100%) and attending the trust induction. Training data also showed that 89.69% of staff had received training in safeguarding vulnerable adults. One staff member told us that, if mandatory training was not maintained, they would be performance managed.

Staff members informed us that they felt they worked within a strong team, which included the doctors and consultants. A student nurse who had been working on ITU for a limited time told us that the consultants were very supportive and approachable.

The trust appraisal rate within ITU and HDU was 86%, which meant not all staff were receiving appropriate support and development through the use of the appraisal system. The written notes from the Medical Devices Committee in November 2013 highlighted concerns about staff members from ITU attending medical devices training because there was no record of attendance.

Working with others (internal)

Staff within the critical care service worked closely together with the required support and input from colleagues who worked outside the service. A doctor told us that, when a patient was admitted, a discussion was held with the consultant as to whether the patient required antibiotics. The gap analysis completed on the Intensive Care Society Core Standards confirmed that a microbiologist did not take an active role in ward rounds; however, they were readily available for advice. The doctor went on to tell us that a microbiologist completed a ward round once or twice a week and patients would be monitored on an individual basis as to whether a prescription for antibiotics needed to be continued. We also spoke with a trainee pharmacist who confirmed that they attended ITU on a daily basis with a senior pharmacist to complete a ward round. A staff member confirmed that the microbiologist did not attend HDU; however, the person was very approachable and could be contacted by telephone.

Staff we spoke with on HDU confirmed that patients admitted to HDU remained under the care of the responsible surgical or medical consultant; ITU consultants were only involved if a patient was ventilated. They told us that this sometimes caused delays in decisions because nursing staff were unable to locate the responsible team. The most notable impact was on delayed discharges from HDU to an adult inpatient ward. The patient safety board highlighted that in the past month 43% of discharges had been delayed.

One staff member told us that as there was no ITU consultant support in HDU, this affected the efficiency of the service and a business plan had been submitted to

Good

Intensive/critical care

increase consultant cover to address this. However, nursing staff were able to request help from a consultant in HDU to ensure a patient's care and treatment was not compromised.

Are intensive/critical services caring?

Good

Patient feedback and experience

We received patients' comments throughout our inspection visit. One, relating to ITU, stated, "The care and treatment that I have received is exceptional. I've always felt in good hands, clean and safe and my dignity preserved. The staff have been kind and respectful yet warm and friendly." Another comment from a patient was the "I have nothing but Praise I have for ITU/HDU."

Patient-centred care

Each patient in an ITU bed had one-to-one nursing care at all times, and for patients in a HDU bed there was one nurse caring for two patients. This followed recognised guidelines. We were told by a staff member in ITU that they could only recall one incident where one-to-one care could not be provided due to staffing levels in the four weeks before our inspection.

Privacy and dignity

The critical care service had had no breaches of same-sex accommodation since April 2013 according to the data reviewed, which included November 2013. However, due to delayed discharges, there was a risk of same-sex breaches without the facilities to provide appropriate toilets or screening for patients. Patients within HDU were cared for in single rooms that ensured their privacy and dignity were respected whenever possible. Delays in discharge and the possibility of breaches were identified on the anaesthetic and critical care risk register.

We saw that patient-centred care was provided in a compassionate manner and that the patients' privacy and dignity were respected at all times.

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

(for example, to feedback?)

Requires improvement

Access

We were informed that surgeons would book a HDU bed, as appropriate, for elective patients post-operatively. Trust data demonstrated that patient surgery had been cancelled on five occasions in the past year due to the lack of an ITU bed; however, this had not occurred since August 2013.

We were aware that, on occasions, patients needing an ITU or HDU bed received nursing care overnight in the anaesthetic recovery area in the main theatres because of delayed discharges of patients from HDU. Incident reports showed that this had occurred once in November 2013 and once in January 2014. A staff member in theatres confirmed that they had been advised in recent weeks that patients requiring ITU support were not to be nursed in the post-anaesthetic recovery area. We witnessed this happening on 29 January on our unannounced inspection.

Discharge planning

We were informed that, because of the unavailability of beds, there were often delayed discharges of patients in ITU and HDU who were medically fit to be discharged to a ward. Trust data from November 2013 demonstrated that delays occurred on a frequent basis. In November 2013, there were a total of 10 delayed discharges from ITU and 32 delayed discharges from HDU.

We noted that in November 2013 there were 9 discharges between the hours of 10pm and 7am. The risk register for the anaesthetics and critical care service highlighted the risk to patients of deterioration in their medical condition as a result of a delayed discharge from critical care to adult wards. We noted that this risk was originally highlighted in June 2011 and was last reviewed in November 2013 with actions still outstanding around the review of the patient pathway through HDU.

We were also informed that the critical care service provided a nurse-led follow-up service that was offered to all patients. This involved a one-hour appointment six weeks after discharge, six months after discharge and one year after discharge. We were informed that this service

Good

Intensive/critical care

had a 90% take up, which suggests its value to the patients however the outcome for the unit such as changes to practise as a direct result were not shared with us on our inspection.

A trust audit on the use of EWS completed in November and December 2013 showed that, following observations taken for eight patients, these patients could be de-escalated because their medical condition had improved. However, this had only been actioned for three of those eight patients.

Complaints

Staff we spoke with explained that patient and relative feedback, particularly about complaints and concerns, were readily encouraged and we saw documented evidence of this. Nursing staff informed us that feedback from complaints and concerns were discussed regularly at ward meetings and they had a strong culture to learn and improve. However, we were unable to see any analysis of the feedback and what actions had taken place as a result of it. We did see one example as a staff member told us that one complaint they received was about noise at night, specifically the noise from rubbish bins. As a result of this, the bins had been replaced with soft-closing ones that we saw in use on the units.

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

The trust had a chaplaincy service that could be accessed by patients, relatives and staff members. A staff member confirmed that chaplaincy services were available throughout the night. If a relative wished to speak with someone, a staff member would make contact through the switchboard to the out of hours service.

Facilities for relatives

The relatives' room displayed patient/relative-centred information on a stand and a board, which included information about the unit, the services provided and the hospital itself. There were basic catering facilities available for people to use, including tea and coffee facilities as well as a microwave. A small overnight room was also available for relatives if they wished to use it.

Are intensive/critical services well-led?

Good

Leadership and vision

Nursing staff told us that the matron for critical care and ITU consultants were very approachable and supportive.

We were informed that the matron was open to suggestions for improvement and that there was an open culture to change across the critical care service. A student nurse also commented that it was a strong team and everyone worked well together.

During our inspection and time on ITU and HDU, we saw that staff on the units readily approached the matron for advice and information to ensure patient treatment and care were maintained and effective at all times.

We saw that changes required to trust-wide practice were communicated by email. Staff members confirmed that these would be printed out and made available to all staff in the staff areas and communication books. However, staff informed us that explanation around change and how to implement change properly was not always given.

Management of risk

The critical care service had a system in place to identify and escalate identified risks onto the anaesthetic and critical care risk register. However, we noted that, at the time of our inspection visit, there were 12 risks on the risk register, of which five had been escalated in 2011. These related to the delayed discharge of patients from HDU out of hours, staff receiving mandatory training, staff appraisals and a lack of suitably trained staff for ITU and HDU beds. These risks were last reviewed in November 2013, two of which were expected to be resolved early in 2014.

Requires improvement

Maternity and family planning

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

Information about the service

At NGH 3,525 babies were delivered in 2013 and the maternity unit had 58 beds across antenatal, intrapartum and postnatal care. The labour ward was subdivided into eight delivery rooms, seven with no en-suite facilities and a birthing pool room with toilet en-suite; a birthing pool; a 17-bedded maternity observation ward (MOW); and two obstetric theatres. The hospital had a midwife-led unit called the Barrett Birth Centre, which consisted of four rooms with en-suite bathrooms and kitchenettes. It included three birthing pools. This provides an alternative for women with low risk pregnancies who did not want home births and did not need consultant-led care. There was also a level 2 neonatal unit.

The gynaecology unit comprised a 14-bedded inpatient ward and an 8-bedded day care unit, with a gynaecology theatre. It also had outpatient facilities and an emergency clinic including an early pregnancy assessment area and a termination of pregnancy service. There was also a dedicated bereavement facility within the unit called the Snowdrop Suite.

During the inspection of maternity and family planning services, we spoke with 12 staff in obstetrics and gynaecology (across the spectrum of professions), 18 patients and 6 relatives over the course of the three days. Information was also obtained from Health Watch Northamptonshire, a listening event, complaints records and comment cards. We observed care and treatments given, and reviewed patient records. The trust performance was also reviewed using the dashboard data.

Summary of findings

The maternity service appeared to have an adequate number of midwives. However, consultant cover on the labour ward was lower than recommendations made by the Royal College of Obstetricians for the number of births undertaken at this unit per year. The unit deserved to be commended for its home birth rate, as this is one of the highest nationally and its recent work to reduce the rate for elective caesarean section; the trust had been an outlier until December 2013.

Maternity services were provided in a clean environment and there had been 100% compliance with mandatory infection control training for the past four months. The audit of gynaecology and maternity services, undertaken by the infection control team, recorded no methicillin-resistant staphylococcus aureus (MRSA), methicillin-sensitive staphylococcus aureus (MSSA) or Clostridium difficile. However, one serious incident related to scalded skin syndrome, which highlighted the need to record all types of infection.

The incidents that occurred within the unit were reviewed by risk managers and matrons, using the Datix system, according to staff involved in this inspection. Although staff were aware of the trust's incident reporting systems, it was clear that staff did not always have time to report each incident that occurred. Within the inspection, two maternity serious incident reports were reviewed. The outcome was that both were thoroughly investigated and resulted in clear action plans to address the risk factors identified.

Requires improvement

Maternity and family planning

Another area of risk related to the maintenance of equipment within maternity services: a cardiotocography (CTG) monitor and baby warmer had not been PAT tested within the time frame indicated on the label.

Risk was also identified in compliance with level 3 safeguarding training, with only 74% of midwifery staff completing this mandatory requirement.

Are maternity and family planning services safe?

Requires improvement

Infection prevention and control

Procedures and practice for the prevention and control of infection were in place. Our observations were that the unit was very clean. The cleaning standards for obstetrics and gynaecology were 100% compliance for the past four months and 99.35% for 2013. Cleaning schedules were in evidence and the team of cleaners was integral to the ward teams. Equipment used was cleaned appropriately and labelled after it had been cleaned. This meant that patients could be certain that they were receiving care in premises that were clean and suitably maintained for the delivery of care and treatment.

We spoke with midwives, junior doctors, nurses and cleaners who confirmed that they had attended the Infection Control (IC) training. Audits had been undertaken for infection control and 100% of staff had attended the mandatory infection control training. Staff were observed washing hands and using hand gel although we did observe one midwife who did not use the gel outside a room and this was reported back to the matron.

We checked procedures for the safe storage and disposal of clinical waste. Sharps bins were labelled appropriately and collected in a timely manner. We checked specimen fridges on the unit and umbilical cord specimens were stored in line with trust policy.

There were new infection control boards in the unit, introduced in recent weeks showing training for all staff and infection rates within the unit for methicillin-resistant staphylococcus aureus (MRSA), methicillin-sensitive staphylococcus aureus (MSSA) and C. Difficile and audits undertaken by the trust infection control team. Both gynaecology and maternity had 0% infection rates. Patients were screened pre-operatively for MRSA as part of the surgical pathway and the trust infection control policy.

Medicines management

It was noted that during medication rounds staff who were administering medicines were not distracted or disturbed from their work. We looked at the management of medicines, including the procedures for storing, recording

and administering controlled drugs to patients on the labour ward and the Maternity Observation Ward (MOW) and the postnatal ward. We checked the controlled drugs books in the labour ward and in the theatres and this accurately recorded information on the administration of controlled drugs to individual patients.

We checked the fridge logs and there were no gaps in the daily recording of fridge temperatures.

Learning from incidents

There was an effective mechanism to capture incidents, 'Near Misses' and 'Never Events'. Staff told us they knew how to report both electronically and to their manager. There was a governance framework that positively encouraged staff to report incidents, and information was available on how to complain.

Staff said they were aware of the trust's incident reporting system and used the online Datix system to report incidents. However, we spoke with a number of staff who told us they did not always report incidents on the Datix system because they were too busy. Staff also said that they did not always receive timely feedback on incidents they reported. Maternity staff told us that the risk manager and the matrons reviewed and investigated reported incidents. This meant that staff were confident of the correct procedures to follow when incidents occurred and that they knew how to access the incident report form. The unit used the maternity dashboard to display the trust's performance. We reviewed two serious untoward incidents and saw that a root cause analysis investigation had taken place. The incidents were well investigated with clear action plans. The action plans referenced national guidance and best practice. However it was not always clear how this was then fed back to the staff.

A serious incident (SI) had taken place on the unit in October 2013 which resulted in a prolapsed cord and a stillbirth. An investigation had been undertaken. The resulting report had been signed off by the Director of Nursing & Midwifery (DoN&M); usual practice was that the Head of Midwifery (HoM) would have seen the report before the DoN&M. However we could not establish why this had not happened. It was reported at the time through the local supervisor of midwives to the Local Supervisory Authority (LSA) East Midlands. There was no training in place for report writing for SIs which meant that report quality could be variable.

Equipment/environment

We saw several pieces of equipment during our inspection of the location. We checked to see if equipment was regularly checked and maintained. We found some equipment had not been checked. This included a CTG monitor, which was due for checking on 10 November 2013 and a baby warmer on the maternity observation ward (MOW), which should have been checked on 9 January 2014. Two monitors on the MOW had sticker dates on them that stated they had been cleaned but they were out of date for checking. It was not clear if they were now obsolete as a cleaner advised us that they were no longer in use; however this was not obvious to inspectors. We also spoke with a number of staff who told us they sometimes had difficulty locating equipment. As we walked around the unit, we checked the emergency resuscitation trolleys; all were signed and checked on a daily basis and nothing was out of date on the trolleys. We checked equipment in the theatre areas and storage of sterile packs. The baby resuscitares on the unit were checked in accordance with the policy. The labour ward has been upgraded with Foetal ECG ST segment analysis (STAN) monitors which allows for foetal ECG ST segment analysis in the rooms. STAN has the potential to reduce the rates of neonatal metabolic acidosis and obstetric interventions, there was also a central monitoring system in place for CTGs to be observed at the main midwife station.

Staffing

There was good consultant presence between the hours of 8am and 8pm Monday to Friday. However, we spoke with a number of staff on the labour ward and the other wards who told us doctors were overstretched out of hours and consultants were much less visible. We spoke with the clinical director who told us there were currently 60 hours per week of consultant presence on the delivery suite. The Royal College of Obstetrics and Gynaecology (RCOG) safer childbirth recommendations state that for the number of deliveries this should be higher. The recommended number of hours for 4560 deliveries is 98 hours per week.

Junior doctors worked eight weekly daily rotas of 8am to 5pm and on-call rotas 8am to 8pm or 8pm to 8am.

The maternity unit had a ratio of midwives to patients of 1:29 slightly above the standard rate of 1:28. This meant there were slightly fewer midwives to patients than the national recommended standard. The head of midwifery confirmed that the unit had put in a business case for an

additional 12wte Maternity Support Workers (MSW) as part of the Nursing & Midwifery Staffing Strategy and was recruiting a further 1.7 Band 6s for the MOW to increase their establishment and afford four midwives on a late shift . The ratio will remain at 1:29 but the skill mix will be richer. There was a high dependency bay with four beds on the MOW and there was one midwife band 6 and one MSW for that area. If a patient required 1:1 care that would include additional midwife support. For the 3 other 4 bedded bays which include the 4 bedded induction bay there were 3 midwives and 2 MSWs.

We were told that it has not been easy to recruit experienced Band 6 midwives but the unit has a very robust preceptorship programme in place for Band 5 midwives. The only challenge had been that the Band 5s do not always stay after preceptorship. The midwives all have access to a supervisor of midwives and there is a ratio of 1:15 across the community and the wards. There are currently 13 supervisors in post and they are allocated a day a month for supervisory work. Some staff told us it was not always easy to have 1:1 designated time with a supervisor but there is 24 hour on call access to a supervisor.

The sickness rate for obstetrics was long term 2.71% and short term .99% which was an improvement from 2012. Sickness rate on gynaecology was 4.06% short term and 3.28% long term. There had an increase in long term sickness from 2012.

Handover

We observed the handover on labour ward at 8am which comprised of a multidisciplinary team and saw there was good evidence of the members of the team engaging in an open and professional discussion regarding their patients. Doctors were made aware of any outlier antenatal patients in the hospital who had come through the A&E route and admitted to other areas of the hospital; an example of this was a pregnant patient who has had her appendix removed. Any outliers were highlighted on the Labour Ward board so that they could be followed up by the obstetric team which meant that the appropriate clinical staff had oversight of the patients. The junior doctor that we spoke with advised us that there are three handovers during a 24 hour period and that details of these are recorded in the labour ward register.

Safeguarding

There were 1.8 whole time equivalent (WTE) safeguarding midwife leads in the community and 2.4 WTE in the unit. Staff we spoke with understood the process for alerting a safeguarding incident and any child protection issues. The system highlighted any potential child protection issues and these were discussed at the matrons' and head of midwifery meetings. The unit had just recently introduced the common assessment framework process (CAF) form and there was training being rolled out for the staff. Safeguarding training was 92% for levels 1 and 2 and 73% for level 3, and an action plan was in place to increase the number of training sessions for the staff. We also saw good practice on the postnatal ward with positive engagement with the safeguarding team

During our visit we saw an event of concern. The incident was that the delivery room door was left open for three minutes and we were just able to walk through unchallenged, which highlighted a potential safety issue.

Are maternity and family planning services effective?

(for example, treatment is effective)

Good

Clinical effectiveness

The clinical director explained the governance framework to the inspectors. There were supervisors of midwives who looked at safe practice and the workforce. There was a clinical effectiveness group which reviewed national reports i.e. NICE, CEMACH and review audits undertaken. There was an antenatal screening project board and a risk management group which looked at health and safety issues and the serious incidents. There was evidence of audits being undertaken and examples seen were for medication and MRSA screening. The unit used the early warning score (EWS) chart on the gynaecology unit and on the maternity unit they adapted a new midwifery early warning score (MEWS) chart. The trust was now reviewing the management of every emergency primigravida CS and whether the management could have been alternative to a CS. Clinical audit was undertaken by the Clinical Lead Consultant for Labour Ward. A recent audit was the review of all third and fourth degree tears and the outcome was

that there were no trends. This was discussed at MIRF and the Obstetric Governance Group on the 10/01/2014. This meant that there was a robust quality monitoring system in place in this service.

Following a maternal death in 2011 the medical director requested the Royal College of Obstetricians and Gynaecologists (RCOG) to undertake a review. In March 2013 the trust had an external review undertaken by the RCOG. It concluded that the trust's maternity services complied with most of the standards. The trust had an action plan in response to the RGOG report and one of the actions was how to disseminate lessons learned. The unit had reintroduced the newsletters STORK and GYNAE TALK in November 2013 and these were also available on the intranet and on the white notice boards on the ward and outpatient areas.

Also as a result of the RCOG review the maternity unit now had a summary sheet in the notes for blood results with normal ranges for the third trimester.

Delivery

We looked at data for the rates of the different types of delivery method at the hospital. Up to 20 December 2013 there had been 3,525 deliveries and 3,569 in 2012. 4,500 was the target data. Of those deliveries, 26-30% were caesarean sections (CS) which is higher than the national average. The CS rate had improved in December 2013 to 23%. There was a new vaginal birth after caesarean (VBAC) process in place with a lead midwife to help reduce the number of elective CS. There is always a debrief with the multidisciplinary team (MDT) following an emergency caesarean section. The debrief is on the same day and recorded in the notes. On the dashboard in December the split for emergency caesarean sections was 9.9% emergency and 13.6% elective caesarean sections. 61.75% of the deliveries were conducted by a midwife.

Guidance from the National Institute for Health and Care Excellence (NICE) states that women should be offered an induction of labour if their pregnancy goes beyond 42 weeks, and this was followed.. We looked at staffing levels on the MOW and the rotas but it was not identified on the rotas if midwives were moved from one area to another to provide safe cover. We saw that a multi-disciplinary discussion took place at 8am each morning to clinically prioritise the work for the day. We also spoke with a woman who had had her labour induced. She told us: "I was booked for an induction because I was overdue". She said that she had felt well supported by staff.

Induction audits were recorded on the labour ward board and in the labour ward diary although we did not see the actual audit documentation.

Multidisciplinary team working

We found that the multidisciplinary approach to care provision in the maternity service was effective. The working relationship between consultants and midwifery staff was responsive to the needs of patients. This meant the service and its staff had worked together to deliver appropriate care.

Equipment and resources

Staff had access to required equipment, including single-use items of stock. We found that stock items and equipment were stored in an organised manner and were available to staff when needed. We also checked the emergency equipment trolleys in the labour ward and found they were well stocked. We saw evidence that these trolleys were checked daily. This meant staff had access to emergency equipment which was routinely checked and maintained.

Are maternity and family planning services caring?

Good

Most of the women we spoke with told us they were happy with their care. One woman told us: "I have had lots of hospital appointments because I am a diabetic and I personally feel that I have always been well informed about my treatment and care". During our visit we also saw good staff interaction which was polite and respectful. However there were some negative comments about lack of care from midwives, particularly on the post natal wards.

We saw evidence that the family and friends test was carried out and the results displayed in the ward areas for staff and people using the service to view. We saw a variety of cards, throughout the unit, for women and their families to write their comments about their experiences. At least once a month they receive a red RAG rating for the number of responses for one of the maternity wards, but overall for

Requires improvement

Maternity and family planning

maternity as a whole they only scored a red RAG rating against two months for the whole department (August and November) where they did not meet the target of 15% of responses. (RAG ratings are a system where colours are used to note performance, Red, Amber and Green). The majority of responses for each ward are within the 'extremely likely' or 'likely to recommend' categories. In terms of the National Maternity Survey the trust scored about the same as other NHS trusts against all questions and sub questions.

Both the staff and women we spoke with assured us there was a culture of caring. However a number of staff explained they often felt over stretched and found it difficult to find the time they felt they needed to give good care. They told us more staff were required to enable appropriate and timely care to be given, particularly on the high risk MOW.

The majority of patients and their relatives said they were happy with care at the hospital. One said, "I'd recommend this hospital to my family and friends."

Other patients told us that the care they had received had been good and they felt very well supported. A partner of a patient we spoke with said, "The staff were kind and caring" and the experience had been good. However, one relative expressed concerns about the standard of care their relative had received on a postnatal ward and one patient expressed concern about a delay in being offered pain relief

We observed staff in all the areas we visited were welcoming towards patients and supported them in a professional and sensitive manner. We noted that there were good working relationships between different professional groups

Are maternity and family planning services responsive to people's needs? (for example, to feedback?)

Requires improvement

Access

The trust has care pathways within both maternity services and gynaecology services. Admission to the maternity unit is via triage, the midwifery led unit, the labour ward or the community. There is also an emergency care pathway for gynaecology patients.

Discharge planning

Sometimes on the postnatal ward there is a problem with discharging mothers when babies are still on the neonatal unit. The unit is looking at developing a transitional care service with paediatrics. There is a breast feeding coordinator who sees mothers before they leave the unit. However there have been complaints to the trust about lack of support for breast feeding. The dashboard does not demonstrate the number of mothers breast feeding on discharge. There are also sometimes delays waiting for postnatal checks. The postnatal checks are undertaken by the medical staff. The review by RCOG in March 2013 had a suggested outcome was to train more midwives to undertake normal new born examinations, this action was underway and training was taking place as part of a rolling programme. Hearing checks are always carried out on the wards prior to discharge.

Complaints

There is a complaints process in place and complaints are discussed at the obstetric governance group. The trust has a complaints leaflet 'We want to make your experience count' and this was highly visible within the unit. We heard from two couples who said that they felt that they had not always received the care or support they needed during labour and particularly after delivery. One couple had been through a very difficult experience through the A&E which resulted in a neonatal death and another had been through a poor experience on MOW which resulted in a stillbirth, they did not feel able to make a formal complaint at this stage however both felt very dissatisfied with the care they received.

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The trust also used a new initiative called the Goldfish Bowl when looking at complaints and the labour ward looked at the patient's journey for any patient complaint. The Goldfish Bowl exercises are used to enable a group of patients, service users, or carers to talk about their experience of services or a care pathway in a safe and facilitated environment, observed by members of staff representing the services or care pathway concerned.

Another patient who was post caesarean section told us that she had to ask for water on three occasions before it was brought to them.

One patient had a very poor experience when it had been decided by her consultant that she would have a CS which booked but after seen a junior doctor at the antenatal clinic the plan was changed. She experienced poor intrapartum care and poor postnatal care. She felt very let down by the hospital. This lady did complain however was not satisfied with her response. She had no written response but a meeting with a senior midwife from whom she did not receive answers or assurance. We saw that complaints were logged and there was a system in place to deal with complaints however we did not see the process for feeding back lessons learnt from complaints. On the dashboard there were three new complaints in December and there was 100% compliance responding to complaints.

Responding to patients' and relatives' needs

We looked at ten care plans and found that staff had assessed patients' individual needs and had documented information relevant to their care.

We looked at 10 MEWS (maternity early warning scores) on Robert Watson Ward which demonstrated excellent documentation of care following delivery. However out of 10 patient handover forms only two had recorded the member of staff taking over the care.

We looked at eight sets of gynaecology patient care plans which were well documented, completed and signed and care had been evaluated. We also looked at four sets of Termination of Pregnancy records and found the HSA1 forms authorising the procedure which must be signed by two doctors had been signed in accordance with the Abortion Act 1967. There is a family planning lead midwife to discuss future family planning but women spoken with said they tended to go back to their own family doctor for family planning advice.

We noted an issue within the labour ward as the second stage rooms are small and so the paediatric resuscitares has to be kept outside of the door. The door was open and although a curtain was in place there was an issue with privacy and dignity for a patient when she was most vulnerable.

We discussed staff comments about the lack of capacity to care with the matron of the MOW. They told us that there are issues if patients come out of theatre into the 4 bedded high dependency beds (HDU) and then patients who may be at a high risk in the antenatal period also require the beds. There is piped oxygen and suction in the high dependency beds and post caesarean section women stay in the HDU between 4-12 hours dependent on bed capacity. They are then moved into the next bay where there is piped oxygen at two beds and portable suction and oxygen is used at the other two beds. They explained to us that the flow of women and their babies through the unit was sometimes poor and this was an environmental challenge as the fabric of the building is old and there is a problem putting more piped oxygen and suction into the bays.

During our visit we noted that women and their babies were moved from bay to bay on the MOW and finally moved to the postnatal ward. We spoke to three patients and they all said that they did not like moving so many times from bay to bay. The matron explained to us that the flow of women through the service had been identified as an issue and an action plan had been developed. There was a refurbishment programme in progress on the postnatal ward and this had reduced the number of postnatal beds. Sometimes on the postnatal ward there had been a problem with discharging mothers when babies were still on the neonatal unit. The unit is looking at developing a transitional care service with paediatrics. There are currently limited facilities for parents to stay overnight in the neonatal unit; this causes a problem as clearly mothers do not want to leave their new born babies.

Bereavement facilities

The MOW had a room with en suite facilities called the Snowdrop Suite dedicated to supporting bereaved patients and their relatives. There facilities and arrangements were in place for staff to support recently bereaved patients and their families. These included photographs and foot and hand prints. Families can spend time in the room and babies are placed in a special cot. The room is also used for

Maternity and family planning

patients who have experienced a foetal abnormalities termination of pregnancy. Patients and relatives were very well supported during this difficult time. This meant that the hospital had effective systems and practices in place to help support bereaved patients and their relatives.

Are maternity and family planning services well-led?

Requires improvement

Leadership and governance

The maternity service at Northampton General Hospital provides obstetrics and gynaecology care for the trust. Staff told us that the Head of Midwifery (HOM) was accessible and high profile in the unit and had been in post for over 4 years. We were informed by the HOM and staff that she meets with her matrons and senior staff weekly. She also had monthly meetings with the Director of Nursing ('DON') and weekly corporate meetings with lead nurses and the Deputy Director of Nursing. Key points from that meeting were cascaded to the matrons. Staff spoken with were aware that the Nursing and Maternity Strategy had been recently reviewed. Staff had recently seen the CEO and were aware of her blogs but junior staff had little or no meetings with the DON for the trust. The Clinical Director was very high profile and met with the consultants, junior doctors and matrons and had an open door policy for anyone to discuss concerns.

The maternity service had clear management and governance structures. There were monthly clinical governance meetings, and key staff attended trust committee meetings on behalf of the service. We saw minutes of the clinical governance meetings and saw that information from local and directorate level was considered. For example, meetings had discussed incidents, investigations and subsequent action plans and major risks. We looked at the major risks identified in the service and noted that risks were monitored and reported through the trust's risk committee however risks remained on the risk register for some time.

Staff support and involvement

Most staff we spoke with, including doctors in training, felt well supported by the consultants and the senior nursing/ midwifery staff. Staff also told us that the trust had encouraged them to develop. The matrons told us that midwifery staff at all levels contributed to local and directorate maternity services meetings and groups. However, we also spoke with some members of staff who felt that management had not always sought or listened to their opinions particularly in relation to the MOW and staffing. There was a whistle-blowing policy in place and there had been a whistle-blowing in relation to this issue.

Training, learning and development

Some staff said that appraisals had not always been completed, which meant that staff were not always able to discuss their personal development with their manager or highlight issues of concern formally. In Maternity only 50% of staff had received appraisals and in gynaecology only 64.71%. However 100% of the consultant staff had appraisals as part of their revalidation and three of the consultants were trained appraisers. The head of midwifery was aware of the low appraisal rate and recognised it as an issue and plans were in place for the matrons to undertake outstanding appraisals. On the maternity and gynaecology wards staff had received safeguarding training at Level 3 and this showed a compliance rate of 73% for maternity and 97% for gynaecology.

Staff said that they are encouraged to develop skills and in the antenatal assessment unit there are midwife ultra-sonographers. The maternity management team told us that it held learning days for staff. These learning days provided learning and governance updates to staff. They also said that they held weekly dedicated training sessions as part of the training programme for the doctors. Junior doctors confirmed this at the meetings we held with them and said they had weekly meetings with the Foundation Director. Mandatory training compliance for maternity staff was 87- 92%. Staff asked had received training for both DOLs and the Mental Capacity Act and this was shown on the training matrix and staff undertake Mandatory Skills and Drills training which would include clinical scenarios such as a cord prolapse.

The Midwifery team were short-listed for the Royal College of Midwives awards for their work on reducing Caesarean Sections through for their new VBAC process.

Good

Services for children & young people

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

Information about the service

Northampton General Hospital provided child and adolescent services for patients between the ages of 0 and 16 years in the Accident and Emergency (A&E) department, short stay surgery, shared care oncology and medical wards.

The inpatient unit consisted of two wards, Disney and Paddington, which had 20 beds plus two high dependency unit (HDU) beds and a paediatric assessment unit (PAU). The aim was for children to be observed and/or treated for a maximum of four hours in PAU or to be discharged. If assessment and/or treatment was deemed to require a longer period of admission, the child would be transferred to an inpatient bed. There were isolation cubicles and facilities for parents to stay overnight.

The neonatal unit (NNU), Gossett Ward, was a level 2 local neonatal unit and cared for new born babies who were either preterm or required a higher level of medical and nursing care following birth. The NNU consisted of a total of 20 cots of which two were neonatal intensive care cots, six were high dependency and 12 were special care cots. There were 368 admissions to the neonatal unit in 2013. The unit provided neonatal care for the local population. Babies requiring level 3 care would be transferred out to Oxford or Leicester. The children's unit was also a shared care centre for oncology for children. There were also school and playroom facilities for children on Paddington Ward.

We visited the inpatient children's wards, children's outpatient department, neonatal unit and A&E. We talked to 9 parents and children and 17 staff including consultant paediatricians, junior doctors, nurses, play therapists, domestic staff and managers. We observed care and treatment and looked at 10 sets of care records. We received comments from people at our listening events, and from people who contacted us to tell us about their experiences. Before our inspection, we reviewed performance information from, and about, the trust.

Good

Services for children & young people

Summary of findings

Children received safe and effective care in the paediatric unit. Staffing arrangements were flexible to meet the needs of children, and children's care and treatment followed best practice guidance.

Parents told us staff were caring and praised the inpatient wards, outpatient clinics and the neonatal unit. Staff engaged well with the children and treated them with dignity and respect. We were told that children were supported by play therapists who were highly visible on the wards and in outpatients. Staff on the children's ward told us they felt supported. There was limited provision for sleeping arrangements for parents who wished to stay with their child on the wards. The national service framework (NSF) 2003 states that facilities should also cater for parents and siblings and provision for overnight stays. These must include access to meals and relaxation and must respect parents privacy One mother described a positive experience through the A&E route in the early hours when her child was triaged straightaway and sent to the ward, whereas other parents experienced long waits before their child was seen and very poor facilities for them to remain with their child.

During our inspection, we spoke with children who were using the children's service and their families. We also spoke with the staff supporting them. This included senior and junior medical and nursing staff. Most parents told us that they were happy with the care and treatment they received. They said they and their families were fully involved in making decisions about treatment and how it would be provided. However, at the listening event we also heard from parents who had poor accounts of their child's experience in the hospital.

All staff spoken with during the inspection had a good understanding of their role and responsibilities in relation to monitoring quality. Staff were involved in monitoring the quality of service provided and they told us that action was taken in response to suggestions they made. They said they felt confident that they could raise any concerns that they had with their line managers and that their concerns would be taken seriously.

Are services for children and young people safe?

Good

Management of Incidents

Staff spoken with, which included nursing and medical staff, were aware of the trust's incident reporting system and used the online Datix system to report incidents and they received timely feedback from either the ward sister or the risk manager. Staff were confident of the correct procedures to follow when incidents occurred and that they knew how to access the incident report form.

Children's Services use the Safety Dashboard QUEST to display the trust's performance. We reviewed one serious untoward incident and saw that a root cause analysis investigation had taken place. The incident was investigated in a timely manner with a clear action plan which had been implemented. The action plan referenced national guidance and best practice. There was evidence of good learning from serious incidents and near misses and this was displayed on the boards on the ward areas.

Infection prevention and control

Children received care and treatment in clean surroundings. Parents told us toilets and bathrooms were kept clean. We observed good practice in relation to infection control. For example, staff used hand hygiene gel when entering and leaving patient areas.

Procedures and practice for the prevention and control of infection were in place. On inspecting the wards and the neonatal unit we noted the environment to be clean and we spoke with cleaners who were highly evident and told us they were part of the ward team. The cleaners were available during the day and the evenings on the ward areas but could be accessed if required at night. Cleaning schedules were in place and equipment used was cleaned appropriately and labelled with a date when cleaned. This meant that patients could be confident that they were receiving care in premises which were clean and suitably maintained for the delivery of care and treatment.

We checked procedures for the safe storage and disposal of clinical waste. Sharps bins were labelled appropriately and collected in a timely manner. We checked specimen fridges

on the unit and specimens were stored in line with the trust policy. Audits had been undertaken for infection control and 90% of staff had attended mandatory training for infection control.

There were new infection control boards in the unit in showing training and infection rates and audits undertaken by the trust infection control team. The boards had been in place a few months. The sisters on the units explained about the Infection Control Care Bundles and the hand hygiene observation tool. They described the system when all entrants to the ward are observed on camera using the gel on entry to the ward. Poor compliance would be targeted to the appropriate staff group or individual. The paediatric wards and the neonatal unit had 100% compliance for cleaning standards and this was displayed on the infection control white boards. This meant that there was an effective system in place to ensure compliance with infection control measures.

Managing risks

The trust used a paediatric early warning score for children (PEWS). This was a system to standardise the assessment of acute illness severity. All staff were trained in the early warning scores, including the junior doctors. The risk register for child health has highlighted a patient safety issue due to the insufficient number of beds on Paddington Ward for the increasing number of acute admissions, which was being impacted by the rising local population. There was daily dedicated consultant input between the hours of 12pm - 6pm to assess new acute referrals but there was lack of capacity for the Paediatric Assessment Unit (PAU) to see any more children. Consultants raised a concern that there was a capacity issue for the PAU.

There was a PAU business case to increase senior medical input, nursing staff and rooms to assess new acute referrals from 9am-10pm and the people we spoke to within the children's service were waiting for ratification of the directorate escalation plan from the trust. Until the business case is approved the service is working under pressure and the environment is also putting constraints on the service. Currently there were only two cubicles which resulted in long waits for children and their families.

Staffing arrangements

Nursing staff told us staffing was maintained at a safe level for children and the safe staffing tool was used, that staffing was increased or decreased depending on the dependency levels of the children being cared for on the wards and e-rostering was also in place. The skill mix on the wards was 70/30 this means 70% of the team were qualified nurses and 30% of the team were healthcare support workers. The staffing model for the High Dependency Unit ('HDU') was 1:2 (one trained nurse to 2 children) and on the ward 1:3 (RSCNs one trained children's nurse to three children). It was highlighted that it had been difficult to recruit experienced RSCNs especially after four left to take up careers in health visiting and as the local university only had one course per year. Staffing arrangements for student nurses and the supervisory role of senior nurses were clear and student nurses we spoke with said they were very well supported on placement.

We spoke with the Clinical Lead who told us there were currently 7.5 consultants in post and 24 hour on call consultant cover. The registrars worked a rota to cover the senior house officers (SHOs) and the SHOs work 1:16. Out of hours cover was one registrar to two SHOs and a consultant on call at night. The lead clinician told us that there were issues recruiting registrars however there was currently one vacancy but this had been covered by a locum. There was on-going discussion with the deaneries to aid recruitment. The consultants worked an extra rota to cover PAU admissions between 12-6pm.

There were sufficient numbers of nurses on duty to meet children's needs and in keeping with the staffing model. Electronic staff scheduling was in place to support effective planning of nursing staff numbers and skill mix on any given shift throughout the wards. Staff sickness levels year to date (YTD) for Paddington ward 4.21%, Disney ward 5.86% and Gossett ward 6.56%.

The sisters told us there were issues at weekends when there was no cover for the ward clerk and this would put pressures on the nursing staff to complete administrative duties.

Medicines management

It was noted during medication rounds that staff who were administering medicines were not distracted or disturbed from their work.

We looked at the management of medicines, including the procedures for storing, recording and administering controlled drugs to children on the wards. We checked the controlled drugs books and these accurately recorded information on the administration of controlled drugs to individual patients.

We checked the fridge logs and found daily recording of fridge temperatures. We observed a child who required medication for pain control and the prompt response to the request from the parent. One parent said that "my child has never had to wait for pain relief the nurses are always quick to respond." We looked at guidelines for prescribing and we checked nursing assessment records for medication competencies. The policies and procedures we saw over the two days on the wards were in date.

Equipment

Patient equipment was clean and regularly checked and serviced on the ward areas. Any equipment failures were quickly reported and fixed. This meant that risks to children, for example, from cross-infection and unsuitable equipment, were reduced. Nurses told us they had the appropriate equipment to provide safe care to children and babies. The trust risk register showed that equipment was monitored to ensure it was fit for purpose. Resuscitation trolleys were checked daily and this was evidenced through records. There were no drugs out of date on the trolleys.

The environment

Children received care in a safe environment. The challenge within the ward environment was lack of space around the bed areas and cubicles to assess children who are attending the ward. There was a range of safety and security features in the neonatal unit and the children's ward areas. For example, access to the wards was controlled and nurses were readily available to supervise children. However children did not have the same security in the hospital's A&E department. Although part of the department was designated as a children's area, we saw that many children and babies also received care in the adult areas.

Safeguarding children

We spoke with the safeguarding/child protection lead for children's services. Policies and procedures were in place and had been reviewed. There was a comprehensive training programme in place and the focus was to ensure that staff knew how to access help. There was also information and a flowchart on the intranet and an update news sheet for staff. Staff who we spoke to were aware of the actions they should take to safeguard children and how to report any concerns, and there were procedures in place to protect children, which included liaising with the social work team based at the hospital. We were told there was good interagency working and a clear structure of responsibility and that this had improved over the past 2 years.

Staff compliance with safeguarding training at Level 1 was 97%, Level 2 87% and Level 3 72%. The trust target for safeguarding training for Level 3 is 85% and there was an action plan in place for staff to access up to date level 3 training as more dates had been allocated, Evidence of this plan was in the minutes of the ward meetings and also on the ward office notice boards.

Parents told us they felt their children were safe. One mother commented that, when she had to leave the unit, she was confident that her child was in safe hands. All senior and junior nursing and medical staff spoken with during our inspection told us that they felt supported in their role in safeguarding. They told us that they were able to contact the safeguarding leads whenever they needed advice. It was evident that staff had a good understanding of their role and responsibilities in relation to safeguarding. They told us that they had undertaken recent training about safeguarding issues. All staff received safeguarding training as part of their induction and two further levels of training were provided depending on their roles. Staff were also supported through 'safeguarding supervisions'. These meetings provided opportunities for staff to ask any questions that they had about safeguarding matters and share their experiences of managing safeguarding concerns. The safeguarding teams link in with local community nurse teams and with the local authorities.

Patient records

Children's pathways were in place for treatment, integrated care and transition. There was a pathway for the PAU. Comprehensive medical and nursing records were well documented and there was good information about the children's care and treatment. Audits were undertaken on a monthly basis to check completeness of records. We checked 10 sets of records on the wards to ensure they were completed appropriately and this included checking that nutritional and fluid balance charts had been completed over the 24 hour period. We also checked pain management records for children. Children's needs were assessed and care and treatment was planned and delivered in line with their individual care plans.

Individual risk assessments had been undertaken that included the risks associated with developing sore skin,

poor nutrition, dehydration and equipment used as part of their treatment. Pain score assessments had also been undertaken. These had been updated and amended regularly and staff spoken with had a good understanding of how to evaluate care.

Theatre teams used the World Health Organisation's surgical safety checklist but these were being audited at the time of our inspection so were not in the patient's records.

Are services for children and young people effective?

(for example, treatment is effective)

Good

Evidence based care/clinical audit

Medical staff that we spoke with told us that there was participation in national and local audit and that they followed NICE guidelines. The service demonstrated that it was using national and best practice guidelines to care and treat children. The trust uses the Paediatric & Neonatal Guidelines for Intra and Inter Hospitals transfers and uses the transfer check list for patient transfer prior to departure. National audits demonstrated the trust was similar to other trusts, for example, in managing pain in children. Staff told us audits were regularly done to check standards within the department and the quality of the service provided. Evidence was seen of the Child Health risk management meetings which are multidisciplinary.

There was evidence of a governance framework in place and evidence was seen of meetings for the Child Health Clinical Governance Group.

The neonatal unit had undertaken a neonatal survey in line with the National Neonatal Audit Programme. An action plan was in place. One outcome was to promote breastfeeding and expression of milk. Babies on the neonatal unit are given breast milk within 24 hours.

Perinatal mortality meetings which discussed foetal deaths after 24 completed weeks of gestation and death before 7 completed days were held every month on a Friday. Cases were discussed with the multidisciplinary team to ensure lessons were learnt and management of care was improved.

There did not appear to be a connection with the A&E and the audits undertaken on the children's wards, although caring for the same group of patients and part of a path of care there was no evidence that the children's experience was considered universally.

Multidisciplinary team working

Children received an effective service from a multidisciplinary approach to supporting children. There was good involvement of doctors, nurse, therapists, pharmacists and play therapists recorded evidenced in patient care records on the wards. Records showed that children's care was coordinated and their care and treatment were reviewed daily; this included discharge planning arrangements. Parents said the service was meeting their needs. Play therapists were involved in preparing children and parents for invasive procedures, investigations and theatre. They attend all areas of the hospital where children are seen including outpatients, A&E and Minor Injuries. Parents and staff spoke positively about the role and how it is fully integrated in the planned care pathway.

Staff told us there was good collaborative multidisciplinary working between maternity and paediatric services within the Trust, particularly regarding the sharing of information about safeguarding issues. There is also a multidisciplinary approach to supporting children and families

They described how the neonatal unit worked in partnership with the local Neonatal network to ensure babies were cared for in the most appropriate setting dependent on their clinical need. Staff spoken with had a clear understanding of their role in coordinating the transfer of babies to other local hospitals. There was close liaison with the retrieval service to ensure effective transfers of patients to other hospitals with appropriate equipment. Babies are transferred out when they require Level 3 support as the unit only offers Level 2 support. The units closest to Northampton are either based in Oxford or Leicester.

Staff training and support

Staff said they felt well supported to provide effective care and treatment to children. Nursing staff told us they undertook a programme of mandatory training and there was a preceptorship programme in place. Annual appraisals are in place to support professional development and the appraisal rate was 67%

Good

Services for children & young people

Staff told us they were able to access mandatory training within the trust and compliance with mandatory training was 80-90% for permanent and bank staff.

The hospital 'bank' of staff (staff on standby) were called upon in times of unexpected demand to support a number of departments. The staff on the bank rota had received inductions into the areas of hospital that they worked. This was in order to ensure that they were competent to work there and meant that people would be cared for by appropriately trained staff.

Are services for children and young people caring?

Good

Patient centred care

We observed staff introducing themselves to children and the parents in a respectful way and we also observed positive interactions between nursing staff and the children and their parents. Overall, parents were appreciative of the care provided and how staff went about their work. The nurses, for example, were spoken about in terms such as “kind, caring, professional and a good listener”.

Staff were kept up to date about the children’s needs and changes in their care through regular ward meetings and handovers. Parents told us they felt involved in their child’s care and had mostly been given the information they needed. Information on children’s care and the involvement of parents and children in planning their care was recorded in care plans. However, there were no learning disability passports for children which meant that there may not be a complete picture of those children’s needs as they accessed different services within the hospital.

There was an end of life care pathway and a lead nurse for these children. We spoke with a mother whose child was receiving shared care for oncology and who was the end of life care pathway. She told us that there is a bespoke service according to the individual child and parents needs and there is very good communication between the community and hospital. She had the personal mobile telephone number of the consultant and of the community liaison nurse. She said her child was very well looked after and she was always supported. She said her child was symptom controlled and happy. Every process was explained to them and the play therapists were very supportive when things were difficult.

We spoke with a parent of a child with life limiting condition. She was very positive about the continuity of care offered to her child. She thought there was a lack of sensory stimulation equipment on the ward. The play therapist assured us it was there, however it was locked away when not in use which meant that children did not always have access to that equipment whenever they required it.

Social and education facilities

There was a school room and a playroom on Paddington ward. Parents and children were very complimentary about the play therapists that are integral to the care pathways and provide social and educational facilities. There were toys and books for children of all ages, and a variety of play areas and equipment available within the playroom and the school.

Children’s and parents’ experiences

The children’s wards received feedback on the experiences of parents and children. Information was displayed in the children’s ward on the outcome of feedback and there was a good level of satisfaction.

Children’s nutritional and hydration needs were being met. Menus identified a variety of nutritious meals. Parents and children told us that they were happy with the choice and quality of food provided.

Comment cards were readily available to people in the children’s wards. Some of the main themes were relating to lack of facilities for parents to stay, cramped bed spaces on the ward areas and the other theme was the lack of accessibility to car parking space.

Are services for children and young people responsive to people’s needs? (for example, to feedback?)

Good

Facilities

There were age appropriate toys available on the wards and a high visibility from the play therapists with

equipment. However there was an issue as out of hours equipment was locked away and therefore not available for the children to access. We spoke to 4 families in Children's Outpatients who said that the nurses and doctors were friendly and cheerful. They told us that they were good at keeping to appointment times and there was good communication from the doctors about the planned treatment for the children. They informed us that the play area was always clean and they had observed the toys being cleaned.

One parent said "the doctor is lovely and I trust him."

Access

Children could access the PAU through the A&E route after triage or through direct referral from the GP or the community nurse. The PAU provides the opportunity for children to be seen by a specialist at short notice on the recommendation of a GP. The PAU was based on Paddington ward. The unit consists of room A and B. The nurse makes the assessment and then the child is seen by the doctor. The unit helps to facilitate both ward attendances and the rapid transfer of children requiring further assessment or paediatric observation. It also operates a GP referral system whereby children can come directly to the unit for paediatric review. Children referred to the unit for further assessment or observations are assessed by a senior Paediatrician and Paediatric Nurse.

Disney ward provides shared oncology care to children and also to children with sickle cell anaemia. There are about 150 children who have direct access to the ward. Paddington ward is the medical ward.

Parents and their children told us the service met their needs and they had a positive outcome to their visit. We spoke with three parents who said there was a prompt service for out of hours. The matron told us that they managed their own bed capacity and a flexible medical and nursing workforce supported each other.

Within the neonatal unit (NNU) 70% of the nursing staff had the neonatal qualification. There are two education sisters on the neonatal unit. The unit is currently being given a quality payment, commissioning for quality and innovation (CQUIN payment) in recognition of the work they are doing on early discharge of babies and babies getting breast milk within 24 hours. Staffing levels were on display in the unit showing that ventilated babies were nursed 1:1 and non-ventilated babies were nursed 1:2 trained nurses in keeping with national recommendations. The nursing establishment on the Neonatal Unit had no vacancies. There were five WTE Consultants with a business plan to increase to six WTE. Babies were transferred out to other units within the network for level 3 care and this was usually to Oxford or Leicester. There were facilities for parents to stay with their babies before discharge on the postnatal ward. Parents spoke very highly about the care on the unit. We spoke with four sets of parents on the neonatal unit and they told us there was excellent support for breastfeeding mothers. There were ward rounds with parents at the cot side and opportunities to talk to the doctors after they had gone round all the babies.

Accommodation for parents

Parents were able to spend time with their children throughout the day but the accommodation for overnight stay was limited because of the lack of facilities. Parents sleeping on the wards were sleeping in chairs. There is a parents' room on the neonatal unit that provides a kitchen area for drinks and snacks. We heard mixed views about the overnight accommodation, as beds for parents were not consistently available.

Discharge planning

There was a discharge process in place from the children's wards and the neonatal unit which included both out of hours discharge and nurse led discharge. It was a multidisciplinary team approach and parents and the child were informed at all stages of the process. A child would only be discharged from hospital when everything practical or reasonable had been done to organise the services the child would need at home. Parents spoken with said that they were always kept informed. Babies discharged from Gossett to home may need long term support from the children's community nurses or health visitors and they were also involved in planning the discharge.

Looked After Children either on the wards or the neonatal unit had a robust process for discharge and all multi-agencies were informed and involved. There was a designated nurse for looked after children who linked with children's liaison and the safeguarding team. We were shown the forms completed for looked after children and the process was explained by the safeguarding lead.

Interpretation services

We were informed that the trust had access to an interpreting service if it was required by a family.

Good

Services for children & young people

Patient information
The trust had information leaflets in the ward areas, A&E and outpatients for children and their families. It was not evident if the literature was available in other languages or other formats. The staff we asked did not know if it was available.

Bereavement facilities
Within the ward area, children would be cared for at the end of their lives in a side cubicle as part of the pathway. There is a consultant who leads on end of life care. There is bereavement support within the unit and also in the community. For the neonatal unit there was also the Snowdrop Suite dedicated to supporting bereaved patients and their relatives. Facilities and arrangements were in place for staff to support recently bereaved patients and their families. These included photographs and foot and hand prints. Families can spend time in the room and babies are placed in a special cot. Patients and relatives were very well supported during this difficult time. This meant that the hospital had effective systems and practices in place to help support bereaved patients and their families.

Complaints
There was a complaints process in place and complaints were discussed at the child health governance group. Staff spoken with were aware of the complaints process and the 4 Cs of 'concerns, comments, complaints and compliments'. Parents we spoke with knew how to complain. There were visible leaflets in the wards and outpatients explaining how to complain. We reviewed some complaints which related to sleeping accommodation for parents and lack of access to car parking facilities. There was also a complaint from a parent relating to a doctor and it was evident that the trust process had been followed in a timely manner and that the parent had been kept up to date with the investigation.

Are services for children and young people well-led?

Good

Managing risk
The service was monitoring quality and safety issues and these were discussed in staff meetings. Participation in national and local audits was improving practice and there was learning from incidents. Risks to children's care were identified and included on a risk register. The risk register clearly described the issue and existing controls in place and proposed actions with ratings and review dates. There were action plans produced in response to these risks and the information on the register showed how the risks were being mitigated and managed. We looked at the major risks identified in the service and noted that risks were monitored and escalated to the trust board.

The risk register identified the lack of capacity in the PAU and the action to move the unit to a larger area. There was nothing on the risk register to highlight the issue of the A&E and not meeting the needs of children in line with national policy and the NSF for children (2003).

Leadership and vision
Staff were aware of the Nursing and Midwifery Strategy which had recently been reviewed. Staff knew the Chief Executive CEO because she had been the Medical Director but had little contact or meetings with the Director of Nursing ('DON'). However the matrons did meet with the DON on a two weekly basis to discuss the workforce strategy and new ways of working. The Consultant Paediatrician Clinical Lead and the matron are very high profile on the wards. The matrons then met with the ward sisters and they met with their teams and this was evidenced in ward minutes. The staff worked well in teams and this contributed to good outcomes for the children. Staff spoke knowledgeably about their role and responsibilities within the wards and the outpatient department.

Child health had clear management and governance structures. There were monthly clinical governance meetings. We saw minutes of the clinical governance meetings and saw that information from local and directorate level was considered. Meetings had discussed incidents, investigations and subsequent action plans.

Training, learning and development
Some staff said that appraisals had not always been completed, which meant that staff were not always able to discuss their personal development with their manager or highlight issues of concern formally. In child health 67% of staff had received appraisals and 100% of the consultant staff had appraisals as part of their revalidation. We spoke with two SHOs who gave very positive feedback of consultant support and the training programme within the

trust. Juniors confirmed this at the focus group. The medical staff on the children's unit had up to date paediatric life support training and also either intermediate life support or advanced life support.

Inadequate

End of life care

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

Information about the service

We visited nine wards where people could possibly be receiving end of life care. We also visited the mortuary. We spoke with six patients and 23 members of nursing and medical staff. In addition, we spoke with the chaplains, specialist palliative care team, porters and mortuary staff. We also observed care being given to patients and looked at 48 sets of patient records relating to their care. The trust gave us data relating to care for patients at the end of life, which we also considered as part of our inspection.

Summary of findings

We found that the wards we visited, and other areas such as the mortuary, followed appropriate guidance regarding maintaining a clean environment and reducing the risk of infection. Staff were aware of how to report incidents and concerns but had mixed views about the effectiveness of the trust's system of feedback so that the staff could learn from them.

There were inconsistencies in the standard of record keeping, with gaps in some patients' records relating to the daily nursing care that they had received. We also had concerns about the level of compliance in completing 'do not attempt cardio-pulmonary resuscitation' (DNACPR) forms.

Patients told us they received care that was caring and respectful and this was confirmed in our observations on the wards. Staff were motivated to provide a good standard of care to patients at the end of their life. However, there were concerns about the wards being noisy at night and the number of times that patients were moved from ward to ward.

Since the concerns that had arisen about the Liverpool Care Pathway (LCP), there had been a lack of clarity about the appropriate guidance to use for patients at the end of their life. This meant that there were inconsistencies across the hospital as to whether the LCP was being used or not. There was also a concern about the availability of doctors at night and at weekends.

The trust had a palliative care nursing team. There is no dedicated Consultant in Palliative Medicine for the

Inadequate

End of life care

hospital. Three clinical PAs are provided by one of the consultants from the local hospice on an ad-hoc basis. There is no cover arrangement for periods of absence and the competing responsibilities as Clinical Director affect his availability to support the specialist nursing team or see patients with complex needs at the hospital. The lack of a dedicated consultant to lead the team has resulted in missed opportunities to provide education and training to teams caring for palliative patients, prevented the development of initiatives to enhance palliative care, inhibited the development of the specialist nursing team and affected the provision of high quality care to patients with complex needs and at the end of life.

Are end of life care services safe?

Requires improvement

Infection control and prevention

We asked patients about the cleanliness of the wards and none of them had any complaints about this. One patient said, "the ward is very clean, the cleaning lady is very thorough". We saw that there were hand gels and protective gloves and aprons available and that staff utilised these. Staff who we spoke with were aware of the importance of good hygiene. We spent some time speaking to the mortuary staff and to the porters. We observed that there was suitable personal protective equipment, such as gloves and aprons, available in the mortuary as well as handwashing facilities. Both the mortuary staff and porters who we spoke with were aware of the importance of good infection control procedures.

Staffing

Staff views about whether the staffing was adequate and the impact of this varied between wards that we visited. On three wards that we visited staff identified that they did not always have time to spend on an individual basis with people who were at the end of their life, or to give enough time to relatives who wanted to discuss the patient's end of life care.

Other staff told us that the staffing levels were adequate but that the staffing teams often included bank or agency staff who did not know the ward or the patients very well. This meant that the permanent staff felt that they were carrying a heavier work load. Staff also said that if the hospitality staff were not available to provide drinks and snacks to patients then this was another pressure on their time and left less time for them to spend on an individual basis with patients. Staff were very clear that they needed to have the time to spend with patients when they were at the end of their life, particularly if they were distressed or anxious and did not have relatives present to support them.

One of the consistent issues that staff at all levels raised with us was the lack of availability of doctors at night time and at weekends. Nursing staff told us that when a patient's observations indicated that their health was deteriorating then they needed to contact a senior doctor for advice about treatment, or they needed them to prescribe pain

relief for someone at the end of their life. On all of the wards that we visited, other than oncology, staff told us that it was, on occasion, difficult to ensure that the doctor visited the ward in a timely way. The doctors who we spoke with confirmed this and told us that this was due to the number of wards that they were covering when they were the 'on call' doctor.

Patients admitted to the dedicated oncology/haematology ward are admitted under the consultant oncologist/ haematologist responsible for their care. Palliative care is provided by the team looking after the patient. Patients with complex/unmet needs are referred to the Specialist Palliative Care Team. Out-of-hours telephone support may be provided for named patients only from the local hospice.

The trust has a dedicated Specialist Palliative Care Team, which comprises 3.6 WTE. They work closely with the 0.8 End of Life Care Facilitator, who provides general advice on end of life care. We spoke with members of this team about their role. They explained their role and how they worked with the ward staff to provide support and training to staff with regard to supporting patients at the end of their life. The Specialist Palliative Care Team is available to advise clinical teams caring for patients with unmet/complex needs. Where appropriate, they take responsibility for managing the holistic needs of patients/carers, including rapid discharge at the end of life to their preferred place of care. The End of Life Care Facilitator acts as a resource, supporting ward teams in providing high quality care at the end of life, utilising the Liverpool Care Pathway (LCP) until new national guidelines are available. Both teams are heavily involved in formal and informal education and training. The Specialist Palliative Care Team has a good working relationship with the local hospice. However, there is no formal agreement to provide out-of-hours telephone advice to clinical teams, which is a peer review requirement. The team members told us that the lack of a named consultant for palliative care within the trust meant that there was a lack of overall co-ordination and governance of this care pathway. We also spoke with the non executive board member responsible for end of life care who confirmed this and said that a business case has been put forward to the board for the appointment of this post.

Ward staff told us that they had good relationships with the palliative care team and that they were able to contact them for advice as needed.

We spoke with staff in the mortuary and with the porters about the arrangements for transporting patients to the mortuary. There were suitable processes in place to ensure that patients were able to be moved in a timely way to the mortuary and that appropriate numbers of porters had received the additional training to ensure that they were able to carry out the necessary procedures in the mortuary when mortuary staff were not available at weekends and overnight.

Equipment

The mortuary had recently been refurbished and as a result the capacity has increased by 40 spaces. The mortuary staff confirmed that there had been no concerns about capacity since the refurbishment. Another improvement from the recent refurbishment has been the provision for bariatric patients within the mortuary. The staff also confirmed that they had appropriate hoists and had received training with regard to moving and handling.

Patient records

We looked at 29 sets of records for patients with particular reference to the recording of information relating to patients at the end of their life or at risk of deterioration in their health. We looked at the records relating to the Early Warning Score system that the trust used which identifies when a patient is at risk of deteriorating health. This then should trigger the nurse who has completed the patient's observations to obtain medical intervention and a treatment escalation plan to be put in place. We also looked at the records relating to DNACPR (Do Not Attempt Pulmonary Resuscitation) decisions. Out of the 29 sets of records that we reviewed only 12 were fully completed and contained the necessary assessments and signatures of the appropriate nursing and medical staff. This is slightly under the trusts own audit of DNACPR records across the trust which was recorded as being at 53% completion in November 2013 and 54% completion in December 2013. We spoke with some staff about whether they were aware of the audit and most of them were but were not aware of any other actions in place to improve this other than staff being reminded of the need to complete the forms appropriately.

During our initial visit to the hosptial we were concerned about the layout of the DNACPR form as this was attached

to the treatment escalation plan which also had DNACPR in large red letters written on it. Whilst staff did not have to complete the DNACPR form at the same time as the treatment plan it was not clear that the signature on the treatment plan did not indicate that the DNACPR was in place. This meant that patients were at risk of not being resuscitated when the decision not to do so had not actually been taken. In addition to this, even where the decision making process had been appropriately followed the DNACPR form was not always completed properly which may also lead to confusion for staff about whether the person was to be resuscitated or not. Due to the seriousness of our concerns about this we provided some feedback to the trust at the end of our initial two day visit. During our subsequent unannounced visit to the hospital, as part of this inspection, we looked at DNACPR records again. We found that the trust had changed the format of the forms so that the DNACPR and the treatment plan were now two separate records which had reduced the risks that we had identified. We checked a sample of patient records and found that the new forms were in use.
Communuication to staff about the new form and reasons for replacing the previous one was limited; however we saw examples of the new form being used appropriately.

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

Requires improvement

National guidance
Following recent guidance from the Department of Health, the trust had stopped consistently using the Liverpool Care Pathway (LCP) in its previous form. Although the trust still advocates the use of the LCP for patients' approaching the end of life, there has been a decline in its use since the national recommendations to withdraw the pathway. A recent audit undertaken by the End of Life Care Facilitator in November 2013 suggests a reduction from 40 to 11%. The inspection team raised concern about the reduction in use and how this was impacting on the identification of patients approaching the end of life and the quality of care they received. There was also concern about the possible lack of identification and referral of patients with complex needs to the Specialist Palliative Care Team. However, from our discussions with staff and our inspection of patient records, it was clear that there was confusion and a lack of clarity about what had replaced it. We spoke with staff about what guidance was used with regard to caring for patients at the end of their life. Some staff told us that they still used the LCP; some told us that they definitely did not use the LCP and others said that they were not sure what they were using. Some staff told us that they kept to the principles of the LCP whilst not referring to the guidance as that. . The trust's operational policy advocates the use of the LCP to ensure high quality care at the end of life. This will be updated once national guidelines have been published later this year.

When we asked staff on the wards and in the palliative care team how many patients there were who were receiving end of life care the majority of staff were not able to provide us with this information. In discussions with staff it was clear that because patients were no longer officially considered to be on the LCP then staff found it difficult to quickly identify those patients who were receiving end of life care.

We discussed this issue with the non-executive board member with responsibility for end of life care and she told us that the trust was in the process of implementing new end of life care guidance known as Amber care. The trust is part of phase two of the national "Routes to Success" program improving end of life care in acute hospitals. As part of this, the Amber Care Bundle, which provides a systematic approach to managing patients whose recovery is uncertain, is currently being piloted on one ward with a view to rolling it out across the organisation. We asked staff about this but the majority were not aware of the details of this guidance. The palliative care team told us that they had previously piloted this at the trust but it had not been successful. The first ward to start implementing the Amber care guidance was planned to do so on 27 January 2014. One nurse told us that they knew that the Director of Nursing had completed an audit of DNACPR documentation but that they had not seen the results of this. The non-executive director who we spoke with confirmed that the results of this audit had not yet been collated and published.

Meeting patient needs
We looked at four patient records with regard to the care plan relating to end of life needs. We found that the completion of the records was not consistent and that there were gaps in all four of the records that we looked at. For example, there were gaps in the daily charts which

recorded the repositioning of patients at high risk of pressure ulcers and their daily nutrition and fluid intake for two of the patients and one patient had not had a pain assessment completed. In addition to this, one patient did not have a care plan for their end of life care at all. However, other individual records were fully completed for those patients. We asked staff about the care plan for patients at the end of their life which would record their individual wishes and they said that since they had stopped using the LCP this was not always recorded. This meant that there was a risk that patients' needs would not be met with regard to their involvement in their treatment and care.

Staff training

The palliative care team told us that they were responsible for providing training to ward staff with regard to end of life care. They had a rolling training programme in place. The trust's own training needs analysis assessed the levels of staffing roles and whether they required basic training or more in depth training with regard to end of life care. This analysis indicated that the majority of ward staff, plus support staff such as chaplains, required the basic training with regard to end of life care. The palliative care team are not resourced to provide training to this amount of staff. The palliative care team and the End of Life Care Facilitator told us that they were working with the local hospice to provide more in-depth training to those staff who work regularly with patients at the end of their life. The five-day training program followed by six months action learning for Band 6/7 nurses will enable them to identify and implement an action/s to improve end of life care on their individual ward. This had started to be delivered to staff at the oncology ward. The non-executive director who we spoke with said that this was also going to be delivered to ward staff and that the first group of staff have completed this five day training.

The trust is part of a national pilot with St Christopher's Hospice to improve end of life care in the acute setting. The Specialist Palliative Care Team and the End of Life Care Facilitator have worked with the local hospice to deliver the five day training program which started on 3 March.

Are end of life care services caring?

Requires improvement

The six patients that we spoke with were positive about the nursing and medical staff. One person told us that they had,"no complaints about treatment at all" and, "what better service could you ask for?". Another told us that the, "nurses answered all my questions and been very kind". One person said that they thought that the staff were genuinely caring and that, "when staff ask 'how are you?' they really mean it". We observed staff to be kind and caring towards patients. They took time to explain to them what they were doing and asked them if there was anything that they needed. All wards have side rooms, however, there are not enough to be able to offer them to all dying patients.

However, we also were told by two patients that the wards were noisy at night. This was confirmed by ward staff who told us that they were aware that this was an issue and had held discussions with staff about this issue in order to try to reduce the noise at night. We were also told by the non-executive director that the trust has identified that there was an issue with the number of times that some patients were moved from ward to ward during their stay at the hospital. She said that there has been no formal audit of this but that anecdotal evidence from patients and staff is that this is an issue and it has been raised at the end of life strategy meetings. The Director of Nursing was also aware of this issue, as were the palliative care team and ward staff. A member of the Specialist Palliative Care Team and the End of Life Care Facilitator had a meeting with the Deputy Director of Nursing to discuss their concerns related to end of life in December but that they had not yet received any feedback about it. They said that they have had discussions with the bed management team with regard to the detrimental effect on patients and their relatives of moving wards, particularly with little, or no, notice. All of the staff with whom we spoke about this issue said that it had not improved although the trust had no audit data for us to look at to ascertain the accuracy of this anecotal evidence.

We spoke with porters and ward staff about the issue of moving patients, particularly during the night. All staff we spoke with about this told us that when patients were moved it was either because their health had deteriorated

Inadequate

End of life care

and was therefore in relation to their health needs or it was to ease the pressures in the A&E department. They said that when the hospital was full overnight then there was very little, if any, movement of patients as there were no free beds to move them to. Records relating to the movement of patients confirmed that the number of patients moved overnight was variable. For example, one night there had been no movement of patients from ward to ward whilst on another night there had been eight patients moved from the EAU to wards between midnight and 3am.

During our unannounced night visit to the hospital we spoke with nursing staff who were working the night shift. They were aware of the importance of reducing the noise levels at night on the wards but said that this was difficult when patients required care during the night or if new patients were admitted to the ward at that time. We observed staff talking quietly and ensuring as much privacy for patients as possible through the use of the curtains. Staff also told us that they tried, wherever possible, to ensure that patients at the end of their life did not have to move wards, unless this was in their best interest.

All of the staff we spoke with, including mortuary staff and porters, spoke very respectfully about patients at the end of their life, or those who had died. Staff were aware of the importance of dignity and respect for patients, and their relatives, at this time. They were motivated to provide good quality care for people at the end of their lives.

The trust Chaplians shared with us details of the annual service held for parents whose children have died. This service is well attended.

According to the data provided by the trust there had been five complaints in the last six months about end of life care. Four of these involved concerns about the lack of communication between hospital staff and the patient and/or their relatives.

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

(for example, to feedback?)

Requires improvement

Responding to patients

We were only able to speak with one patient about whether the trust was responsive to their needs and they told us that they were and that they had been, "diagnosed in December and received treatment very quickly"

The palliative care team told us about the rapid discharge team that was in place which aimed to support patients to go home from hospital more quickly when they wished to be at home for their end of life care. This involved a multi-disciplinary approach, involving social services as well, and ensured that patients were able to obtain their medicines more quickly and that steps were in place to ensure that any equipment and support that they needed at home was in place.The Specialist Palliative Care Team also said that they had good relationships with the local hospice and that they were able to arrange transfer there if it was appropriate to their ongoing care needs.

The Specialist Palliative Care Team completed an audit of opioid medicines in 2013. This identified that there was a lack of adherence to the trust's guidance on recording occasions when opioids were not administered. It showed that during the period of December 2011 – November 2012, of 45 patient records involved in the audit, none had all omissions correctly recorded. It also showed that of those patients prescribed Modified Release Opioids only 50% of patients received all doses within the two hour 'window' as advised by National guidance. The action plan developed by the Specialist Palliative Care Team proposed further training for staff as well as producing guidance for the trust to ensure that it complies with the NICE guidance re: Opioids in Palliative Care.

Facilities

The staff told us that they felt that the introduction of a bereavement office where relatives could go to obtain information in the event of their relative's death had been

Inadequate

End of life care

an improvement for relatives. They said that this meant that relatives were able to discuss issues and sign appropriate documents in privacy rather than on the wards where it had previously taken place.

There were appropriate arrangements in place on the children's ward and in maternity services to support bereaved parents. There were suitable rooms for parents to spend time with their baby or child and sensitive arrangements in place to support them at this time. However, the facilities available on the wards were varied with many wards lacking any private space at all. Many of the wards did not have side rooms and so patients at the end of their life, and their relatives, were in a bay with only a curtain between themselves and other patients and staff. This meant that their privacy and dignity was compromised despite the staff's attempts to provide a good level of care and support. The nursing staff told us that they offered to speak with relatives in a private office but that this was not always possible, and certainly not possible to do this with the patient.

The mortuary had an appropriate viewing room which was pleasantly and sensitively decorated. There was information available for bereaved relatives to take away with them with regard to the procedures following bereavement. The mortuary staff told us that they had provided training to some of the senior porters so that they were able to provide appropriate support to relatives who wished to come for a viewing during the hours that the mortuary staff were not working. The senior porter who we spoke with confirmed this and said that there were always appropriately trained porters on duty 24 hours a day, seven days a week. During our unannounced night visit to the hospital we confirmed that there was a porter on duty that night able to provide this service if necessary.

The hospital employed two Christian chaplains. The chaplain who we spoke with explained that they were able to obtain the services of ministers from different faith groups if patients wished to see them. The chapel within the hospital held Christian and Muslim services on a weekly basis and was open for patients, relatives and staff of all faiths to use for quiet reflection and prayer or to speak with one of the chaplains.

Are end of life care services well-led?

Inadequate

Leadership

The trust lacked clear leadership with regard to the provision of end of life care. Whilst all of the staff that we spoke with were motivated to provide good care for patients there was a lack of direction and co-ordination. The situation regarding the Liverpool Care Pathway has meant that there was confusion amongst the medical and clinical staff with regard to the appropriate identification and therefore pathway for patients at the end of their life. The lack of co-ordination and leadership means that there is a risk that patients were not being correctly identified as being at the stage of end of life care and may be receiving ongoing proactive treatment rather than palliative care. There is also a risk that if patients are not recognised as being at this stage of their life then their views, and those of their relatives, where appropriate, are not taken into account with regard to proper planning for their care. In the absence of a Consultant in Palliative Medicine, one of the Consultant Clinical Oncologists acts as the clinical lead for End of Life care lead for the trust.

The nature of end of life care means that there are many areas across the hospital in which patients are at the end of their life, including those for whom this can be planned for, and those for whom this is not possible. Therefore, the lack of overall leadership and clarity around this area of care for patients has an effect on many of the areas of the hospital and not just in those areas, such as oncology, where it may be expected that there are patients requiring end of life care.

Quality assurance

Whilst the palliative care team, and some staff on the wards, were aware of the best practice guidance and national frameworks regarding end of life care it was very difficult for them to put these into practice due to the lack of clear leadership in this area. The trust board had recognised that this was an area that was in need of improving within the trust and had taken some steps to identify the issues. This included the appointment of a non-executive board member with relevant experience to take the lead on end of life care, the implementation of an end of life strategy group and the carrying out of some audits which had identified some of the issues.There is some evidence of actions arising from audits undertaken

Inadequate

End of life care

by the Specialist Palliative Care Team and the End of Life Care Facilitator but further audit work could usefully be done to ensure that the issues concerning patient moves is formally identified and measured in order to allow monitoring of improvements, for example, the moving of patients from ward to ward, no formal audit had been carried out to identify the accuracy of the issue and therefore to be able to monitor improvements.

Requires improvement

Outpatients

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

Information about the service

The hospital did not have a dedicated outpatients department but clinics linked to the inpatient specialty. From data we received from the trust, we could see that there were about 30 different outpatient clinics and in 2012 there were 35,000 outpatient appointments.

We visited eight outpatient services in orthopaedics, endocrinology, children's, neurology, ophthalmology, audiology, falls and stroke. We spoke with nine patients and nine staff. Information about the children's outpatients clinic is described in more detail in the children's section. We received information about the outpatients' service through our learning event and 'comment cards' completed by staff and patients during our inspection. We also spent time in the clinics observing interactions between staff and patients. In addition, we spent time in the medical records department and spoke with the staff there. Before the inspection, we reviewed information provided to us by the trust about the outpatients service.

Summary of findings

The outpatients clinics that we visited were clean, and staff followed good infection control practices. The physical environment varied between clinics with some providing spacious waiting areas and others having more restricted space. Staff were aware of the reporting procedures for incidents. The main risk to patient safety was the number of occasions when patient records were not available at the time of their outpatient's appointment.

Patients and their relatives told us that they were treated with respect and dignity. They said the staff were caring and gave them information. This was confirmed in our observations. The main concerns raised by patients were the issue of parking and the current system for booking appointments.

There were breaches of the timescales for some follow-up appointments in some of the clinics and there were variations within clinics as to the percentage of patients who were seen for their initial appointment within the 18-week target.

The outpatients clinics each came under the leadership of the inpatient specialty that they were linked to. This meant there was a lack of clear leadership over the outpatient's service as a separate entity. The records relating to staff training and appraisal were included within the wards' statistics, which meant it was difficult to ascertain levels of compliance in either mandatory training or personal development plans (PDPs) undertaken for the staff working in outpatients.

Requires improvement

Outpatients

Are outpatients services safe?

Requires improvement

Managing risks

The nine staff we spoke with were aware of the procedure in place in the hospital for reporting incidents and told us that they knew how to use the computerised reporting system. Staff told us that they felt that they were informed of learning from incidents but were not able to provide us with examples of these as they said that they had not reported any recently.

Infection prevention and control

The outpatients clinics that we saw were clean. There was hand gel available for staff and patients and hand washing facilities which we observed staff using. We received two completed comment cards that particularly mentioned the high standard of cleanliness within the outpatients clinics. The latest patient led assessment of the care environment (PLACE) showed that the hospital scored 99.4% in its overall cleanliness scores.

Safeguarding patients

Staff told us that they received mandatory training about safeguarding vulnerable adults and children as part of their induction and then received updates at set intervals. The staff we spoke with were aware of how to make a referral if they were concerned about possible abuse. We were not able to look at training records relating to staff working in outpatients clinics as the records relate to the clinical areas that each clinic is linked to rather than individual outpatients clinics. On 16 January 2014 the overall rate across the trust was 76% for completion of the introduction to safeguarding training and 64% for attendance at the half day safeguarding vulnerable adults training. The training records show that across the trust 96% of staff had attended an introduction to safeguarding children training and 68% had attended a half day course with regard to safeguarding children.

Patient records

The staff who we spoke with in the outpatients clinics told us that there was a problem with the availability of patient records and that this had got worse over the previous few months. We were told by senior clinicians that on one day of our visit there were 29 sets of patient records missing from the required 97 relating to patients being seen that day. This was also raised with us as a concern by staff from other departments throughout our inspection.

We spoke with two of the reception staff who showed us the system that should be used to track the patient records from the medical records department to wherever they were used within the hospital site. We saw that the receptionist used this system effectively. However, other staff told us that they did not always use the tracking system as "it took too long". We received a comment card from a patient who said that they had attended an outpatients' clinic and their notes were not available. This issue was also raised with us by staff throughout our inspection.

One of the consultants told us that the effects on the patients of missing records was slightly mitigated through some of the records, including GP letters, being available on the computer. However, not all patient records are digitalised and there was a risk that clinicians were treating patients without their full medical history and treatment plan being available. In addition to this, staff told us that delays to appointments occurred whilst staff were trying to find missing records.

We spent time in the medical records department and spoke with the staff there. They confirmed that there were regularly issues with missing notes and that the staff did not all use the tracking system that is available to them. The trust's risk register included an entry about notes not always being available in the oncology unit but it did not include the issue of missing notes within the various outpatient departments. We did not see and were not advised of any action being undertaken to address this issue. The impact of not having records affected both the clinician seeing the patients as they did not have all the information to inform their decision and the patients experience as they often had to explain their past medical history, it was noted on the inspection that patients were aware of this issue within the trust.

Staffing

Patients told us that they thought that the staff were well trained and appropriately qualified for the role that they were carrying out. Staff told us that they "usually" had the correct staffing numbers on duty. They said that they used bank nurses to cover any gaps in the nursing staff in the clinics. There was also a system for 'bank' administrative

Requires improvement

Outpatients

staff and we spoke with one member of staff who was covering at a clinic where the receptionist was on leave. They said that they had worked there previously and had received an induction to the clinic at that time. One of the nursing staff told us that they rarely had to cancel patients due to issues with staffing and that all staff did what they could to enable appointments to go ahead.

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

National guidelines and clinical audit
There was little evidence of clinical audit or that the trust was monitoring the effectiveness of clinical practice against standards across outpatient services other than in the ophthalmology clinic. One of the consultants in this department told us that the trust had requested that the Royal College of Ophthalmology carry out a review of their ophthalmology department. This had taken place last year and the consultant said that there had been improvements in the effectiveness of this clinic following the implementation of the reviews recommendations.

Clinical management
Most patients told us that they had enough time to talk with staff and ask questions of the nursing and medical staff, although one person told us that they had felt that one of their appointments had been, "rushed, with no time to discuss details".

We spoke with one person at our listening event who told us that they regularly received treatment from more than one outpatients clinic and that they had nothing but praise for the nursing and clinical staff. They said that they were always kept informed about the treatment options available and asked for their opinion about their treatment plan. They also said that there was good communication between clinics as the staff at each clinic were aware of the treatment they had received from other outpatients clinics and could plan their treatment accordingly.

Are outpatients services caring?

Good

We spoke with people who were waiting to be seen in the different outpatients clinics. They all told us positive things about the quality of the care that they had received from the staff. One person told us, "we just can't praise them enough", whilst another said, "they are really kind". Two relatives of patients told us that they were always made to feel included and that the medical and nursing staff were happy for them to accompany their relative into the clinic. One patient told us that the consultant that they had seen had been, "excellent in every way". Another patient told us that the doctors were, "brilliant, an excellent service".

There was one patient who described to us at our listening event how "amazing, super and caring " the nurses were on Rowan ward; however he went on to tell us he should have seen the consultant in OPD four weeks after discharge and at the listening event three months later he was still waiting to see him. He had called his secretary five times.

During our observations in the clinics we observed staff to be kind, friendly and caring in their interactions with patients. They spoke with people in a clear way and explained to them what the process would be with regard to their appointment. We also observed two examples of patients who had additional needs relating to dementia and in both situations the staff communicated effectively and patiently. One of the relatives who we spoke with told us that the staff always communicated with their relative at a level they could understand.

Are outpatients services responsive to people's needs?
(for example, to feedback?)

Requires improvement

The environment
We received a completed comment card that stated that there had recently been improved access at the ophthalmology clinic for those patients who have difficulty in mobilising. The clinics that we saw varied greatly with regard to the physical environment. For example, the

waiting room in the falls and stroke clinic was large with plenty of room for people to sit and with enough space for people using wheelchairs to mobilise. There were electronic doors which enabled people to easily access the clinic. However, the environment of the fracture clinic was crowded with little space for people to move around easily and wait in comfort.

Communication with GPs

We looked at data relating to the length of time that it took for letters to be sent to the patient's GP following an outpatient's appointment. The overall scorecard which was being presented to the Board looked overwhelmingly positive, however on closer inspection the majority of clinics where consistently taking longer than the target of five days to send letters to GP.

Waiting times

We spoke with patients about whether their appointments took place at the allotted time. Their views were mixed but the majority said that they did not wait excessively. Their views were split equally between patients who said that they were informed about any delay to their appointment time and those who said that they were not kept informed. One person told us that they had not had any information regarding why their previous appointment had been cancelled the month before and had just been sent a letter to say it had and then another letter confirming the new appointment. There had been one month between the appointment dates. Staff told us that the consultants saw their own patients and so if a consultant was unavailable then appointments may need to be cancelled or rearranged. We looked at the hospital episode statistics which showed that for the period of April 2010 to August 2013 the hospital was above the average median percentage for patient cancelled appointments but below the median percentage for hospital cancelled appointments. However, this data did not provide us with details about the individual clinics that this related to.

We spoke with staff in the stroke outpatients clinic and they said that they met the targets set for GP-referred patients to see the consultant. For example, if a patient scored a '4' or above on their assessment then they saw the consultant within 24 hours. They showed us the assessment paperwork that they completed and described the assessment process. This information was audited by the trust as part of their on-going monitoring of whether the stroke service. They explained that when the clinic was not open then patients were either seen at the clinics run by specialist nurses or were admitted to the wards.

We looked at data that the trust had provided for us and this showed that there had been breaches in the timescales for follow-up appointments for urology and ophthalmology. We also saw from the most recent outpatients performance data (6 January 2014) that over 98% of patients had been seen for their first appointment within the 18-week target, except for trauma and orthopaedics which had a score of 93.8%.

A consultant told us that they had improved the waiting times for patients in the ophthalmology department following the review. This was confirmed to us by someone at our listening event who said that the waiting time for appointments at that clinic had reduced over the last few months and that it appeared to be more organised.

Vulnerable patients

We spoke with the member of staff responsible for the management of the staff who takes a lead on ensuring that the needs of patients with a learning disability are met. They told us that the learning disability liaison nurse was working with the community learning disability team to improve the number of people with a learning disability who have a hospital 'passport'. This is a document that includes information the person's health and personal care needs are as well as how to effectively communicate with them. They also gave us examples of how the learning disability liaison nurse had been working with the care team that support a person with a learning disability so that they were as prepared as they could be for their forthcoming appointments. They said that the trust could offer extended outpatient appointments and also visits to the clinics prior to the appointment to help the person orientate themselves. The same manager also line managed the staff who took on a lead role for patients with dementia.

Booking appointments

We spoke with patients about the booking system and we also received information about this at our listening event. Patients' views were mixed with an almost equal split between those who said that they had never had any problems with the booking system and had not had appointments cancelled and those who said that they were not happy with the booking system, and/or that their

appointment had been cancelled. The views of patients were not consistently positive or negative about any one clinic. There appears to be issues for some patients at all clinics that we visited. One patient told us that they used more than one clinic and that there are different ways of booking appointments. They said that sometimes they booked future appointments directly with the reception staff and other times they were sent an appointment by post at a later date. The trust uses an external company to confirm bookings with patients. This is done by an automated telephone call to the patient varying from two to seven days prior to their appointment. The patient is required to respond to automated questions through using their telephone key pad. Two patients raised concerns with us about this system as they felt it was not easy for frail patients, or those with dementia, to use. They were also concerned that it would be very easy to accidentally cancel the appointment without realising it. One patient explained they accidentally cancelled their appointment and could not be rescheduled until May.

Administrative staff told us that the consultants saw their 'own patients'. This was positive with regard to the patients seeing a consultant who knew them and who had possibly also treated them as an inpatient on one of the wards. However, the consultants did not cover for each other and so if one was unavailable then their patients' appointments were rearranged which led to the risk of patients having their appointments delayed. We spoke with someone at our listening event who was concerned about this as it had happened to their relative. On a positive note, the administrative staff told us at one of the clinics that they were contacting patients to see if they could come in for an earlier appointment than planned as the consultant was unexpectedly free that week.

Parking

Every patient that we spoke with about the parking situation said that it was difficult to find a parking space and that this caused them particular stress when they were attending for an appointment as they were worried about being late. One patient who we spoke with was in the waiting room for nearly an hour ahead of their appointment time and they said that this was because they had left so much time to allow for finding a parking space. One relative told us that they always brought their relative to their appointments so that they did not have to worry about finding a parking space which they did if they came on their own.

Are outpatients services well-led?

Requires improvement

Leadership

As the trust does not have a dedicated outpatients department there was little overall management and oversight of the outpatients clinics. There was no shared vision for the future of the outpatients clinics and how improvements may be made. Improvements and learning from situations appeared to happen in isolation. However, within the different clinics there was strong clinical leadership. The nursing staff told us that they felt well supported by the consultants and medical staff. There were senior medical staff present in the outpatients clinics and so support and advice was able to be obtained quickly.

In the most recent national outpatients survey (2011) the trust scored 'about the same' as other trusts. However, they did score 'better than expected' with regard to patients being told how to find out their test results and having the results explained to them.

Managing quality and performance

The individual clinics had audits of some of their performance data but there did not appear to be any clear system for overall governance of the outpatient's clinics. For example, there was no action plan for the issue of missing patient records. There was no evidence of shared learning from complaints or compliments.

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
Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services. How the regulation was not being met: People who use the service were not protected against the risks associated with unsafe care because of inadequate monitoring of food supplements and the calculation of body mass index. Regulation 9 (1) (b) (ii).

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 16 HSCA 2008 (Regulated Activities) Regulations 2010 Safety, availability and suitability of equipment. How the regulation was not being met: People who use the service were not protected against the risks associated with unsafe or unsuitable equipment because of inadequate maintenance. Regulation 16 (1) (a).

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records. How the regulation was not being met: People who use the service were not protected against the risks associated with a lack of proper information and documents (including the DNACPR) being accurately recorded about their care and treatment. Regulation 20 (1) (a).

This section is primarily information for the provider

Compliance actions

	The registered person has not ensured that records can be promptly required when people attend outpatient appointments. Regulation 20 (2) (a).The registered person has not ensured that records can be promptly located when people attend outpatient appointments. Regulation 20 (2) (a).

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting workers. How the regulation was not being met: Staff were not supported to deliver care and treatment safely to people using the service as they did not receive appropriate training, supervision and appraisal. Regulation 23 (1) (a).

Regulated activity	Regulation
Maternity and midwifery services	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises. How the regulation was not being met: People who use the service were not protected against the risks associated with appropriate measures in relation to the security of the premises as the door to the delivery room was left open for a period of three minutes during our inspection. Regulation 15 (1) (b).