Care Quality Commission

Hinchingbrooke Health Care NHS Trust

Hinchingbrooke Hospital

Quality Report

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

The Care Quality Commission (CQC) carried out a comprehensive inspection which included an announced inspection visit between the 16 and 18 September 2014 and subsequent unannounced inspection visits on 21 and 28 September. We carried out this comprehensive inspection of the acute core services provided by the trust as part of Care Quality Commission's (CQC) new approach to hospital inspection. We returned on 2 January 2015 to ensure that the care provided on Apple Tree and Juniper wards and in the Emergency department had improved. We did not re-inspect the whole hospital nor did we look at every aspect of care at this inspection. We reviewed many aspects of the domains of safe and well led in the Emergency services, safe caring and well led in Medicine and caring in Surgery as these were all previously rated as inadequate. Where we inspected we have amended the report in line with our most recent findings.

Hinchingbrooke Hospital is an established 304 bed general hospital, which provides healthcare services to North Cambridge and Peterborough. The trust provides a comprehensive range of acute and obstetrics services, but does not provide inpatient paediatric care, as this is provided within the location by a different trust. The trust is the only privately-managed NHS trust in the country, being managed by Circle since 2012. The Trust's governance is derived from the Franchise Agreement and Intervention Order approved by the Secretary of State for Health**.** This approach empowers all members of staff to take accountability and responsibility for the planning and implementing of a high quality service.

Prior to undertaking the inspection in September 2014 we spoke with stakeholders and reviewed the information we held about the trust. Hinchingbrooke Health Care NHS Trust had been identified as low risk on the Care Quality Commission's (CQC) Intelligent Monitoring system. The trust was in band 6, which is the lowest band.

The hospital was first built in the 1980s. It was the first trust in the country to be managed by an independent healthcare company, Circle, which occurred in February 2012. It is led by a multidisciplinary team of clinical and non-clinical executives partnered with a non-executive Trust Board. However we found that the trust was predominantly medically led but a new director of nursing had been appointed four months prior to our visit and was beginning to address the input of nursing within the hospital.

We found significant areas of concern during our inspection visit in September 2014 which we raised with the chief executive, director of nursing, head of midwifery and the chief operating officer of the trust and the next day with the NHS Trust Development Authority. We were concerned about patients safety and referred a number of patients to the Local Authority safeguarding team. Since the inspection the Trust Development Authority have given the trust significant support to address the issues raised in this report. CQC served a letter which informed the trust of the nature of our concerns in order that action could be taken in a timely manner. CQC also requested further information from the trust as we considered taking urgent action to reduce the number of beds available on Apple Tree Ward. However the trust took the decision to reduce the number of beds as part of their action plan and so this regulatory action was therefore not necessary. The matter has been kept under review and the CQC has undertaken two unannounced inspections, attended the Annual Public Meeting [i.e. the Annual General Meeting] on 25 September 2014 and held two follow up meetings with the trust to ensure that action has been taken. We returned on 2 January 2015 to review progress made in Apple Tree and Juniper wards and in the ED in respect of the inadequate ratings. We found that improvements had been made in respect of the inadequate ratings for medicine and surgery but that there was little or no improvement within the emergency department. We have rated the domains of safe, caring and well led in medicine and caring in surgery as requiring improvement but the emergency department remains inadequate for well led but has moved to requires improvement in safe. Overall the location is now rated as requires improvement.

Our key findings were as follows:

Summary of findings

- We found many instances of staff wishing to care for patients in the best way, but unable to raise concerns or prevent service demands from severely impinging on the quality and kindness of care for patients. In both maternity and critical care we noted good care, focused on patients' needs, meeting national standards.
- In September 2014 we found that the provision of care on Apple Tree Ward, a medical ward, was inadequate and there were risks to patient safety. This required urgent action to address the concerns of the inspection team. We re-inspected this area in September 2014 and in January 2015 and found that the hospital had taken action. We found that risks to patient safety were reduced on this visit.
- In September 2014 we found that there was a lack of paediatric cover within the ED and theatres that meant that the care of children in these departments was, at times, increasing potential risks to patient safety. However the trust took immediate action and employed temporary peadiatric staff. The trust has since appointed permenent peadiatric start who should be in place by the end of February 2015. Therefore mitigating the risks in this area, however we have yet to be assured that the risks are sufficiently mitigated.
- The senior management team of the trust are well known within the hospital; however, the values and beliefs of the trust were not embedded, nor were staff engaged or empowered to raise concerns by taking responsibility to 'Stop the Line'. Stop the line is a process which empowers all members of staff to raise immediate concerns when they believe that patient safety is being compromised. Initiating a "Stop the Line" facilitates management support to the area identified and action to address the issue. We did not review this issue in January 2015 as we were aware that the trust was reviewing their governance systems.
- In September 2014 we found that there was a lack of knowledge around Adult Safeguarding procedures, Mental Capacity Act and Deprivation of Liberty processes. The trust has taken action to improve the knowledge of staff in these areas however we did not inspect all areas of the trust in January 2015.
- In September 2014 we found that response to call bells in a number of areas, in Juniper Ward, Apple Tree ward and the Reablement Unit for example, was so poor that two patients of the 53 we spoke to in the medical and surgical areas stated that they had been told to soil themselves. A further one patient advised that they had soiled themselves whilst awaiting assistance. We brought this to the attention of the trust and they investigated. However neither CQC nor the trust could corroborate these claims. Since September we have had information of concern that supports that this was still occurring in November 2014. At our January 2015 inspection we found that responses to call bells had improved on the two wards we inspected.
- In September 2014 we found that risk assessments were not always reflective of the needs of patients in surgery and medical wards. This was evidenced by review of 46 sets of notes of which 19 were found to have incomplete information or review. At our inspection in January 2015 we reviewed eight sets of notes and found that risk assessments continued to be poorly documented and personalised to individual patients.
- In September 2014 we found that infection control practices were not always complied with in ED, Apple Tree ward, Cherry Tree ward, Walnut ward and in the Treatment Centre. When we inspected Apple Tree ward in January 2015 we noted significant improvements in infection control practices.
- In September 2014 we found that medicines, including controlled drugs, were not always stored or administered appropriately in ED, Juniper ward, Apple Tree ward or Cherry Tree ward. When we inspected in January 2015 we found that medicines in ED, Apple Tree and Juniper wards had improved but required action to be taken to ensure the safety and efficacy of medication.

In September 2014 we saw several areas of good practice, which we did not reinspect in January 2015, including:

- In both maternity and critical care we noted good care, focused on patients' needs, meeting national standards.
- The paediatric specialist nurse in the emergency department was dynamic and motivated in supporting children and parents. This was seen through the engagement of children in the local community, in a project to develop an understanding of the hospital from a child's perspective, through the '999 club'.
- The support that the chaplaincy staff gave to patients and hospital staff was outstanding. The chaplain had a good relationship with the staff, and was considered one of the team. The number of initiatives set up by the chaplain to support patients was outstanding.

Summary of findings

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

Importantly, the trust must:

- Ensure all patients' health and safety is safeguarded, including patient's nutrition and hydration needs are adequately monitored and responded to.
- Ensure that staffing levels and skill mix on wards is reviewed and the high usage of agency and bank staff to ensure that numbers and competencies are appropriate to deliver the level of care Hinchingbrooke Hospital requires.
- Ensure records, including risk assessments, are completed, updated and reflective of the needs of patients.
- Ensure that there are sufficient appropriately skilled nursing staff on medical and surgical wards to meet patients' needs in a timely manner.
- Ensure medicines are stored securely and administered correctly in the ED and that liquid preparations are marked with opening dates in the medical and surgical wards.
- Ensure that all staff are trained in, and have knowledge of their responsibilities under the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS).
- Ensure that patients are treated with dignity and respect in the Emergency department.
- Ensure that all staff are adequately supported through appraisal, supervision and training to deliver care to patients.
- Ensure pressure ulcer care is consistently provided in accordance with National Institute for Health and Care Excellence (NICE) guideline CG:179.
- Ensure that catheter and intravenous (IV) care is undertaken in accordance with best practice guidelines.
- Ensure patients are treated in accordance with the Mental Capacity Act 2005.
- Ensure that the staff to patient ratio is adjusted to reflect changing patient dependency.
- Review the 'Stop the Line' procedures and whistle blowing procedures, to improve and drive an open culture within the trust.
- Standardise and improve the dissemination of lessons learnt from incidents to support the improvement of the provision of high quality care for all patients.
- Ensure that all appropriate patients receive timely referral to the palliative care service.
- Ensure action is taken to improve the communication with patients, to ensure that they are involved in decision-making in relation to, their care treatment, and that these discussions are reflected in care plans.
- Review mechanisms for using feedback from patients, so that the quality of service improves.
- Ensure that the checking of resuscitation equipment in the A&E department, and across the trust, to ensure that it occurs as per policy.

In addition, the trust should:

- Take action to reduce the over burdensome administration processes when admitting patients into the acute assessment unit (AAU).
- Review intentional rounding checks to ensure that they cover requirements for meeting patient's nutrition and hydration needs.
- Involve patients in making decisions about their care in the A&E department.
- Review the training given to staff, and the environment provided, for having difficult discussions with patients.
- Provide adequate training on caring for patients living with dementia, to improve the service to patients living with dementia.
- Review the clinical pathways for termination of pregnancies in the acute medical area.
- Review the policy on moving patients late at night.
- Review the out-of-hours arrangements for diagnostic services, such as radiology and pathology, to ensure that patients receive a timely service.
- Review mechanisms for fast track discharge, so that terminally ill patients die in a place of their choice.

Summary of findings

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	Requires improvement 	In September the emergency department at Hinchingbrooke Hospital was inadequate in respect of the safe and well-led domains. We could not be assured that there were sufficient assurance processes in place to demonstrate that patients were not at high risk of harm when we inspected. There was minimal incident reporting and recording within the emergency department. We could not see that completed incident reports had a clear 'lessons learnt' approach. We looked at equipment which was visibly clean, but found that some equipment was not maintained to the manufacturer's recommendations with service labels highlighting that a service was due. Medication was not securely stored appropriately, and daily checks on emergency resuscitation trollies were not carried out by staff. Staff vacancies were covered with bank and agency staff which accounted for over a quarter of the staff numbers. We returned in January 2015 and found that these issues persisted. However we reviewed the key question of safety and found that this had improved and rated the department as requiring improvement for this question, but remained inadequate in leadership as this had yet to be embedded. In September 2014 we found that paediatric cover for children in this department was not sufficient to cover 24 hours, and staff did not have the competency to care for children when paediatric nurses were not on duty. Since our visit the trust has employed paediatric agency and bank staff to cover 24 hours. At our inspection in January 2015 we found that the trust had recruited two paediatric nurses who would be in post by the end of February 2015. Clinical outcomes and monitoring of the service showed that the trust was not an outlier when compared to others however we found that the provision of care was not assured by the leadership, governance or culture in place during our inspections. Patients were routinely triaged within the waiting room area with no consideration for their privacy or dignity. This practice was not in line with

departmental expectations; the trust does provide a private room suitable for triage and expects staff to offer patients a choice. There was a senior member of nursing staff who was designated as a shift coordinator, but we found that the management of the department was weak. When busy, two staff told inspectors that they accepted that they could not give the care that they would wish to do so. We heard one patient request assistance and a member of staff told them that they did not have time but would return. However after 30 minutes the patient stated that no one had returned. We raised this issue to a member of staff who assisted the patient.
The department was not responsive to the needs of all of the people who used it. Children had no separate waiting area and treatment rooms designed for children were not always used for them. There were higher than the England average number of people who left the department before being seen due to long waiting times and those who were to be admitted also spent considerable lengths of time in the department. The escalation protocol was not used effectively to reduce patients waiting times
Mental capacity assessments were being undertaken appropriately, and staff demonstrated knowledge around most of the trust's policy and procedures. We saw that staff were rushed with their workload, but took the time to listen to patients, and explain to them what was wrong and any treatment required. The staff we spoke with were proud to work in the emergency department.

Medical care — **Requires improvement**

At our September 2014 inspection we found medical services were inadequate because we found poor emotional and physical care which was not safe or caring. This was not reported by leaders of the service to the trust management therefore we judged the leadership to be inadequate. Services were not caring because people were not treated with dignity or respect. We were also concerned that people were not being treated in an emotionally supportive manner. Hand hygiene and infection control techniques were poor. Staffing numbers were not always reflective of patient dependency. Examples of treatment without consent were identified on one patient who lacked mental

Summary of findings

capacity but we found an under recognition of patients who may lack capacity throughout the medical wards. Services were not effective because pressure ulcer prevention and treatment was not always provided in line with NICE guidelines. There were no seven day services provided by the hospital. The service was not responsive; we found that medical patients were not always classed as outliers despite requiring specialised care. This meant that the frequency of review by their own consultant might be reduced. The Medical Short Stay Unit and the Reablement Centre were not utilised for their intended purpose.

The service was not well-led. We found that the culture of identifying, reporting and escalating concerns was not open. We found that teams were not engaged or felt enabled to raise concerns. We wrote to the trust to express our concerns and with the support of the Trust Development Authority action is underway to address these.

In January 2015 we found that the standard of care on Apple Tree ward had improved. We saw that patients were treated with dignity and respect. The leadership of the ward team had improved and staff felt able to report behaviours which were not in keeping with a good standard of care. Audits were undertaken in order to ensure that an acceptable level of care was being provided by staff. Staff felt better engaged and supported by senior managers. The team had a greater understanding of the care of vulnerable patients and had good working relationships with the local safeguarding and deprivation of liberties teams. However documentation required improvements to ensure that the care of patients was recorded and utilised to improve treatment.

Surgery

Requires improvement

In September 2014 the surgical services required improvement because there were significant risks and deficiencies evident across four areas of our inspection domains. The safety of patients was at risk due to delays in nurses attending when patients call for help. In Juniper Ward there was a clear consensus from many patients that they were not cared for safely because it took too long for nurses to respond, in particular at night time. However the trust produced data which demonstrated that the

Summary of findings

average response time in the week prior to our visit was on average four minutes, this meant that this may have been an emerging issue. We found that there were continuing problems of medication not being administered as prescribed. Nursing care records and plans did not always reflect the current needs of the patient, or have clear guidance of the care to be provided.

Patient outcomes were good in certain respects, such as low incidence of pressure ulcers, and low readmission rates indicating successful overall treatment. Many issues were evident and had been identified by the trust, but action had not been taken to improve the issues or actions taken had not been effective. It was not evident that staff could easily raise issues they were concerned about, either in their own teams or across professional boundaries.

In January 2015 we inspected Juniper ward in respect of the issues which we found in September 2014. We found that the response times to call bells was on average 3 minutes during our inspection and patients reported that staff attended them appropriately. During January 2015 we received information from a relative that a patient had been told to soil their bed in November 2014 however we did not see this practice during our inspection. We found that issues relating to documentation still required improvement to ensure that patients received appropriate care.

Requires improvement

Hinchingbrooke Hospital

Detailed findings

Services we looked at
Accident and emergency; Medical care (including older people's care); Surgery;

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Background to Hinchingbrooke Hospital

Hinchingbrooke Hospital is an established 304 bed general hospital, which provides healthcare services to North Cambridge and Peterborough. The hospital provides a comprehensive range of acute and obstetrics services. The trust does not provide general inpatient paediatric care, as this is provided within the location by a different trust. However children are seen in the A&E department, operating theatres and in outpatients by Hinchingbrooke Health Care NHS Trust staff. The trust is the only privately-managed NHS trust in the country, being managed by Circle since 2012.The Trust's governance is derived from the Franchise Agreement and Intervention Order approved by the Secretary of State for Health**.** This approach is intended to empower all members of staff to take accountability and responsibility for the planning and implementing of a high quality service.

The average proportion of Black, Asian and minority ethnic (BAME) residents in Cambridgeshire (5.2%) is lower than that of England (14.6%). The deprivation index is lower than the national average, implying that this is not a deprived area. However, Peterborough has a higher BAME population and a higher deprivation index.

The Care Quality Commission (CQC) carried out a comprehensive inspection which included an announced inspection visit between the 16 and 18 September 2014 and subsequent unannounced inspection visits on 21

Detailed findings

and 28 September and attended the Annual Public Meeting on 25 September 2014. The trust had been identified as a low risk through CQC's intelligence monitoring. We returned to inspect Apple tree and Juniper wards and the Emergency department on 2 January 2015 to ensure that actions had been taken to ensure patients safety.

Our inspection team

In September 2014 our inspection team was led by:

Chair: Jonathan Fielden, Medical Director, University College London Hospitals

Head of Hospital Inspections: Fiona Allinson, Care Quality Commission

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

In January 2015 our inspection team was led by:

Head of Hospital Inspections: Fiona Allinson, Care Quality Commission

The team included five CQC inspectors of which four were nurses and one a paramedic.

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 announced inspection visit took place between the 16 and 18 September 2014, with subsequent unannounced inspection visits on 21 and 28 September and attended the Annual Public Meeting on 25 September 2014. The focused inspection took place on 2 January 2015 at 10am and lasted for approximately four hours.

Before visiting in September 2014, we reviewed a range of information we held, and asked other organisations to share what they knew about the hospital. These included the clinical commissioning group (CCG); Monitor; NHS England; Health Education England (HEE); General Medical Council (GMC); Nursing and Midwifery Council (NMC); Royal College of Nursing; College of Emergency Medicine; Royal College of Anaesthetists; NHS Litigation Authority; Parliamentary and Health Service Ombudsman; Royal College of Radiologists and the local Healthwatch.

We held a listening event on 16 September 2014, when people shared their views and experiences of Hinchingbrooke Hospital. Some people who were unable to attend the listening event shared their experiences with us via email or by telephone.

We carried out an announced inspection visit between 16 and 18 September 2014. We spoke with a range of staff in the hospital, including nurses, junior doctors, consultants, administrative and clerical staff, radiologists, radiographers and pharmacists. We also spoke with staff individually as requested. We carried out unannounced visits on Sunday 21 September to Apple Tree Ward, Thursday 25 September to the Annual Public Meeting, and Saturday 28 September 2014 to the emergency department, Juniper and Apple Tree Wards. During these unannounced visits we spoke with staff, patients and relatives.

In January 2015 we spoke with a range of staff at the hospital including nurses and doctors and spoke with 11 patients on the wards and areas we inspected.

Detailed findings

In September 2014 we talked with patients and staff from all the ward areas and outpatient services. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' records of personal care and treatment.

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

Facts and data about Hinchingbrooke Hospital

Beds

304 (260 General and acute, 38 Maternity and 6 Critical care)

Inpatient admissions

Outpatient attendances 93,000 (2012/13)

A+E attendances 38,813 (2013/14)

Births 2,193 births April 2013 March 2014

Deaths 493 (April 2013 – March 2014) 102 (April 2014 – June 2014)

Annual turnover £111.5m

Surplus (deficit) -£1m

Intelligent Monitoring

Elevated risk scores in well led 1

Risk score in well led 1

Total risk score 3

Individual risks/elevated risks

- NHS Staff Survey - KF7. The proportion of staff who were appraised in last 12 months (01-Sep-13 to 31-Dec-13)

By Domain

Safe

Never events (April 2013 -May 2014) 0

Serious incidents (STEIs) (April 2013- May 2014) 41

National reporting and learning system (NRLS) (April 2013- May 2014)

Deaths 5, Severe 31, Moderate 86 Total 122

Effective:

HSMR: IM Indicator: No evidence of risk

SHMI: IM Indicator: No evidence of risk

Caring:

CQC inpatient survey 2013:

The trust scored average for all 10 sections.

- In Subsection 4: The hospital and ward the trust scored below average question 19. Did you feel threatened during your stay in hospital by other patients or visitors?

Cancer patient experience survey 2012/13:

Of all 68 questions the trust scored

- In the highest 20% of all Trusts for 6 questions
- In the lowest 20% of all Trusts for 8 questions

Responsive:

Bed occupancy: In Q1 2014 the trusts average daily bed occupancy for all General and Acute beds was 82.7% which is less than both the England average of 89.5% and the 85% percent standard where it is suggested level of patient care would be affected.

length of stay:

April 2013 to March 2014

- Elective
  - Trust Average = 4 days
  - England Average = 4 days
- Non-Elective
  - Trust Average = 6 days
  - England Average = 7 days

A+E: 4 hour standard:

IM Indicator: Composite indicator: A&E waiting times more than 4 hours (05-Jan-14 to 30-Mar-14) - No evidence of risk April 2014 – May 2014

- Average A&E 4 hour waiting time target is 96%

Detailed findings

Out of 52 weeks which ended in 2013/14, the trust missed the 95% target 13 times. Hinchingbrooke was above the England average in 38 of 52 weeks, or 73% of the time. However the current year to date figure is just over 95% which is in line with the expected average.

Cancelled operations:The proportion of patients whose operation was cancelled (01-Jan-14 to 31-Mar-14) - No evidence of risk

18 week RTT

IM Indicator: Composite indicator: Referral to treatment (01-Mar-14 to 31-Mar-14) - No evidence of risk April 2013 – March 2014

- 18 week RTT consistently above operational standard of 90%

Well led:

Staff survey

Of all 28 questions the trust scored

- Above average for all NHS Trusts for 2 questions
- Below average for all NHS Trusts for 13 questions

Sickness rate

IM Indicator: Composite risk rating of ESR items relating to staff sickness rates (01-Apr-13 to 31-Mar-14) - No evidence of risk April 13 – Dec 13

- Average Trust sickness rate was 4.2% while that for England was 4%

The trust's average sickness rate was greater than that for England for seven out of nine months.

GMC Training Survey 2014: Out of 12 survey areas the trust scored within the interquartile range (so about average) for 11, but was significantly worse than expected for one area, which was Feedback.

GMC - Enhanced monitoring (01-Mar-09 to 21-Apr-14)

Detailed findings

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Inadequate	Requires improvement
Medical care	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement
Surgery	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Overall	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement

Notes

Urgent and emergency services

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

Information about the service

The emergency department (ED) at Hinchingbrooke Hospital provides a 24 hour, seven day a week service to the local area. Patients present to the department either by walking into the department via the reception area, or arriving by ambulance. The department has facilities for assessment, treatment of minor and major injuries, a resuscitation area and a children's provision ED service. There is an acute assessment unit (AAU) within the same directorate, for which patients are admitted for up to 24 hours.

On average, the emergency department saw around 38,800 patients a year between 2013 and 2014, which equated to around 746 patients a week. The emergency department is a member of a regional trauma network. The hospital does not provide any other hyper-acute services

In September 2014 our inspection included two days in the emergency department as part of an announced inspection, and an unannounced visit on Sunday 27 September 2014. During our inspection, we spoke with clinical leads from medical and nursing disciplines for the department. We spoke with six members of the medical team (of various levels of seniority), seven members of the nursing team (of various levels of seniority) and administration staff. The emergency department sees, on average, just over 100 patients in any given day. During our inspection, we spoke with 13 patients and undertook general observations within all areas of the department. We reviewed the medication administration and patient records for patients in the emergency department.

In January 2015 our inspection in the emergency department was an unannounced inspection following up from concerns within our previous inspection in September 2014. During our inspection, we spoke with nursing leads for the department. We spoke with three members of staff (of various levels of seniority); We also spoke with four patients and undertook general observations within all areas of the department. We reviewed the medication management and emergency equipment records in the emergency department.

Urgent and emergency services

Summary of findings

In September the emergency department at Hinchingbrooke Hospital was inadequate in respect of the safe and well-led domains. We could not be assured that there were sufficient assurance processes in place to demonstrate that patients were not at high risk of harm when we inspected. There was minimal incident reporting and recording within the emergency department. We could not see that completed incident reports had a clear 'lessons learnt' approach. We looked at equipment which was visibly clean, but found that some equipment was not maintained to the manufacturer's recommendations with service labels highlighting that a service was due. Medication was not securely stored appropriately, and daily checks on emergency resuscitation trollies were not carried out by staff. Staff vacancies were covered with bank and agency staff which accounted for over a quarter of the staff numbers. We returned in January 2015 and found that these issues persisted. However we reviewed the key question of safety and found that this had improved and rated the department as requiring improvement for this question but remained inadequate in leadership as this had yet to be embedded.

In September 2014 we found that paediatric cover for children in this department was not sufficient to cover 24 hours, and staff did not have the competency to care for children when paediatric nurses were not on duty. Since our visit the trust has employed paediatric agency and bank staff to cover 24 hours. At our inspection in January 2015 we found that the trust had recruited two additional substantive paediatric nurses who would be in post by the end of February 2015.

Clinical outcomes and monitoring of the service showed that the trust was not an outlier when compared to others however we found that the provision of care was not assured by the leadership, governance or culture in place during our inspections. Patients were routinely triaged within the waiting room area with no consideration for their privacy or dignity. This practice was not in line with departmental expectations; the trust does provide a private room suitable for triage and expects staff to offer patients a choice. There was a senior member of nursing staff who was designated as a shift coordinator, but we found that the management of the department was weak. When busy, two staff told inspectors that they accepted that they could not give the care that they would wish to do so. We heard one patient request assistance and a member of staff told them that they did not have time but would return. However after 30 minutes the patient stated that no one had returned. We raised this issue to a member of staff who assisted the patient.

The department was not responsive to the needs of all of the people who used it. Children had no separate waiting area and treatment rooms designed for children were not always used for them. There were higher than the England average number of people who left the department before being seen due to long waiting times and those who were to be admitted also spent considerable lengths of time in the department. The escalation protocol was not used effectively to reduce patients' waiting times

Mental capacity assessments were being undertaken appropriately, and staff demonstrated knowledge around most of the trust's policy and procedures. We saw that staff were rushed with their workload, but took the time to listen to patients, and explain to them what was wrong and any treatment required. The staff we spoke with were proud to work in the emergency department.

Urgent and emergency services

Are urgent and emergency services safe?

Requires improvement

In September 2014 the emergency and urgent care services were judged as inadequate because safety systems, processes and standard operating procedures were not fit for purpose. We found that there was significant bank and agency use within the department, equipment was not always maintained and medicines areas were not secure despite CQC raising this as an issue. Staff were not utilising the system for reporting of incidents as this process too long, this meant that there was no improvements made to the service as issues could not be analysed and trends identified. The 'Stop the Line' process designed for ensuring senior management support to staff in cases where patient safety was a risk was not utilised by staff as they saw it as ineffective. There were substantial and frequent staff shortages. We found that children were not always assessed by staff who had received training for triaging them, and children shared the same emergency department waiting area as adults, which was not in line with 'Children and Young People in Emergency Care Settings 2012' standards. We were concerned that the department had not used an acuity tool to determine the number of children's nurses required to safely staff the department. Since our inspection the trust has employed agency paediatric nurses to support children's services within this department.

At our inspection in January 2015 we found that the trust had employed two additional substantive paediatric staff who will be in place by the end of February 2015 and the service level agreement is currently under review to ensure that paediatric patients are cared for appropriately in the department. However following a review of nurse staffing levels there remained vacancies across the unit staffing. The trust was addressing the management shortages in the department with two further managers having been put in post. Systems, processes and standard operating procedures were not always reliable or appropriate to keep people safe. Monitoring whether safety systems are implemented was not robust. For example: we found the storage of clinical equipment was not conforming to infection prevention and control requirements with sterile equipment open within a store cupboard. Emergency equipment was not checked on a regular basis and we still found some equipment not maintained or serviced as identified within the trust's own system. Monitoring processes to ensure the safety of items were not robust as checking processes were not reviewed by the units' management. Safety concerns are not consistently identified and there was limited use of systems to record and report safety concerns, incidents and near misses. Some staff were wary about raising concerns as evidenced in the non reporting of missing equipment.

Incidents

- The hospital reported one serious incident (SI) to both the National Reporting and Learning System (NRLS) and the Strategic Executive Information System (STEIS), relating to the accident and emergency department between 2013 and 2014.
- In September 2014 we asked staff directly if they reported incidents and had knowledge of the reporting system. The incident data supplied to the CQC during inspection shows that the emergency care centre reported 256 incidents since April 2013, accounting for only 4% of the total incidents reported. Staff indicated that this low level of reporting reflected the amount of time it took to complete reports and the limited feedback on outcomes or closure of reported incidents.In January 2015 one member of staff told us that they reported an incident and received no conclusion or feedback. Another member of staff identified to us two incidents which should have been reported but had not due to work load within the department. This mean that issues could not be identified, addressed or am reoccurrence prevented.
- In September 2014 we spoke with senior nursing staff, who could not demonstrate to us evidence of learning from incidents. Staff told us that the trusts 'Stop the Line' policy is ineffective, and involvement by executive management did not always happen. (The trust employs an initiative called 'Stop the Line', which aims to empower any member of staff to raise concerns regarding patient experience or safety.) In January 2015 we spoke with senior nursing staff who could not demonstrate to us about evidence of learning from incidents. We found that a piece of emergency equipment had gone missing which was used for transfers. However, this had not been reported at the time of our inspection and we were told it had been

missing for two weeks. Staff were wary of reporting this. Following our feedback meeting with the trust we were informed that this piece of equipment had been used earlier in the day and this was why it was unavailable at our inspection. However despite how long it had been missing in reality the impact of not having this piece of equipment for transferring potentially critically ill patients would have been significant during the period of time it was not available. This piece of equipment should have been replaced immediately. The trust stated that there were two transfer bags in the department but staff we spoke to were unaware of the presence of a second bag.

- The department holds monthly clinical governance meetings, with a regular agenda. Both clinical and nursing staff are invited to attend these meetings. We attended a clinical governance meeting during our inspection, and found no nursing staff present. There were doctors present representing senior, middle and junior grades. We were told that feedback and actions are then taken to a consultants meeting. In September 2014 we looked at previous clinical governance meeting minutes and pathway tracked an action point whereby a fracture was not diagnosed. We then observed a consultant provide education to other doctors around this issue and signing off the action point where required to report back at the next meeting.
- The department displayed key safety related issues in the public areas; However, This information did not inform people who use the services of any measurement, assessment, lessons learnt to improve the safety of the care provided. In January 2015 we found that there was safety and audit data information displayed at the time of our visit for public information. The department was displaying out of date information. For example, the monthly environment audit data was from Sept 2013 to Dec 2013, Attendance data was dated July 2013 to Dec 2013, Incident by cause group data was from Oct 2013 to Dec 2013.

Cleanliness, infection control and hygiene

- Evidence provided by the trust, in September 2014, demonstrated a high level of compliance with hand hygiene practices across a number of months, as observed during hand washing audits, however at all inspections we observed limited personal protective equipment and hand hygiene practices in use during our inspection. Not all staff were witnessed to be wearing gloves, or washing their hands between dealing with patients.
- We observed during our inspection, in September 2014, that patients who may have an infection, or were awaiting confirmation of any infection, were nursed within a side room on the acute assessment ward. During the period of our observations we did not see treatment rooms routinely cleaned between patients.
- We noted during our inspection that there were hand cleaning stations within all treatment areas; however in September 2014, some dispensers were empty, including the main entrance for patients entering the emergency department treatment area. We observed ambulance staff remove dirty linen and clean ambulance stretchers within the same area that patients were handed over, and could not see a specific area identified for this activity. During our inspection in January 2015 we observed limited infection prevention and control practice, whereby not all staff were witnessed to be wearing gloves or washing their hands between patients. We saw two nurses and one doctor not wash their hands or use alcohol gel between providing patient care. Therefore there was little change in the practices of the staff within the A&E department.
- At our inspection in January 2015 we found a number of infection control issues including: that the clinical store room had a secure lock to prevent open access. We entered the store room and found 21 boxes stored on the floor despite a sign stating 'Do not store boxes on the floor' A majority of the boxes were open and freely used rather than storing clinical stores on the shelves. We also found a sterile suturing kit within the clinical store room open on a shelf and available for someone to use. The floor and shelves within the room were heavy with dust. The trust stated that the department had just received a delivery from the main stores due to the increased demand and pressures experienced over the weekend.

Environment and equipment

- Resuscitation equipment was available and clearly identified. There was a specific children's equipment trolley. Not all resuscitation trollies had been checked daily at both our inspections in September 2014 and

January 2015. In September 2014 we found that the trolley had not been checked for three days and in January 2015 we found that during December 2014 the trolley had not been checked on ten days.

- Treatment cubicles were clean and well equipped with appropriate lighting. However in January 2015 we found that Major treatment cubicles were not consistently signed off and checked daily as the department asked staff to do. We found three cubicles had not been checked and therefore could not be sure that they were fit for patient care although patients were being cared for within these cubicles. The emergency department was busy within the major's treatment area at the time of our January 2015 inspection. We found that patients were being bedded within the corridor and a room set aside for relatives suffering a bereavement which was inappropriate and not fit for patient care as it lacked emergency equipment.
- In September 2014 we looked at equipment which was visibly clean but found that some equipment did not have maintenance labels attached to it. The trust provided a schedule of maintenance and we could see that 94% of equipment had in fact been maintained. The trust stated that there had been previous issues with labels being incorrectly applied to the lead of the equipment rather than the main body. The trust has reported that this practice has now been amended. Whilst this schedule shows equipment to be serviced the inspectors found that at least 12 pieces of patient assessment equipment, such as defibrillators and blood pressure monitoring equipment, did not have the date of the last PAT test or servicing and that some had stickers which stated when the last test was undertaken and some when the next test was due. However in January 2015 we found that a bladder scanner which was due for inspection in December 2014 and a sphygmanometer for taking a blood pressure showing it had not been serviced since May 2013.
- In September 2014 the children and young people's areas department was not fully compliant with standards for 'Children and Young People in Emergency Care Settings 2012'. We saw that the children's department was not dedicated only to children and young people. This meant that children waited in the general A&E waiting area, were triaged in the same system as adults, and were treated in areas where adults were seen. Staff raised concerns to us that this was not safe for children, but told us that the department was planning a renovation inclusive of a separate paediatric A&E department; however, neither staff nor documents could confirm when and how this was going to happen. We were therefore not assured that the environment was suitable for purpose.
- In January 2015 we found a secure door open with the key pad pinned back to allow free access. This door was in the same corridor as a children's treatment cubicle and was also near a public corridor and the main hospital entrance. This meant that people had free access into the treatment corridor and a room designated for the treatment of children.

Medicines

- During our inspection in September 2014, we checked the records and stock of medication, including controlled drugs, and found some discrepancies with regards to controlled drug management as outlined below. Appropriate daily checks were carried out by qualified staff permitted to perform this task in September 2014 however at our inspection in January 2015 we found that this had not been maintained and 11 daily checks had not been completed.
- In September 2014 we found that the outer door of the cupboard housing the locked controlled drug cupboard could be opened; the controlled drug cupboard and medicines remained secure but this potentially allowed access to the controlled drug book, which could enable tampering with the documentation confirming the issue of controlled drugs. Therefore medicines were inappropriately stored. We also found the drug fridge within the resuscitation area unlocked which contained a selection of muscle relaxants. We were told that there was an on going investigation with regards to an ampoule of diamorphine that could not be accounted for. This had been formally reported and was being investigated. In January 2015 we found these cupboards were locked.
- We looked at patient prescription charts, which were completed and signed by the prescriber and by the nurse administering the medication.
- In September 2014 we found that on a number of occasions we observed insecure drug cupboards, including an outer door on a controlled drug cupboard, and a storage room containing intravenous fluids with the door propped open. We spoke with the nurse and a senior manager around the associated risk of this practice, and requested that it be addressed straight

away, and we were assured that this would be actioned. On the second day of our inspection we again found, on numerous occasions, the intravenous fluid store door open and insecure. At our inspection in January 2015 we found insecure drug cupboards within a locked room. There were three drug cupboards within the room. Two drug cupboards were found open upon our checks. We enquired as to why this was the case and found that the locks were broken and not reported.

- In January 2015 the controlled drug record book was full with entries and staff were completing entries onto blank A4 paper. The controlled drug book was kept outside of the controlled drug cupboard which meant that it was open to alteration by anyone and not allowing a safe practice.
- In September 2014 we found that fridges to store appropriate medication did not have the temperature recorded and checked on a daily basis, and the fridge was not locked.
- The trust reported that they were awaiting delivery of digital locks and have replaced all locks with digital lock to ensure security of these areas. In January 2015 we saw that these are now in place.

Records

- We looked at 14 sets of patient notes during our inspection in September 2014. One of the sets of notes highlighted delays in the recording of patient observations. One patient arrived in the department via ambulance and did not have an initial recording of observations for 53 minutes.
- All of the notes we looked at had completed observations taken, with regular re-assessment, which were recorded.
- During our inspection in September 2014 we observed that the emergency department notes and acute assessment notes were stored securely. Notes were easily defined between clinical observations and nursing/medical notes. Documentation was of a high standard, with legible notes, and in line with best practice guidance. Children had a thorough history recorded, as well as further assessments of their risks and needs, a diagnosis, and a treatment plan. The records reflected the holistic needs of each child.
- We saw, within the accident and emergency notes, that risk assessments were undertaken in the department when patients were in the department for some time (it is recommended by the Royal College of Nursing that if patients are in an area for longer than six hours a risk assessment for falls and pressure ulcers should be completed). We did not review records at our inspection in January 2015.
- In September 2014 we observed that intentional rounds took place by nursing staff on the admissions unit but not within the accident and emergency unit. This is where staff check on patient's welfare at regular periods throughout the day. In January 2015 the trust stated that intentional rounding was taking place in the majors area of the accident and emergency unit for patients who had been in the unit for more than one hour. However we did not see this occurring despite inspecting the unit for four hours.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff were knowledgeable about how to support patients who lacked capacity. They were aware of the need to assess whether a patient had a temporary or permanent loss of capacity, and how to support patients in each situation. If there were concerns regarding a patient's capacity, the staff ensured that the patient was safe and then undertook a mental capacity assessment.
- According to the emergency department mandatory training database in September 2014, all nursing and medical staff had undergone their mental capacity training.
- We observed nursing and medical staff gaining consent from patients prior to any care or procedure being carried out at both our inspections.
- There was a robust practice in place to support people with drug and alcohol misuse, with referral to the appropriate supporting mechanisms available.
- Staff obtained patient and/or parental consent appropriately. The trust had appropriate policies in place in relation to consent to treatment in children. Staff were knowledgeable about Gillick competence. These guidelines are tools used to assist professionals in determining whether a child is mature enough to make their own decisions about care and treatment.
- In September 2014 the trust stated that one child had waited 19 hours to be seen by the CAMHS in the department. The trust ensured that the safety needs of the child had been met during this time through appropriate escalation and actions taken. However the trust needs to work in partnership with local partners to

address children's mental health needs. CAMHS delays are a recognised issue across the region, and this is discussed at the combined safeguarding paediatric clinical governance meetings. In January 2015 we saw that one patient had to wait overnight for the CAMHS team to see them the following day as the night team could not support the request. This person had been in the department for over nine hours.

- Records confirmed that at times the department was seeing a high number of paediatric attendances with a history of self-harm. For example in 2013, 94 children attended the department with a history of self-harm, and in 2014 to September 2014, there had been 13 attendances.

Safeguarding

- The emergency department had a safeguarding lead within the department who was knowledgeable, and demonstrated underpinning knowledge of both safeguarding children and vulnerable adults.
- We looked at training records in September 2014, and saw that all nursing and medical staff had undergone mandatory safeguarding training at an appropriate level.
- All safeguarding concerns were raised through an internal reporting system. The concerns were reviewed at a senior level to ensure that a referral had been made to the local authorities' safeguarding team.
- The staff we spoke with in September 2014 were aware of how to recognise signs of abuse, and the reporting procedures in place within their respective areas.
- There was a team within the trust dedicated to children's safeguarding. Staff gave examples of how they and the safeguarding team had worked effectively with other children's services, including the local authority, to actively safeguard children. Staff said that the safeguarding team were highly visible and effective.
- Systems were in place to safeguard children, including a screening tool used during initial assessment, which identified those children at high risk. There were audits in place which demonstrated that this tool was not always being used effectively; however, we saw that an action plan was in place to support improvements. This system had also been implemented in other areas of the hospital.

Mandatory training

- We looked at mandatory training records in September 2014, which showed us that staff received core subject mandatory training, such as manual handling, fire safety, safeguarding, and basic life support. However, we spoke with medical staff who told us that they did not receive a comprehensive induction; for example, doctors received presentations with regards to spinal immobilisation assessment, but the practical assessment was not carried out.
- At our inspection in January 2015 we found that all staff had been trained in Paediatric Immediate Life Support.
- Mandatory training was provided in different formats, including face-to-face classroom training. Staff told us that there was limited time allowed to complete learning. One member of staff told us that they rarely got to see the staff that they should be mentoring and meeting with, due to workload, and not being permitted a day to complete this, due to low staffing availability to back fill.

Management of deteriorating patients

- There were appropriate systems in place to assess and monitor patient risk. The emergency department operates a national early warning score (NEWS), and this is used to alert clinicians of any deterioration in a patient's condition.
- The service had implemented a paediatric early warning score (PEWS) system for varying ages of child. Early warning scores are generated by combining the scores from a selection of routine patient observations, such as pulse, respiratory rate, respiratory distress and conscious level. Different observations are selected for children and adults due to their naturally different physiological responses. If a child's clinical condition is deteriorating, the 'score' for the observations will (usually) increase, and so a higher or increasing score gives an early indication that intervention may be required. There were display boards visible to the public which explained the PEWS system.
- In September 2014 we observed that the department operates a triage system of patients presenting to the department either by themselves or via ambulance, and patients are seen in priority, dependent upon their condition. Children were seen as part of this triage system and did not have a separate area for triage. At our inspection in January 2015 we were not assured that this process was followed for all patients. For example, we saw that a patient was handed over from the ambulance service and placed on a trolley in the corridor. When we asked the patient if they were told

why they were here in the corridor, they did not know. We then asked a senior nurse about this patient and they did not know either; we note that nursing staff are allocated to specific cubicles.

- Paediatric audits received from the trust in September 2014 showed that 99% of children receive an assessment within the target of 15 minutes. However during our inspection in September 2014 parents told us that the service needs "a separate A&E for children", and that "the waiting time in this department [for children] is unacceptable". During our inspection we observed that one child waiting more than 15 minutes to be assessed; this was a very unwell child who required prompt assessment. We immediately bought this to the manager's attention, and appropriate action was taken.
- Patients arriving as a priority call are transferred immediately through to the resuscitation area. Such calls are phoned through in advance (pre-alert), so that an appropriate team are alerted and prepared for their arrival.
- We looked at a pre-alert form with regards to a pre-alert that occurred during our inspection, and found that the forms had been completed fully, with any clinical observations recorded, estimated time of arrival of the ambulance to the accident and emergency department, and details of who took the information over the telephone from the ambulance service.

Nursing staffing

- Information provided by the trust in September 2014 indicated that the establishment for the emergency department was not operating at the required whole time equivalents (WTE), with a number of qualified nurse posts vacant. Senior staff acknowledged that they were looking at the RCN 'BEST' policy to understand their staffing needs. The current vacancy percentage across the emergency department at the trust is 13.5% and this equated to 61 whole time equivalent staff. Bank and agency staffing were used to support at times when there were known gaps in the rota. The use fluctuated but was around 3% of total staff in the department. In January 2015 we were informed and saw that the units staffing has improved and there is now an emergency care practitioner and an emergency nurse practitioner to support primary care and out of hours (OOH) patients.
- Staffing records in September 2014 confirmed that there was only one junior paediatric nurse who worked full time to cover the entire department. There was also a senior paediatric sister who worked full time; however, their role was supernumerary, although they told us that their role was adaptable, so they could work a clinical shift, as required. Staff told us that other registered nurses who were not children's nurse qualified, provided emergency care to children when a paediatric nurse was not on shift or available. These nurses had obtained additional training, such as Advanced Paediatric Life Support qualifications. However, the Royal College of Nursing (2013) guidance advises that there must be a minimum of one registered children's nurse available at all times in emergency departments. This meant that the service was not following national guidance in regard to safe staffing numbers. In January 2015 we found that a specific paediatric nurse recruitment had taken place and the trust had employed two additional substantive paediatric staff. However, this is still not enough provision of paediatric trained nurses to provide a 24 hour, 7 day week service. We were informed that on average the unit see's approximately 1 child after midnight. We looked at records dated Sept 2014 to Oct 2014 which supported this data for this short period sample. The trust are currently reviewing the service level agreement with the provider of children's services at the trust to ensure that specialist paediatric care is available at all times.
- In September 2014 we found that a specific paediatric acuity tool had not been used to determine safe nurse staffing levels. This meant that the service had not planned the establishment of the paediatric nurses it required to provide safe care for children and young people. Senior managers told us that due to the increased number of paediatric attendances recently, paediatric staffing in A&E had been identified on the A&E risk register.
- In September 2014 senior managers told us that the nurses who were triaging at the front desk in A&E were not always trained in paediatric assessments. This is not in accordance with the national standards set out in 'Children and Young People in Emergency Care Settings 2012', which states that nurses who are responsible for triaging children must undergo an assessment of competencies in the anatomical, physiological and psychological differences of children. In January 2015 we found that staff undertaking paediatric assessments were trained to do so competently.

Urgent and emergency services

- We observed that there was a professional handover of care between each shift in September 2014.
- All bank and agency staff received local induction prior to starting their shift.
- In January 2015 the trust had recruited an emergency care practitioner and an emergency nurse practitioner who assist with the out of hours and primary care flow through the department.

Medical staffing

- The department currently has 14 whole time equivalent (WTE) doctors, who are present in the department, with consultant cover available from 8am until 9pm. There are middle grade doctors and junior doctors overnight, with an on-call consultant system.
- Within the emergency department, we saw that there was a better ratio within the doctor staffing skill mix than the England average. The emergency department provided a whole time equivalent of 28% within consultant level (England average of 23%), 43% within middle grade doctors (England average 39%), and 29% within junior grade level doctors (England average 25%).
- We looked at the doctor's rota, and saw that the middle grade doctor utilisation level was consistent in using doctors who had received the trust induction programme, and were familiar with the department and protocols.
- In September 2014 the emergency department had no clinical director, and this was identified as a risk by the department and senior managers. This has caused a limitation within the scope of practice and development of the department, with regards to leadership and interaction with other directorates in the trust.
- During our observation within the clinical governance meeting in September 2014, we were told that junior doctors had not received a full induction into the emergency department, as two days induction had been condensed to one day, and elements of practical scenarios, such as for cervical spinal immobilisation and management, were delivered by presentation rather than with hands-on practice.

Major incident awareness and training

- All major incident equipment was available and we saw that it was checked on a regular basis
- We requested evidence of training for major incidents for all staff within the A&E department. We were provided with training data for nursing and medical staff. This demonstrated that staff had completed major incident training and that 70% of nursing staff had completed chemical, biological, radiological and nuclear training. We were also told that all staff completed major incident training, as part of their induction.

Are urgent and emergency services effective?

(for example, treatment is effective)

Requires improvement

At our inspections we found that the department used a range of policies, procedures and pathways which reflected national guidance to ensure that patients received good care and outcomes from treatment. However care plans and care pathways were not always followed by nursing and medical staff. We found that improvements were required to ensure that care plans and pathways were followed by staff. we also found that results of audits were not always available for staff to learn and develop practice from. We reviewed this aspect of care in September 2014 but did not re-inspect in January 2015.

Evidence-based care and treatment

- Departmental policies were easily accessible, which staff were aware of and reported they used. A range of emergency department protocols were available, which were specific to the emergency department.
- There were further trust guidelines and policies operating within the emergency department and acute assessment unit, such as sepsis and needle stick injury procedure. We saw treatment plans which were based on the National Institute for Health and Care Excellence (NICE) guidelines.
- We found reference to the College of Emergency Medicine (CEM) standards, and spoke with medical staff who demonstrated knowledge of these standards.
- We looked at the process followed with regard to admitting patients, and found that the acute assessment unit (AAU) was not aligned to the emergency department processes. We saw that when admitting patients into the AAU, there were six processes to record the admission. We asked why the system was not streamlined and were told that it was to overcompensate for information technology (IT) failure.

- We examined co-ordinated and integrated pathways for children's services, which ensured collaborative working between A&E and the children's ward within the hospital run by another trust.
- Staff demonstrated that they practised evidence-based care. During our inspection in September 2014 we observed a paediatric burns patient and were assured that their care was delivered in line with current burns and scalds guidance issued by the National Institute for Health and Care Excellence (NICE).

Nutrition and hydration

- During our inspection in September 2014 we pathway-tracked a patients care plan against the care they received. Entries into the care plan were inconsistent and care pathways were not followed. For example, diabetic care was observed to be below what is expected. One care plan stated 'diabetic patient, consider providing food'. We spoke with this patient and were told that they had not received a regular meal and were provided biscuits at an unreasonable time.
- In September 2014 we observed that intentional rounding was taking place within the acute assessment unit; however, this focused on observations being taken and we did not witness any checks that food or drink were offered. During our inspection we did not see any intentional rounding taking place within the emergency department. We observed catering staff within the AAU offering breakfast to patients who had been in the unit overnight. We found that fluid charts had not been fully completed, with observation times missing. We found that children's nutrition and hydration needs were not always met.

Patient outcomes

- The emergency department took part in national College of Emergency Medicine audits, and they were able to provide us with the results of these, but there was no evidence that they had used the results to assess the effectiveness of their department.
- The College of Emergency Medicine recommends that the unplanned re-admittance rate within seven days for accident and emergency should be between 1-5%. The national average for England is around 7%. The trust has consistently performed well against unplanned re-admittance since January 2013. Their rate in February 2014 was just below 6%.
- At local level, a number of audits within the children's A&E services had been conducted. This included documentation audits which demonstrated good compliance with national standards. During August 2014, the documentation audit revealed that 100% of notes reviewed included the child's name, school and investigations undertaken. Other audits included the use of the safeguarding tool. This meant that the trust was actively monitoring the quality of its service.

Competent staff

- In September 2014 we saw that appraisals of both medical and nursing grades were undertaken, and staff spoke positively about the process and said that it was of benefit. The trust was going through a change within their appraisal system and process; therefore figures are not reliable at the time of our inspection.
- We saw records which demonstrated that both medical and nursing staff were revalidated in basic, intermediate and advanced life support.

Multidisciplinary working

- Medical and nursing handovers were undertaken separately, during the nursing handovers which occurred twice a day, staffing for the shift was discussed, as well as any high risk patients or potential issues. Medical handover occurred twice a day, and was led by the consultant on the A&E floor.
- In September 2014 we found that there was a clear professional conjoined working relationship between the emergency department and other allied healthcare professionals within other departments and hospitals. For example, the mental health teams provide intervention from community services to enable patients to be discharged home with an appropriate care package and support from other hospitals.
- Staff we spoke with were aware of the protocols to follow, and key contacts with external teams. We witnessed a professional patient experience, from transition from the care of the ambulance service to the accident and emergency staff.

Seven-day services

- There was a consultant out-of-hours service provided via an on-call system.
- Accident and emergency offered all services, where required, seven days a week.
- We were told by senior staff within the A&E department that external support services are limited out of hours, and it often proves difficult at weekends, which has an effect on patient discharges and care packages.

Urgent and emergency services

Are urgent and emergency services caring?

Requires improvement

At our inspection carried out in September 2014 we found that there were times when people did not feel well supported and cared for therefore we have judged caring as requiring improvement. Some people told us that they were concerned about the ways staff treated them. In September 2014 we received 17 comment cards from this department. Twelve comments indicated that patients were not always treated with respect and in one stated that they were not believed when receiving treatment; however, Friends and Family feedback and the national A&E patient survey commissioned by the CQC contradicts this finding. Staff in the department focused on the task in hand rather than ensuring that patients had information about their care and treatment.

We saw patients getting frustrated that they were waiting extended periods for treatment and lack of information; however staff reported that they wished they had more time to care. The department has worked hard to increase the Friends and Family Test response rate; during our inspection in September 2014 we did find Friends and Family Test questionnaires in view, and available within the ambulance triage and reception areas. We reviewed this aspect of care in September 2014 but did not re-inspect in January 2015.

Compassionate care

- We saw that nursing staff were busy at both our inspections in September and January, and this was demonstrated in the lack of time that each nurse was able to spend with an individual patient for whom they were providing care. In September 2014 we spoke with staff and they told us that they were frustrated that they could not provide sufficient time at the patient's bedside to understand each patient's full needs.
- In September 2014 the trust performed better than the England average for the NHS Friends and Family Test (the Test was introduced in 2013 and asks patients whether they would recommend hospital wards, A&E departments and maternity services to their friends and family if they needed similar care or treatment). The trusts performance is better than the average for the accident and emergency department.
- During our inspection in September 2014 we saw three occasions whereby patients had to wait a considerable amount of time when they called for a nurse via a call bell in the cubicle, and when the nurse arrived there was very little compassion shown. For example, we saw that a nurse spoke abruptly to the patient and was rushed in spending time with the patient and told the patient that they were very busy. We informed a hospital manager about this.
- Out of 17 comment cards completed by patients during our inspection in September 2014,16 contained negative comments. We saw some significant concerns about the lack of compassionate care. One patient felt that their condition was not taken seriously despite later finding out that they were suffering with a serious condition. We informed the director of nursing about some of these comments.
- The national A&E patient survey commissioned by the CQC, which had a trust response rate of 35% compared with a national response rate of 34% and that was responded to by 293 patients who had used the trust's emergency department services, contradicts our comment card findings, with patients scoring the trust at 9/10 for patients feeling they were treated with dignity and respect, an increase from 8.5/10 in 2012.

Patient understanding and involvement

- In September 2014 patients told us that they did not always feel informed about the care they were receiving, and had to ask nurses and doctors to update them, rather than staff keeping patients informed. The patients we spoke with told us that staff were polite when speaking to them. During our inspection in September 2014 there were delays during the day for patients waiting to see a doctor. We did not observe staff explaining to patients if there was going to be a delay in seeing a doctor, what the reason for that delay was, and how long they would have to wait to be seen.
- In September 2014 one person in the waiting room told us "there are too long waiting times and the screen to tell people information is out of view and I can't see it from the waiting area". Another person told us that they

had not heard their name being called, and when they brought this to the attention of the triage nurse they were told that they would just have to wait, without being asked what was wrong.

- We received a number of concerns in respect of the care of diabetic patients within the department in September 2014. People attending the listening events prior to the site visit told us that despite asking for food and/or insulin staff lacked an appreciation of their need for these to control their blood sugar.
- The department arranged the nursing staff into teams that looked after specific areas; this did not always facilitate a better patient experience. For example, one nurse we spoke to told us that when the department is understaffed, patients may wait for a longer period, as nurses are not moved around, and remain working in the one area.

Emotional support

- We spoke with staff about their understanding of bereavement services offered within the emergency department, and we were told that staff call upon the chaplaincy service.
- During our inspection in September 2014 we spoke with staff, including reception staff, and asked what training they had received to deal with distressed people that attend the emergency department; we were told that no training was provided to initially support these people.
- There was limited information available to support people during a time of bereavement, and also taking into account religious and cultural needs.

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

(for example, to feedback?)

Requires improvement

Services do not always meet the needs of patients therefore we have judged the responsiveness of the service as requiring improvement. There were shortfalls in the services for children in terms of the waiting room and the treatment areas which were not exclusively used for children despite being decorated for them. In September 2014 there were a higher than the England average number of people who left the department before being seen and those who were due to be admitted waited long periods of time before being taken to a ward.

The department struggled with surges of activity, which occur on a regular and potentially anticipatory basis. The escalation protocol is insufficient, and does not provide a sufficient or measurable safe response, as evidenced by patients waiting above fifteen minutes within the ambulance triage area whilst ambulances are waiting to handover. We reviewed this aspect of care in September 2014 but did not re-inspect in January 2015.

Service planning and delivery to meet the needs of local people

- We were told in September 2014 by senior staff within the department of who, within the site team, should be contacted when there were delays to patient flow. There was an internal 'live' electronic system of monitoring to evaluate and manage the effectiveness of patient flow to assist with bed demand.
- At both inspections in September 2014 we saw that during periods of demand, the department started to struggle; there was a lack of co-ordination within teams, resulting in a failure to achieve a better patient experience and flow through the department. For example, we witnessed nursing tasks that were overdue to be completed and no ownership of patient centred care with staff not knowing the condition of patients under their care when there was a telephone enquiry. In September 2014 we saw patients waiting to be transferred out of the department and when we spoke to a senior nurse about the cause of this we were told that it's like this all the time and they shrugged their shoulders.

Access and flow

- On average in September 2014 we found that the trust maintained the 95% target of assessment of people within four hours of arriving in the emergency department. There have been seven occasions of breaching the 95% target between April 2013 and April 2014. Prior to the week of our inspection in September 2014, the trust achieved 86.5% of patients seen within 4 hours.
- In September 2014 the trusts percentage of emergency admissions via the emergency department, waiting 4-12 hours from the decision to admit until being admitted,

have been consistently worse than the expected England average of 5%. The trusts emergency department had an average of 20% of patients waiting 4-12 hours from the decision to admit to being admitted in September 2014.

- In September 2014 the national average for percentage of patients that leave the department before being seen (recognised by the Department of Health as potentially being an indicator that patients are dissatisfied with the length of time they are having to wait) was 26% (July 2013 – July 2014). The England average was 16%.
- In September 2014 patients, parents, staff and our observations confirmed that patient flow throughout the service was not always seamless, because there was not a separate pathway for children and young people.

Meeting people's individual needs

- In September 2014 staff we spoke with were unaware of the translation service available for those patients whose first language was not English. Within the department we were told by staff that it was not possible to request a translator. The staff we spoke with told us that they would usually use other staff members to translate.
- In September 2014 there were no information leaflets available for many different minor injuries. Those that were provided were available in English.

Learning from complaints and concerns

- The A&E department advocates the Patient Advice and Liaison Service (PALS), which is available throughout the hospital.
- Information was available for patients to access on how to make a complaint, and how to contact the Patient Advice and Liaison Service.
- All concerns raised were investigated, and there was a centralised recording tool in place to identify any trends emerging.
- In September 2014 we did see that learning from complaints was within the agenda of the clinical governance meeting, and was discussed amongst the doctor peer group; however, this was not disseminated to the whole team in order to improve patient experience within the department.

Are urgent and emergency services well-led?

Inadequate

During the period of our inspections, in September 2014 and January 2015, we were not assured that governance procedures that would maximise the opportunity to identify, report and learn from incidents to improve services were followed in the emergency department. In September 2014 the department had a lower than expected rate of incident reporting, at 4% of the trust's overall rate. At both inspections staff reported that this was reflective of the time it takes to complete reports coupled with lack of feedback from the incidents reported. The trust stated that they had recognised this and invested in web-based incident reporting and risk management software to reduce administrative burden on frontline staff and facilitate improved triangulation and learning from incidents. However this was not in place in January 2015. Patient outcomes data and the CQC's own national A&E patient survey confirm that the trust is not a negative outlier in respect of harms or patient experience. The trust's performance in July 2014 fell to 92.9%; its first monthly drop below a 95% achievement. The trust was again struggling to maintain the 95% target to treat patients within 4 hours but this was due to the unprecedented demand for services since November 2014.

In September 2014 we found that the trust were clear about the vision and values, and produced may leaflets on these, that they and its staff subscribed to however there was a lack of awareness of these within the department. Governance procedures were not being followed in respect of reporting incidents, and improving services in response to these. Whilst risk was identified and audits undertaken there was little evidence that these were addressed or used to improve services. We found a similar picture at our inspection in January 2015

At our inspection in September 2014, the front line leadership was not robust enough to flex to the needs of the department. We saw that the organisation of staff to manage the department was ineffective at times of increased demand. There was poor collaboration between teams during these times which impacted on the safety, caring, effective and responsiveness of the service. Universally throughout the department, there was an acceptance of a lower standard of care due to

pressure, but staff were concerned by the departure of numerous senior managers within the emergency department. The staff we spoke with demonstrated an attitude of commitment, but morale was low. In January 2015 we found that whilst the trust had taken action to address the leadership within the department there was not the level of improvement or the leadership of the department that we would have expected to see. For example the acting matron had yet to commence these duties and the clinical lead for the department had yet to make an impact on the leadership of the department. As yet the leaders do not have the necessary experience, knowledge, capacity or capability to lead effectively. However, the new leaders are supported by a divisional head of nursing and a newly appointed operations manager. We also found that the information that was displayed to monitor performance was out of date.

Vision and strategy for this service

- The future vision of the accident and emergency department was not embedded within the team, and was not well described by all members of staff we spoke to including managers. This included the development of the A&E department and its growth plans in building size and development of children's services it may offer .
- In January 2015 we found that there are plans to improve the department with charitable funds available, however this is within its early stages and no papers have been presented to the executive board at the time of inspection for sign off.
- In September 2014 we found that the children and young people's service within A&E did not have a clear vision and strategy with identifiable aims and objectives. Whilst staff told us that there were trust plans to renovate and separate children's A&E, records did not support this happening in a timely way. We could not be provided with any dates or business plans for completion of this work when we spoke with a senior manager. Staff also told us that "these plans have been on the cards for years but nothing happens". In January 2015 we were told the department wishes to improve the facilities for its children's services in further treatment rooms. Data demonstrated that child attendances were low, particularly between 00:00 and 07:00hrs, negating the need for full 24 hour paediatric nurse presence. This risk was mitigated by the intended review of the service level agreement with the paediatric provider on site.

Governance, risk management and quality measurement

- Monthly departmental meetings are held. We were provided with minutes of the previous meetings held. There was a set agenda for each of these meetings, with certain standing items.
- Within the minutes, the top risks were discussed, There did not seem to be any embedded concern around the management of the risk register including current updates or any regular review within an accepted time frame.
- In September 2014 we saw a live information dashboard was displayed within the emergency department and acute assessment unit at Hinchingbrooke Hospital for the public to see; we spoke with staff about quality indicators and there was a lack of demonstrable knowledge. In January 2015 we looked at data displayed within the public areas and found this to be out of date. For example, monthly environment audit data was from Sept 2013 to Dec 2013, incident by cause group data was from Oct 2013 to Dec 2013 and the last infection prevention and control audit data was dated 28 January 2014. Serious incident data displayed for public information was dated Oct 2013 to Dec 2013.
- The trust held three monthly children's clinical governance meetings in partnership with Cambridgeshire Community Services NHS Trust. Staff said that this was an opportunity to learn and discuss complex cases and incidents. We were concerned that these meetings were not occurring frequently enough. This meant that there could be missed opportunities in relation to improving and learning from practice. We were also concerned that the most senior person attending from children's services at Hinchingbrooke Health Care NHS Trust was the lead nurse for safeguarding and/or the senior paediatric nurse from A&E. This meant that there was an absence of senior management at the clinical governance meetings.

Leadership of service

- The departmental team was respected and led by the divisional head of nursing for emergency and urgent care.
- In September 2014 the senior management team were interviewed separately, and the conclusions drawn from the interviews were that the leaders visions were not aligned, and at the time of the inspection there was a lack of joint ownership of the issues faced by the

department. For example, a number of key leaders had left the department, including the emergency department matron. A decision was made to have one matron looking after both the acute assessment unit and the emergency department. In January 2015 we heard that the trust had appointed one of the existing staff to this role however this person was currently undertaking their normal duties and not supernumerary. This person was a junior sister who had been appointed to an acting matron post and had little experience in a management role.

- During our inspection in September 2014, we observed that there was a disengagement of leadership from the emergency department matron, with regards to the priorities and management of their department. This disengagement impacted upon the effectiveness and responsiveness of the department. This person has since left the hospital.
- The senior paediatric nurse of A&E was dedicated, enthusiastic and inspiring. They demonstrated clear leadership principles and the trust's values. Staff spoke highly of their seniors. They said that they felt respected, valued and incredibly supported by the senior paediatric nurse.
- Staff we spoke to in other departments told us that the most senior professional, with regard to paediatrics at Hinchingbrooke Hospital, was the senior paediatric nurse in A&E. The paediatric nurse was evidently taking the lead and influencing many positive, trust-wide paediatric decisions. However, they were not supported appropriately, as there were no senior managers, in relation to paediatric service provision, above them. This lead nurse reported directly to the divisional head or director of nursing.

Culture within the service

- The high percentage of consultants within the emergency department contributed to the cohesive working within the medical staff. In September 2014 we were told that there was an executive director for the emergency department and medical services but staff felt that the lack of an identified senior leader for this service had the potential to impact on the culture within the service working with other directorates in the trust and external stakeholders. In January 2015 we found that the department now has a clinical lead to drive the culture forward in the department.
- At both inspections we spoke with nursing staff, and universally, throughout the department, there was an acceptance of change and aspirations to improve. Staff believed that with departmental improvements and redesign, a better working environment would be created in which to care for patients and raise morale.
- Staff told us that the trust has policies and procedures in place to protect both patients and staff, but they are not effective. For example in September 2014, one member of staff told us that the trust has a 'Stop the Line' procedure, and when they try to use it they are made to feel that they are to blame, and that they have done something wrong when instigating 'Stop the Line'. Another member of staff told us that they were told to "just get on with it" when using the 'Stop the Line' procedure. ('Stop the line' procedure is a policy that is in place throughout the trust whereby any staff member who may witness an unsafe practice being carried out or concerns around health and safety can instigate and invoke the 'stop the line' policy. There is a senior executive on call each day who will attend and deal with any issue as appropriate within trust policy and procedure)

Public and staff engagement

- The emergency department scored consistently better than the England average in the Friends and Family Test.
- The trust confirmed that feedback was given to staff in a number of ways, however the staff we spoke to in September 2014 told us that they do not get department feedback from staff surveys.
- We asked if the A&E department engages with members of the public within a forum and were told that there is no forum for this other than completing a feedback card and handing it in to the trust.

Innovation, improvement and sustainability.

- In September 2014 we were informed that information for all staff about the trust's vision and strategy was available but staff were not aware how to access it. Staff told us that they were not aware of updates or amendments on the department's priorities and performance.
- In January 2015 we observed senior managers having to complete clinical shifts which inhibited their ability to deliver any innovation and improvement. We saw one improvement since our inspection in September 2014 with the installation of an electronic access to the

clinical store room. We were not assured during our inspection that learning and improvement takes place in a pro-active manner and the department has more of a reactive approach to any issues highlighted.

- The lead paediatric nurse in A&E had developed an innovative new scheme, which was designed to engage young children from the local community with the hospital. Children from local primary schools are taken on a tour of the hospital, and get the chance to experience some hands-on activities with regard to how the hospital works, and gain insight into the varying job roles. This scheme had been effective, and had also been rolled out to include children and adults living with learning disabilities. The nurse had been awarded an Executive Board Certificate of Recognition for her outstanding work in this area.

Medical care (including older people's care)

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

Information about the service

The medical care services at Hinchingbrooke Hospital Comprise of five areas. Cherry Tree ward is a 30 bed ward caring for elderly patients with acute medical conditions. There is also a focus on dementia care, within a dementia-friendly environment. Walnut Ward takes patients with acute medical conditions, but has a specialist interest in respiratory conditions. Apple Tree Ward has 25 beds, and focuses on rehabilitation after treatment of acute illnesses, such as stroke. The Medical Short Stay Unit is a 30 bed ward that cares for patients with a range of medical conditions, for up to three days. The ward also provides a short stay service for gynaecological conditions. The Reablement Centre is a 25-bedded non-acute unit. It provides care for patients with confirmation of their medical fitness for discharge. Patients admitted to the ward do not necessarily require rehabilitation and are a mix of patients requiring long term residential nursing care provision in the community, as well as those returning to independent living arrangements.

Monitoring had not indicated any increased risk in respect of pressure ulcer, urinary tract infections of falls with harm. The Trust has a low incidence of hospital acquired pressure ulcers and falls with harm. We had been notified by stakeholders prior to this inspection that there were concerns around infection control practices, and cleanliness in the medical areas.

In September 2014 we visited all of the medical areas as part of this inspection over two days. We returned to visit Apple Tree Ward on both unannounced visits. We examined 15 sets of patient records; spoke with 23 patients, 10 relatives or carers, and 28 members of staff, including doctors, nurses and support staff.

In January 2015 we visited only Apple Tree ward and spent a morning on the ward. We spoke to three patients, and reviewed their records and we spoke with seven members of staff including doctors, nurses and support staff.

Medical care (including older people's care)

Summary of findings

At our September 2014 inspection we found medical services were inadequate because we found poor emotional and physical care which was not safe or caring. This was not reported by leaders of the service to the trust management therefore we judged the leadership to be inadequate. Services were not caring because people were not treated with dignity or respect. We were also concerned that people were not being treated in an emotionally supportive manner. Hand hygiene and infection control techniques were poor. Staffing numbers were not always reflective of patient dependency. Examples of treatment without consent were identified on one patient who lacked mental capacity but we found an under recognition of patients who may lack capacity throughout the medical wards. Services were not effective because pressure ulcer prevention and treatment was not always provided in line with NICE guidelines. There were no seven day services provided by the hospital. The service was not responsive; we found that medical patients were not always classed as outliers despite requiring specialised care. This meant that the frequency of review by their own consultant might be reduced. The Medical Short Stay Unit and the Reablement Centre were not utilised for their intended purpose.

The service was not well-led. We found that the culture of identifying, reporting and escalating concerns was not open. We found that teams were not engaged or felt enabled to raise concerns. We wrote to the trust to express our concerns and with the support of the Trust Development Authority action is underway to address these.

In January 2015 we found that the standard of care on Apple Tree ward had improved. We saw that patients were treated with dignity and respect. The leadership of the ward team had improved and staff felt able to report behaviours which were not in keeping with a good standard of care. Audits were undertaken in order to ensure that an acceptable level of care was being provided by staff. Staff felt better engaged and supported by senior managers. The team had a greater understanding of the care of vulnerable patients and had good working relationships with the local safeguarding and deprivation of liberties teams. However documentation required improvement to ensure that the care of patients was recorded and utilised to improve treatment. However we have rated safe, caring and well led as requires improvement as whilst improvements were seen we were not assured of the sustainability of these actions. We found that the need to develop leaders was not identified and that support was limited. Some people who used the service did not always have their care needs reflected in their care plans and these were not always documented in a timely manner. We found that staff were not always informed of actions taken to address incidents raised on the internal risk system. We only reviewed the significant issues on Apple Tree ward and did not inspect the issues raised about other wards such as Cherry Tree ward and the reablement ward.

Medical care (including older people's care)

Are medical care services safe?

Requires improvement

In September 2014 we found that patients using the medical services were at risk from avoidable harm or abuse in Apple Tree ward. Staff throughout the service were not always adhering to the National Institute for Health and Care Excellence (NICE) Guideline CG:179 'Pressure ulcers: prevention and management of pressure ulcers', because we found little evidence that preventative measures were consistently being implemented. Care plans for monitoring of cannula sites and catheters were not always being completed. Infection control protocols were not being adhered to. We observed poor hand-washing technique between patients, and poor practice of hand hygiene by medical and nursing staff between patients.

Where patients had the mental capacity to consent to treatment, consent was taken. Where patients did not have the capacity to consent, best interest procedures in accordance with the Mental Capacity Act (MCA) and the Deprivation of Liberty Safeguards (DoLS) were not always undertaken prior to treatment being given.

Whilst the staffing number had been met, the quality and competence of these staff members varied; we noted that many of the concerns that we raised to the senior management team related to the bank and agency staff members on duty. Nurse staff levels are calculated based on patient to staff ratio. This model of staffing was not reflective of patient needs, and wards were not able to complete basic nursing tasks due to patient dependency outweighing the staffing numbers.

We returned in January 2015 to inspect Apple Tree ward as this was the ward where we had most concerns. We found that actions had been taken to reduce the risk of avoidable harm in this ward. We rate this area as requiring improvement because staff were still not receiving feedback on all incidents they reported and elements of care planning were not well documented. We saw that assessment for the prevention of pressure sores had improved and that equipment was in use. However this was not always well documented in the patients' records. We did not reassess IV cannula care at this inspection. Hand washing following patient care had improved and on Apple Tree ward the understanding of patients with reduced capacity had improved as had links with the local deprivation of liberty safeguarding team. We found issues relating to the storage and administration of medicines which required improvement to ensure the safety of patients. We did not inspect Cherry Tree ward or the reablement service.

Incidents

- Staff were able to provide us with examples of when they had reported incidents, and understood what constituted an incident.
- We spoke with a range of staff across the service, and found that staff were aware of how to report incidents. However, in September 2014, a nurse on one of the wards told us "we are always told to do incident forms, but who has the time and nothing changes, therefore we don't do them". A junior doctor (CT1) on another ward told us that they had had to report an incident the day before our inspection. This doctor told us that they had to get a nurse to report the incident because they didn't know how to do it. The doctor did not know the process for reporting incidents, or how the outcomes of incidents reported were fed back. In January 2015 staff on Apple Tree ward told us that whilst they reported incidents there was often no feedback received for many incidents reported.
- In the 12 months preceding the September 2014 inspection there had been two unexpected deaths and 14 serious incidents reported from the medical care services, including older people's care. Of the serious incidents, five involved pressure ulcers that had been acquired whilst under the care of the trust, four involved patient falls, and one was due to serious infection.
- Lessons were learnt from incidents, at both inspections we observed information on notice boards and on the monitor screens displayed in the wards detailing what incidents or concerns had been reported and what action the trust had taken to make improvement.
- Mortality and morbidity was monitored by the clinical leads for the service. The Staff discussed mortality at ward meetings with the meetings being led by the lead consultant. Mortality levels were within the expected range for the size of the hospital.

Safety thermometer

- In September 2014 we found that pressure ulcers prevalence in medical areas has been consistently high in the period between May 2013 and May 2014, with 85 reported pressure ulcers at grade 2, 3 or 4, however the

trust states that 53 patients had been admitted to the wards with pressure sores from the community. We reviewed three serious incident investigations in relation to pressure ulcers, and found that they were completed through with lessons learnt identified.

- The medical care service has reported 44 catheter-associated urinary tract infections (UTI's) between May 2013 and May 2014. This is higher than the England average.
- In September 2014 we examined the records of six patients who had catheters in situ on Apple and Cherry Tree Wards. We found the recording of catheter care to be poor. Staff informed us that they were required to check on patients' catheters during their 'care around the clock' on each shift; however, they could not demonstrate or assure us that they undertook those checks. Two patients with catheters we spoke to on Cherry Tree Ward raised concerns to us that their catheters were causing them discomfort, and staff had not returned to check on them. We raised this with the senior sister on Cherry Tree Ward, who assured us that they would address the patient catheter concerns. We did not visit Cherry Tree ward in January 2015.
- The service had a lower than England average number of patient falls resulting in harm to the patient. At both inspections we observed that where patients were identified as high risk of falls, additional staff were booked to observe the patients, to minimise the risk of falls.
- In September 2014 we examined the cannula site recording and cannula sites of patients who had cannulas in situ. This is a measure on monitoring site infection risks. On Apple Tree Ward we observed that three people with cannulas had their sites bandaged, and therefore the cannula site was not visible. Two patients we spoke with informed us that their cannula was causing them discomfort. All three patients did not have a completed cannula care management plan in place. It is best practice to have these plans in accordance with the 'Department of Health (2007) Saving Lives: reducing infection, delivering clean and safe care. High Impact Intervention no 2, Peripheral intravenous cannula care bundle'. We did not review this at our January 2015 inspection.

Pressure ulcer care

- In September 2014 during examination of 15 sets of records across all medical areas, we found that only four pressure ulcer assessments had been completed correctly. We also found that in five cases where pressure-relieving equipment was required, this had not been provided to the patients. Therefore, we were not assured that lessons learnt from pressure ulcer investigations were embedded, or that practices were improving. In January 2015 we inspected Apple Tree ward and found that assessments had been correctly completed but that review and individual care planning was not always undertaken.
- On Apple Tree Ward, in September 2014, we observed one patient who was at risk of their skin breaking down. Their pressure ulcer assessment had been incorrectly calculated because a key medication had not been considered. We also found that they were not on pressure-relieving equipment, including an air mattress, as required by the outcome of their assessment. In January 2015 we found that pressure relieving equipment was in use for patients assessed at being at risk of their skin breaking down.
- In September 2014 a second patient on Apple Tree Ward had skin that had broken on their legs, for which they were receiving regular treatment in the community. This person's assessment had also been incorrectly calculated and appropriate equipment had not been provided. When escalated to the matron, the person was re-assessed. However, during the unannounced inspection, we returned and found that the patient had sores which were grade 2 on their leg, which had not been assessed or treated. A swab for infection had been undertaken on 16 September, but the result had not been received or chased by the team six days later. This meant that there was a potential delay in treating any infection that may have been present.
- In September 2014 we found that some staff were not classifying the grade, size or type of pressure ulcer, as defined by the 'European Pressure Ulcer Advisory Panel' (EPUAP). In three sets of notes that we reviewed, we found that staff had not classified the grade, size or type of pressure ulcer. There were no defining factors on the wound type, size, depth, colour, temperature, or if the area was blanchable or non-blanchable. We reviewed three patient records at our January 2015 inspection and found that these records showed that sores were classified appropriately.
- In September 2014 we examined the training matrix for the trust, and found that staff were provided with training on tissue viability. However, evidence found

throughout the inspection challenges how robust the training methods provided to staff are, as they have been unable to demonstrate competency around tissue viability in all medical ward areas. In January 2015 we found that the knowledge amongst staff on Apple Tree ward had improved and aids were in place for the three patients we reviewed.

- Patients who were identified as being at risk of pressure ulcer development, and required support with repositioning, should have been supported to do this during the 'care around the clock' rounds. In September 2014 we found inconsistencies in the recording of the turns and repositioning of patients. We spoke with two members of staff about this on Cherry Tree Ward, who informed us that they were unsure whether the previous shift had repositioned patients. In January 2015 we did not visit Cherry Tree ward.

Cleanliness, infection control and hygiene

- Visual observations of the ward areas showed that they were clean, and cleaning was being regularly undertaken.
- In September 2014 we examined clinical equipment, including four commodes, two mattresses and resuscitation trolleys across the wards, and found them to be cleaned to a good standard.
- In September 2014 the medical area had had a recent increase in the number of reported C. difficile cases. We were aware of concerns from stakeholders prior to our inspection regarding the infection control practices within the medical care service. We observed care between staff and patients, and found that care was not being provided in accordance with the trust's own infection control policy.
- In January 2015 we found that Apple Tree ward was caring for significant numbers of patients with infections. We saw through review of patient records, policies and discussions with staff that patients had been appropriately cohorted, grouped together, and infection control practices were in use. We noted that temporary hand washing facilities were in use to prevent the spread of infection to other patients.
- There had been no MRSA infections reported in the previous 12 month period.
- In September 2014 on Cherry Tree Ward we observed staff on three occasions come away from a patient, write in the patient notes, then remove their apron, and then wash their hands. This meant that the notes had been cross-contaminated. We did not inspect Cherry Tree ward in January 2015.
- During our first inspection in September 2014 we found on Cherry Tree Ward we observed a consultant doctor exit a side room, where a patient was being treated for C. difficile, write in their notes on the notes trolley, then remove their apron and use alcohol gel prior to going to another patient. The consultant did not wash their hands with soap and water, which is the most effective method of controlling the spread of C. difficile between patients.
- On Apple Tree Ward and on Walnut Ward, September 2014, we observed staff walking around the bays to care for patients, then exiting the bays whilst still wearing gloves and aprons when this was not required. On Walnut Ward we observed nurses wash their hands before removing their aprons; in one instance we observed a bank nurse wash their hands in the patient toilet area, then remove their apron and leave the bay. We raised our concerns to the senior sisters in charge of each ward.
- In September 2014 on Apple Tree Ward we intervened to prevent a final year student nurse from preparing an injection after undertaking a patient intervention, without washing their hands in between. In January 2015 we saw that hand washing practices had improved.
- In September 2014 we saw that patients were not given the opportunity to clean their hands prior to eating their food. In January 2015 we also saw that this was not offered to all patients.
- We observed that a majority of staff adhered to the 'bare below the elbows' protocol defined in the trust's policies. However, in September 2014 we observed two staff members wearing watches and three female staff members with jewellery on their hands that contained jewels. These members of staff were providing care to patients when the jewellery was identified. In January 2015 we noticed that the staff on Apple Tree ward were adhering to the trusts bare below elbows policy.

Environment and equipment

- Equipment was cleaned regularly, on Walnut, Apple Tree, Medical Short Stay and the reablement wards we visited.
- Resuscitation trolleys and equipment were checked, and records were kept.

- All sharps bins were dated, signed, and were not overfull.
- In September 2014 we observed that some patients had bed rails in situ across all wards visited. Some bed rails were older style and clipped on to the side of the bed. These bed rails had larger gaps between the rails and risked entrapment. We examined eight bed rail risk assessments for patients who had the older style bed rails in place. We found that the assessment did not determine what the appropriate bed rail type for the patient was. On Apple Tree Ward we observed one patient with their arm and leg through the bed rails. Therefore, the use of bed rails was not always safe because the assessment for use did not cover all associated risks of bed rail use. We saw that these rails were still in use we did not see any patients at immediate harm from these rails. Whilst risk assessments had been completed there were no actions recorded or seen to reduce the risk of harm from these rails during our inspection in January 2015.

Medicines

- In September 2014 we found that the storage and monitoring of medicines was appropriate. Fridge and room temperatures were being regularly recorded. All items stored matched in tally to those recorded as given from the records. The controlled drugs were checked and all accounted for.
- On Cherry Tree Ward we identified one medication error in September 2014, where a patient had been prescribed both regular and ad hoc paracetamol. We identified that this person had been administered over the recommended dosage of 4g per day. We raised this with the person in charge, and with the lead consultant. We saw positive action taken by both to report the incident, to inform the patient and their family, and to undertake tests to ensure that no harm came to the patient.
- On Apple Tree Ward, in September 2014, we identified three patients who had not received their medicines on time. One patient was to receive antibiotics for an infection. The antibiotics had been missed from the medicine rounds on more than two occasions. We examined the medication chart, which confirmed what we had been told by the relatives of this patient.
- In January 2015 we found that blue medication charts had been introduced to the ward to reduce the risks associated with missed or late doses of medication for patients who had Parkinson's disease. At the time of our inspection we saw that a patient was due to receive their Parkinson's medication at 11am. We checked to see if this had been administered at 11.50am. The medication chart had not been signed to state the medicine had been administered. We asked the nurse about the medication. The nurse told us the patient had received the medication but they had forgotten to sign the administration record. This meant that patients could be at risk of receiving a further dose of medication by another member of staff who may think the medicine had not been given.
- In September 2014 on Apple Tree Ward area we found that the medicines fridge was being monitored on a daily basis, but had been out of range since July, and no action had been taken by staff to report it or resolve it. Medicines within the fridge on this ward were not being managed appropriately, and patients were at risk of receiving medicines that could have been compromised. We escalated this concern immediately to the ward matron.
- On Apple Tree Ward, in September 2014, we found that the medicine trolleys used to transport medicines to patients were overstocked, and were kept in an unhygienic manner. Dust and debris was visible, both on the inside and on the outside of the medicines trolley. One of the trolleys had three bags of a patient's own medication being stored in it. In January 2015 we found that the trolleys were clean but remain overstocked with patient medication.
- In September 2014 all the medicines we looked at were within their expiry date. We saw that staff were dating and signing bottles of liquid preparations, such as antibiotic syrup and eye drops, at the time of opening. However, on all of the medical wards we inspected we found that staff were not dating and signing the bottles of oramorph on opening. On Walnut Ward we found that insulin had not been dated and signed on opening. These preparations should be used within a specified number of days once opened. On our inspection in January 2015 we found the same issue with the dating of liquid preparations. We spoke with a pharmacist who was visiting the ward at the time of our inspection and they confirmed that these preparations should be used within a specific timeframe once opened. These medicines were not managed appropriately, and patients were at risk of receiving medicines that had expired.

Medical care (including older people's care)

Records

- All records were in paper format. Nursing notes were generally kept on the wall outside the patient bay, observation charts were retained at the end of patients' beds, and medical notes were stored in trolleys on the ward areas.
- Healthcare professionals completed the records, and good examples of multidisciplinary entries were seen in the records to guide other professionals.
- The quality of conversations being recorded with patients, together with visiting professionals advice, including dietician, and speech and language therapy services, was good.
- The quality and consistency of the medical staff notes was variable, with some doctors writing being illegible to read.
- In September 2014 we found that admission checklists and patient safety checks were not consistently completed, and risks around falls, venous thromboembolisms, and moving and handling, were varied, with some noticeable gaps in recording. This was especially evident on Apple Tree and Cherry Tree wards.
- We reviewed three sets of records on Apple Tree ward in January 2015 and found that this issue had not been fully addressed with gaps in recording as to action taken to address specific patient needs. We found that admission checklists and patient safety checklists had not been completed. We saw that although one of the patients was being fully hoisted, the manual handling assessment had not been completed. We checked this with a member of staff who confirmed the assessment should have been completed as the patient had been in hospital for 14 days.
- In January 2015 we saw that core care plans were in place, and some attempt had been made to individualise the care plans, for example by inserting the location of the patient's pain. However, we saw that patient's care plans were not always updated to reflect the care given. For example, we saw from one patient's medication administration record that they had required significant pain relief on 1 January. This had not been entered into the evaluation or summary records of the care plan and there was no evidence to establish whether the pain relief had been effective.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients were consented appropriately and correctly, where people were able to give their consent to care and treatment.
- In September 2014 we examined the training matrix provided by the trust, which showed that the training requirement in consent, the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) was not routinely monitored as a mandatory subject. We spoke with staff who confirmed that they had completed training in MCA and DoLS online through an e-learning module.
- In September 2014 we identified one patient who had been referred for review by the adult safeguarding lead, due to challenging behaviour and the need for additional support. On the first day of our inspection we found that they were in bed and asleep or quiet for a majority of our visit, which was a contradiction to the entries in the notes and information from the family regarding this person's behaviour. We identified, through examining their records, that they had been given a sedative medicine. There was no best interest assessment or mental capacity assessment referred to in the records, prior or post administration of this medicine, despite the patient lacking the mental capacity to consent to receive this medicine. A referral to the DoLS team does not sufficiently cover the requirements of the Mental Capacity Act or Deprivation of Liberty Safeguards. The trust state that the capacity assessment was undertaken and the relatives spoken with on the phone but that the doctor did not document this in the notes. Following our inspection the trust commissioned an independent audit of this case that concluded that the medication given was appropriate but documentation of assessments did not refer to either best interest or mental capacity assessment.
- We identified in September 2014, through examination of 15 sets of medical notes on Cherry Tree Ward, Apple Tree Ward and in the Reablement Centre, that there was an under-recognition of delirium. Therefore, no clear interventions were identified, and this placed patients at risk of inappropriate treatment when they do not have capacity. We established, through speaking with staff and examining the training records, that staff had not received any awareness training on delirium.

- In January 2015 we discussed the issue of delirium and capacity with four members of staff on Apple Tree ward. We noted increased awareness of delirium and assessment of patients when there may be capacity issues. We reviewed two sets of notes and found that appropriate referrals to the deprivation of liberty team had been made and that these along with the outcomes had been recorded in the patients notes. We saw that patients who required an extra level of support were assessed and extra members of staff employed to assist these patients to ensure their safety.

Safeguarding

- There was a lead nurse for safeguarding. However in September 2014, when we spoke with staff, only some senior staff knew of the safeguarding lead. Most staff we spoke with were not aware of their presence. On our return inspection in January 2015 we found that staff on Apple Tree ward were aware of this lead and worked closely with them and the local safeguarding team.
- In September 2014 on Apple Tree Ward, during our observations we observed an agency nurse enter a patient's bay whilst they were asleep. The curtain was drawn and no introductions or consent were heard to be given or received. The staff member then proceeded to wash the patient with little interaction. We heard the patient say 'ouch you are hurting me'. We reported our concerns to the matron in charge to ensure that appropriate action was taken immediately.
- During the September inspection, two members of the inspection team observed two different members of staff move people in an unsafe manner. The manoeuvre used is known as a drag lift. A drag lift is when the carer/ person pulls a patient up by pulling/dragging them under their arms. In once instance this manoeuvre whilst not lifting the patient was used to reposition the patient. This can cause shoulder and spinal pain in the patient and carer and is classed as abuse by Age UK. During our inspection in January 2015 on Apple Tree ward we did not witness this manoeuvre being carried out.
- In September 2014 we were not satisfied that safeguarding concerns were always identified, or safeguarding alerts made when they should have been. Throughout our inspection we saw staff speaking to patients in an abrupt manner, and we saw unsafe moving and handling practices were being undertaken in Apple Tree ward that we inspected. At our inspection of Apple Tree ward in January 2015 we found that safeguarding concerns were being raised and responded to by members of the ward team.
- In September 2014 the trust requested an independent review of safeguarding from another trust. This review found that whilst the decisions made around safeguarding and mental capacity had been correct the documentation of these decisions was poor. The trust have altered the job role of the safeguarding lead and introduced new systems to highlight to management on a daily basis those patients who may be vulnerable

Mandatory training

- Mandatory training for the service is classed as fire safety, infection control, moving and handling, information governance, Safeguarding Adult's level 1, Safeguarding Children level 1, and equality and diversity. In September 2014 in acute medicine around 79% of staff had received training. Within care of the elderly services 68% of staff had received mandatory training. We did not review mandatory training in January 2015 as we were focused on the review of Apple Tree ward.
- Locally, staff informed us that they had online access to other training courses, including health and safety and training on the Mental Capacity Act. Records of attendance for this training was not routinely monitored, and we found the uptake of this training locally was sporadic.

Management of deteriorating patients

- The medical wards used a recognised national early warning tool called NEWS. There were clear directions for escalation printed on the reverse of the observation charts, and staff spoken to were aware of the appropriate action to be taken if patients scored higher than expected, and may need intervention.
- We looked at completed charts and saw that staff had escalated patients' conditions correctly, and in most cases, repeat observations were taken within the necessary timeframes. In September 2014 there were some gaps in the recording of routine observations on Cherry Tree Ward and Apple Tree Ward. At our inspection in January 2015 to Apple Tree ward we found that appropriate escalation had occurred for the three patients we reviewed.
- There was a critical care outreach team, who were present on site seven days a week. The team could be

contacted by any member of staff, and their contact details were accessible on all wards, as well as on the observation recording document. The ward staff reported that the outreach team were responsive to the patient's needs.

- Staff on several wards told us that when they escalated concerns regarding a deteriorating patient to the medical team, they were quick to respond at any time of the day, and would respond swiftly.
- In September 2014 on Walnut Ward we observed staff intervene at the early signs of a patient's health deteriorating due to a life threatening complication (pneumothorax). The action was swift and resulted in a positive outcome for the patient

Nursing staffing

- We found in September 2014 that the wards had recently completed the Shelford safer staffing tool. In each area staffing levels were calculated based on patient to staff ratio, which equated to approximately one nurse to eight patients during the day. This model of staffing was not reflective of patient needs, and wards, including Cherry Tree and Apple Tree, were not able to complete basic nursing tasks, due to patient dependency outweighing the staffing numbers. In January 2015 we reviewed the staffing on Apple Tree ward and found that the expected numbers were advertised on the door to the ward area. The actual number of staff was also recorded here. On the 2 January 2015 the numbers of expected staff and actual staff were the same. The ward manager was not counted in the numbers on most shifts and was therefore available to assist as required.
- In September 2014 nursing numbers had been assessed for each ward. However, this was inflexible and staffing levels were not co-ordinated according to the patient's dependency or needs. Staffing cover was provided through the use of temporary agency staff, while new permanent staff were recruited into posts.
- During July, of the staff on duty in all medical wards, between 12% and 29% were agency or bank staff. In August, the percentage of bank and agency used was between 9% and 26%. There was a higher use of agency staff on Apple Tree Ward and Cherry Tree Ward.
- At our inspection in September 2014 nursing staff told us that the trust had difficulty recruiting and retaining staff, although we met many staff who had worked at the trust for many years. One told us "we can't keep staff". Doctors we spoke with were aware of some nursing shortages, and reported that they were kept informed of nurse vacancies.
- Ideal and actual staffing numbers were displayed on every ward we visited. During our September inspection, boards indicated that, in the main, the ideal numbers of staff were maintained on those days. On Apple Tree Ward, there was a shortfall of a nurse and a support staff member for an afternoon shift. The matron told us that she was trying to fill the shifts with temporary staff. However at our inspection in January 2015 we saw that on Apple Tree ward where patients required an increased level of care extra staff were allocated to the ward to provide this level of support. During this inspection in one bay there were two such patients and a health care assistant was delegated to monitor these two patients.
- Agency staff had an induction when they commenced their shift, which covered the ward layout, emergency procedures, and information to assist them with patients' care.
- In September 2014 four patients we spoke with raised concerns about the non-English speaking nursing staff. Patients all reported to us that the staff were "lovely", but shared that they were unable to communicate with the staff. The trust confirmed that action was underway to provide support to those staff to improve their English.

Medical staffing

- There were ward rounds seven days a week on the Medical Short Stay Unit. There was an acute medical consultant on the unit from 8am to 8pm. After 8pm and at the weekends there was on-call consultant cover only.
- We spoke with a range of junior medical staff, who reported that working hours and shift time were better than any other training placement that they had been on. No concerns were reported by staff on medical staffing numbers.
- Daily ward rounds were consultant-led throughout medicine, except for weekends, which had limited consultant rounds. We found that there was a handover from consultant to consultant, and from junior doctor to junior doctor on each shift.
- We observed MDT ward rounds, which were thorough, well organised, and well attended.

Medical care (including older people's care)

Major incident awareness and training

- The trust had established an emergency planning steering group to provide assurance to the board that plans established were updated regularly. These plans had been developed in conjunction with the local health economy.
- Staff within the local departments were unclear of the specific requirements of their role during a major incident. Staff were able to show us where the major incident plan was, and who they would contact if they needed advice. We did not review this as part of our January 2015 inspection. .

Are medical care services effective?

Requires improvement

In September 2014 medical care services were not effective as people were at risk of not receiving effective care or treatment. Care plans did not always reflect current evidence based guidance in cannula care. Patients were offered a variety and choice of food; however, fluid balance monitoring was not always effective. There were gaps in the management arrangements and support for staff in regards to supervision. We found that agency nurses and student nurses were not always supervised sufficiently which led to poor care being delivered. Outcomes for diabetic patients was below the national standard and patients we spoke to on site and at our listening events supported that care for patients with diabetes was not as good as it could be due to lack of understanding of the condition amongst nursing staff.

There was no on site seven day cover for medical staff; cover was provided on-call and not on site. With the exception of support for respiratory services, there were no occupational therapy or physiotherapy support services at weekends. There were also reported delays around medicines, due to the pharmacy closing at 4.30pm, and not working at weekends. However there were good arrangements for multidisciplinary team working. The service had undertaken local and national audits. Length of stay is in line with the England average for emergency medical admissions.

The change in the facilities on Apple Tree Ward and the Reablement Centre did not effectively support discharge from hospital. The service had increased bed capacity by five beds on each ward, and taken away rehabilitation facilities. This had had a negative impact on the length of stay for patients.

In January 2015 we did not review this aspect in full we focused on nutrition and hydration on Apple Tree ward. We found that some charts were not completed correctly and whilst this requires further improvement we did note that documentation in general had improved since our September 2014 inspection.

Evidence-based care and treatment

- The medical care service used a combination of National Institute for Health and Care Excellence (NICE) and Royal College of Nursing guidelines to determine the treatment they provided. Local policies were written in line with this and other national guidelines, and were updated every two years, or if national guidance changed.
- There were specific care pathways for certain conditions, in order to standardise the care given. Examples included falls, sepsis and infections such as MRSA.
- There were care bundles in place to ensure that treatment for the most common conditions, such as chest pain, reflected best practice and national guidelines

Pain relief

- We observed staff provide medicines during the visits; when medicines were administered, pain relief was offered to the patient or given as prescribed. We examined 15 medicine charts which supported our observations.
- In September 2014 three patients on Cherry Tree Ward and four patients on Apple Tree Ward told us that they regularly had to wait for their medicines. Two patients on Cherry Tree Ward told us that staff were "very busy" and did not give them their pain relief in a timely way. On Apple Tree Ward four patients all reported to us that there were delays in receiving pain relief, despite requests to staff. They informed us that they believed this was because there were not enough staff on duty.

Nutrition and hydration

- We observed on all wards that regular fluids were provided. However, we observed that the recording of fluid intake was not consistent. For example, in September 2014 on Apple Tree Ward we noted a patient

was on a fluid balance restriction of 1500mls per day. This patient informed us that they had to remind staff of their fluid balance because staff were not keeping track of what the patient had already had. On our inspection in January 2015 we found similar issues with fluid balance charts not being completed, an example of this is that for one patient between the hours of 6am and 11pm on one day of their stay. There were other days when recording was patchy for this patient.

- In September 2014 we observed a patient on Cherry Tree Ward who had three drinks provided to them during our observation period; all three were removed by staff during the course of our observation, and no details of the amount of fluid taken were recorded in the patient's notes. This patient was on fluid restriction, and therefore fluid intake recording was required.
- On day one of our inspection in September 2014 we observed on Cherry Tree Ward that fluids were out of the reach of eight patients. We spoke with staff, who ensured that people had drinks nearby. We noted that four patients had drinks out of reach during the second day of the inspection.
- Patients were positive about the choice and quality of food offered to them. Patients reported that the food they were given was of a good quality. During the September inspection we spoke with 23 patients about the food. All were mostly positive about the food; comments received included "food is nice", "there is a good selection", "they make me salads, I do like their salads". This was confirmed at our January 2015 inspection.
- Whilst all patients were complimentary about the quality of the food and the options, in September 2014 we received feedback from three people that there was no option on portion size, and meal portions were often larger than they could manage. This had not significantly changed during our inspection in January 2015.
- In January 2015 we saw that other risk assessments were undertaken and action taken as appropriate. For example one patient's nutritional score had deteriorated over the course of ten days and the patient was then referred to the dietician.

Patient outcomes

- Standardised relative risk of readmission for the trust and Hinchingbrooke Hospital was lower than expected for all specialties, other than clinical haematology which had a value of 107. The ratio of observed to expected emergency readmissions is multiplied by 100. Value below 100 is interpreted as a positive finding, as this means there were less observed readmissions than expected.
- The Myocardial Ischaemia National Audit Project (MINAP) is a national clinical audit of the management of heart attack. The MINAP audit showed that the hospital provided data as part of this audit, but no results specific to the hospital were available at the time of our September inspection because they did not provide a dedicated cardiac service.
- National Diabetes Inpatient Audit (NaDIA) participation showed that the trust performed worse than expected on five out of 22 questions, with the trust performing worse than expected in questions covering foot care, meal timing and staff knowledge. During our September inspection we spoke with patients who corroborated this audit result.
- Length of stay at Hinchingbrooke Hospital is in line with the England average for emergency medical admissions.
- Walnut Ward is the medical ward which provides specific respiratory care, including non-invasive ventilator care (NIV). During the September inspection we were informed that patients on NIV could be placed in other wards around the hospital, and there was an inpatient being NIV treated outside of Walnut Ward at this time. The staff on the other medical ward were not as competent as those trained on Walnut Ward. Other ward staff are supported with NIV management by Critical Care Outreach Practitioners of staff from Walnut.
- The medical care wards currently have a high occupancy rate of patients. To accommodate this increase in September 2014, the Reablement Centre and Apple Tree Ward had converted their day rooms into additional patient bays. This had directly impacted the quality of care being provided to patients who required reablement to facilitate their discharge. During the intervening months the trust had removed the curtain rails from the day room on Apple tree ward and this are was no longer used as an inpatient area during our inspection in January 2015.
- The trust provided us in September 2014 with a list of all ongoing and completed audits during their past year. Most were in line with expectations, except venous thromboembolism (VTE), which locally showed poor results on Cherry Tree and Apple Tree Wards.

- The majority of national and local audits were ongoing. Where completed audits identified areas for improvement in clinical effectiveness and outcomes for patients, there were action plans in place to address issues raised.
- The in patient survey showed that the trust was performing in line with national expectations in all areas of the questionnaire.

Competent staff

- Nursing staff and medical staff we spoke with in September 2014 had received an appraisal within the last year. We examined the appraisal data, which showed that 87% of acute medicine staff, and 79% of care of the elderly staff had received an appraisal. In January 2015 was were told that all staff on Apple tree ward had received an appraisal.
- Doctors reported appraisal and revalidation taking place according to General Medical Council guidelines.
- Bank and agency staff working at the trust are trained by their respective agencies. The management team on the wards were clear on the procedures for feeding back about competency of bank and agency staff. We were provided with examples of when agency staff had not performed in a competent way, and what action the hospital had taken to ensure that improvements were made. In September 2014 we observed, in a case where a nurse had inappropriately moved a patient by performing a drag lift on them, that this person had been reported to their agency, and the ward had requested that this person was not sent back to the trust. In January 2015 staff told us that they were confident and vigilant about reporting unacceptable behaviour from temporary staff. This information was passed to the nursing bank and the ward manager checked to ensure that these issues had been dealt with.
- We were made aware during the September inspection that the nursing establishment had raised concerns about the quality of care provided by some agency workers. On discussion with senior nursing staff this information had been escalated to the senior management team, who were reviewing the concerns raised about agency workers.

Facilities

- In September 2014 on Apple Tree Ward and in the Reablement Centre, the day room facilities had been changed into additional ward bays, to allow for times of high capacity. The day rooms on both wards were for rehabilitation, and were where allied health professionals, including physiotherapy and occupational therapy teams, provided rehabilitation support, to enable a quicker discharge into the community.
- Both wards had increased their bed capacity by an additional five beds, and had not had rehabilitation facilities available for over two months. We spoke with the nursing and medical staff about the change of these facilities to beds. We were informed by staff that they felt the change in facilities had directly impacted patients' length of stay, as they were receiving less enablement therapies. Therefore, the change in facilities was not effectively supporting the discharge of patients from hospital.
- In January 2015 we found that the rehabilitation facility on Apple Tree ward had been returned to a rehabilitation area. The trust had removed the curtain tracks and the ward manager had plans to fully utilise this area for rehabilitation.
- The trust participated in patient-led assessments of the care environment (PLACE). The hospital scored slightly below average for food, privacy, dignity and well-being.

Multidisciplinary working

- There was clear evidence of multidisciplinary team (MDT) working on the wards. There was regular input from physiotherapists, occupational therapists and other allied health professionals, when required. The level of information from MDT teams in patient records was comprehensively detailed, with clear plans and instructions.
- There was evidence that the trust worked with external agencies, such as the local authority, when planning discharges for patients. However, senior staff reported that discharges were often delayed when dealing with some social services departments. In September 2014 we were informed of an example of a patient who had been an inpatient for over 100 days, despite being medically fit for discharge. The trust reported that this was a situation beyond the control of the trust. This patients discharge plans were escalated by the MDT to the executive team for action at a higher level, we observed entries from the discharge coordinator, nursing and medical staff regarding these plan in the person's medical records, though the person remained an inpatient at the time of our September inspection.

Medical care (including older people's care)

- We found that the services were accessing the local authority Deprivation of Liberty Safeguarding team to approve and review DoLS applications for patients who lacked capacity to make decisions regarding their care. In January 2015 we found that there was closer working between the staff on Apple tree ward and the local authority team in respect of these patients.

Seven-day services

- There was a medical presence on the wards seven days a week. Consultants' ward rounds took place daily in some areas, such as in the Medical Short Stay Unit, and in other wards at least once on a weekend. Medical patients on other wards would be seen by on-call physicians if they became unwell, or if there were concerns about deterioration. We noted that the trust was reviewing a business case to support the need for acute physician cover on site, seven days per week.
- Patients were seen by allied health professionals during week days. Support services, including physiotherapy and occupational therapy services, were not available at the weekends. Nursing staff informed us that they aimed to follow care plans at weekends, to continue rehabilitation therapy with patients; however, they often did not have the time to complete this.
- Physiotherapists who gave respiratory support were available on a call out basis at the weekends, and were called in when required for Walnut Ward.
- There was a daily ward round on the medical assessment unit (MAU), including at weekends. Medical patients on other wards would not be seen routinely, and would be seen by on-call physicians if they became unwell, or if there were concerns about deterioration.
- All medical care areas reported challenges with access to the pharmacy service after 4.30pm daily, and at the weekends. All areas reported to us that the lack of pharmacy support led to delays in treatment and patient discharges.

Are medical care services caring?

Requires improvement

In September 2014 patients were not treated on Apple Tree ward with compassion therefore we judged this aspect of the service inadequate. On Apple Tree Ward we observed poor patient experiences, and from our observations of care on the ward we established that people were not treated with dignity or respect. We also found that on the Reablement Centre a patient who's needs had not been met and left them feeling undignified. We were concerned that people were not being treated in an emotionally supportive manner. We heard patients talk negatively about the interactions that they had with staff on Apple Tree ward. Some patients were afraid of certain nursing staff on this ward. We heard some staff being rude to patients or being dismissive of them. Some patients and relatives on Apple Tree and Cherry Tree wards felt that they were not involved in their care. We spoke with 23 patients during the inspection, and the majority, 17, were complimentary about the care they received from their local hospital but we spoke with, saw and heard extreme examples of where care was inadequate.

On 2 January 2015 we returned to Apple Tree ward and found that staff treated patients with dignity and respect. We witnessed mostly meaningful and positive interactions between care staff and patients. We did not see staff spending time with patients and explaining their care to them. We witnessed patients undergoing one carer to two patients who were on close observation for their safety however there was little interaction with these two patients during our observation period. We did not inspect Cherry Tree ward at this inspection therefore we cannot be assured that all patients have their social needs met or are involved in their care in this service.

Compassionate care

- In the June 2014 NHS Friends and Family Test results, three wards scored above the England average of 72%, for people who would recommend the hospital wards.
- Between September 2013 and January 2014, a questionnaire was sent to 850 recent inpatients at Hinchingbrooke Hospital, with responses received from 413 patients. The ward areas scored on average with all other hospitals in England for care and treatment with dignity and respect.
- We spoke with 23 patients during the inspection in September 2014, and most were positive about the care they received from their local hospital. We spoke with three patients during our inspection in January 2015 and they confirmed that care was generally good.
- In September 2014 we observed good examples of one-to-one care of a patient living with dementia on Cherry Tree Ward. The health care assistants approach to the patient needs was calm and respectful.

- In September 2014 we observed that the way medicines were administered by the staff nurse to patients in the Reablement Centre was done in a caring and respectful manner. The staff member took the time to explain each medicine and why it was needed to all patients we observed who asked

Patient understanding and involvement

- At both inspections the majority of patients and relatives we spoke to stated that they felt involved in their care. They had been given the opportunity to speak with the consultant or the doctors looking after them. However in September 2014 we found that those without mental capacity did not always have their best interests discussed with family. We spoke with a family of one patient who lack capacity who informed us that they were not involved in best interest decisions being made for their relative.
- In September 2014 some patients on Apple Tree Ward and Cherry Tree Ward told us that they had not been involved in their care. One said "they tell me what I need and then change their mind but don't tell me". Another patient told us "I don't know what is going on", whilst another said "I am told to take my tablets, but they don't tell me what they are for". During our inspection of Apple Tree ward in January 2015 one patient stated that they felt informed and involved in their care stating that "they are kind and they explain things to me." In September 2014 some patients and relatives said that they were unaware of the arrangements for their discharge home. Some people made comments such as "no one tells us what is happening", and "we are told different things by different staff", "it seems like no one knows what is going on".

Emotional support

- Patients' emotional well-being, including anxiety and depression, were assessed on admission to each ward area, and appropriate referrals for specialist support were made, where required.
- Clinical nurse specialists were available to offer advice and support to patients and relatives about diagnosis and treatments.
- In January 2015 we saw that patients who required a closer level of observation were assessed appropriately but that some shortages of staff meant that two patients were being observed by one carer. We saw little interaction with either of these patients during our observation. The one interaction we witnessed was paternalistic rather than emotionally supportive.

Dignity and respect

- In September on Cherry Tree Ward we observed that patients' cleanliness and hygiene were not always maintained. This related to the cleanliness of people's hands and fingernails. We observed five patients who had long fingernails, with dirt underneath them; their hands were also unclean. On examination of three of the patient records, there was no evidence to support the patient requirement of cleanliness and nail care.
- During the September 2014 inspection our 'expert by experience' observed a poor interaction on Apple Tree Ward between a staff member and a patient. We observed the staff member push a tray table towards a patient after they pushed it away; this was repeated several times; when the staff member pushed the tray back, soup spilt down the front of the patient. The staff member was then rude towards the patient for the soup being spilt. This patient was treated in an undignified and emotionally unkind manner.
- We observed a lunch time meal on Apple Tree Ward at both inspections. In September 2014 we saw that patients received help to eat their food where it was required, but this was not always done in a way that respected the dignity of the patient. We observed a health care assistant helping one patient to eat some soup. The health care assistant did not engage with the patient and stood over them. We observed that the health care assistant was abrupt with the patient, and did not respond to the patient's attempts to communicate that they did not want any more of their meal. We observed this health care assistant assisting two people to eat their meals at the same time. In January 2015 we found that the way in which patients were assisted to eat their meals was more respectful and dignified.
- In September 2014 we completed a SOFI observation on Apple Tree Ward at the time that the night shift changed over to the day shift. Short Observational Framework for Inspection (SOFI) is a specific way of observing care to help us understand the experience of people who use the service, including those who were unable to talk with us.

Medical care (including older people's care)

- We heard the audible interactions of a patient who was washed behind a curtain in the morning. The agency staff member entered the bay and did not ask for consent to wash the patient, and did not introduce themselves to the patient. The patient was heard to ask "who are you?" We also heard the patient ask if they were clean and they said "I don't feel clean"; this was not answered by the staff member who, after a short silence, instructed the patient to "roll on your side".
- During breakfast we observed three members of staff standing over the patients whilst supporting them with their food. The food was provided to the patient at a fast pace, and gave them little chance for rest in between. Two of the three staff members did not offer the patients a drink during the breakfast. This is an undignified way to provide support at meal times to a patient.
- We spoke with each individual staff member, who proceeded to sit down and provide support to eat; however there continued to be little or no interaction with patients.
- We spoke with five people on Apple Tree Ward about their food. One patient told us that the portions were too large and they struggled to finish them. They also told us that they were "told off" when they did not eat all of their food. When this was explored further with the patient, they informed us that "staff tell me off if I don't eat everything". They were concerned about this, and said that they felt they must eat all their food.
- During our observations in the morning we saw a patient being supported by a staff member who was standing up and leaning over them. We heard the staff member say to the patient "don't misbehave you know what happens when you misbehave". We later asked the patient what they thought the staff member meant by this; the patient became withdrawn and was unable to provide us with an answer.
- A patient on Apple Tree Ward, who required support during the night to go to the toilet told us that staff were "often too busy". They said "they tell me to go in my bed and they will change me when they have time". This patient was able to give an example of waiting twenty minutes for a nurse, by which time they had already opened their bowels and wet the bed.; the nurse advised them that they had to wait and it then took another twenty minutes before they were cleaned. The patient told us that they felt their dignity had been taken away.
- A patient who was immobile with back pain said that they had waited over an hour in the Reablement Centre for their call bell to be answered when they required the toilet, and it had been too late when the nurses attended. This patient told us "I try to let them know as early as I can but they don't come, I don't feel good about it".
- Overall, the patients we spoke with reported that they felt the care was good on Apple Tree Ward. Our own observations led us to conclude that patients on this ward were not consistently treated with dignity or respect or in an emotionally supportive and personalised manner. We were so concerned that we made a referral to the local authority's safeguarding team.
- We visited on the following Sunday lunchtime, 21 September 2014, and found that the number of beds on the ward had been reduced. The staff available provided assistance with eating the Sunday dinner with dignity and respect and engaged in meaningful conversation with patients. We saw that call bells were responded to promptly and patients were reassured appropriately. One patient told us that the care they received had greatly improved since our last visit.
- At our inspection in January 2015 we found that staff treated patients with respect and dignity speaking in a personalised manner to patients.

Are medical care services responsive?

Requires improvement

In September 2014 the medical care services were not sufficiently responsive to the needs of all patients.The Medical Short Stay Unit and Reablement Centre were not utilised for their intended purpose. This was because they were often utilised as general medical wards so patients using these wards did not always get the therapy required to improve. Medical patients were not always classed as outliers in medical areas despite requiring specialised care. This meant that patients did not always get to see their consultant team during their admission and that potential treatment for their individual condition may be affected. Patients reported high numbers of overnight moves between wards. This was disruptive to all patients and not

in line with the trusts policy. Some patients did not find it easy to raise their concerns, they were unaware of the complaints procedure. Staff stated that they did not get feedback from complaints that had been made.

There was access to specific support for people who had more complex needs, such as dementia and learning disabilities. Patients had access to the support services they needed, such as to therapists when they needed them.

During our inspection in January 2015 we focused on Apple Tree ward and the response to call bell times which had improved since our September inspection.

Service planning and delivery to meet the needs of local people

- All medical wards were medical wards with small elements of specialist areas. Walnut Ward provided some respiratory and cardiac care, Cherry Tree Ward provided inpatient care for people with dementia, Apple Tree Ward provided rehabilitation stroke care. However, due to capacity, these services were not always used to their potential, with people being moved to other wards not in this speciality.
- A medical termination of pregnancy service was provided on the Medical Short Stay Unit. The service was provided to women at less than 12 weeks of pregnancy, and covered chemically-induced terminations only. This service was provided in consultation and joint working with the gynaecology service. However, We did not see any formalised care plan or care pathway for the undertaking of this service on the Medical Short Stay Unit despite the trust stating that there was one. The pre-planning and arrangements were undertaken through gynaecology.

Access and flow

- Bed occupancy was above the national average of 89% at the time of our September inspection.
- The average length of stay for medical care was above the national average. This was attributed to issues relating to the accessing of care packages and care facilities in the community. Between April 2013-April 2014 the number of patients waiting to receive a care package in their home was 19%, against the England average of 10%; the number of patients waiting for a completion of assessment for further care was 44%, against an England average of 19%. These care issues resulted in delayed discharge as planning for discharged only occurred once the patients was medically fit for discharge.
- The medical care service was working with the commissioners and local authority across two counties, to find placements in the community for patients awaiting discharge. There was confusion amongst families on the discharge arrangements into the community for their relatives. Five relatives we spoke with felt that communication from all stakeholders, who were involved in discharge, was poor.
- Referral to treatment times (RTT) for all medical specialties, including gastroenterology, cardiology and geriatric medicine, were all meeting standards, with most services achieving 100% compliance with RTT, with the exception of gastroenterology and gynaecology, who achieved 98.3% respectively.
- If a patient in medical services was placed on a surgical ward, they would be classed as an outlier. However, when a medical patient required a specific service, such as respiratory care, but was placed on the stroke ward, then they were not classed as an outlier. This meant that those patients, who should see a specific consultant for their condition, did not see them outside of the specialist ward area. Consequently, the trust reported that patients did not always get to see their consultant team during their admission.
- In September 2014 on the Medical Short Stay Unit patients reported that they could be moved at any time of the day, including at night time. The trust policy recommends that patients are not moved after 9pm at night; however, patients had experienced bed moves out of hours due to capacity issues. We spoke with senior nursing and medical staff on the ward who informed us that this did take place however they aimed to avoid this where possible. The trust do not currently measure the number of transfers that take place after their deadline time of 9pm.
- The Medical Short Stay Unit is a medical area, ideally used to provide care to patients for a period of up to 72 hours. We found, in September 2014, that on the ward, four patients had been on the ward for over a week, and in one case, over two weeks. We were provided with examples by staff of recent patients who had been on

the ward for more than one month. This supports the view that the patient flow within the hospital is affected because the Medical Short Stay Unit is not able to be responsive due to hospital bed capacity issues.
- The Reablement Centre is meant to be a ward that provides support to people to get back into the community. At the time of our September inspection, 14 of the 24 patients on the ward were long-term nursing care patients, and were not on the ward to use the rehabilitation services. This was due to delays in discharge arrangements which may be out of the control of the hospital however the trust reported that this did prevent people who required rehabilitation from using the services provided by this specific rehabilitation ward.

Meeting people's individual needs

- We observed call bell times on each ward throughout our September 2014 inspection. We noted that in the Reablement Centre, out of 25 beds observed, that nine patients did not have patient call bells within reach. We raised this with staff, who checked and ensured that call bells were placed within reach.
- In September 2014 the trust has recognised from patient feedback that they need to audit a baseline of call bell response times and make improvements. However, they had not planned to start this project until October 2014. During our inspection in January 2015 we were shown audits which included response to call bell times on Apple Tree ward this had generally improved since our September inspection. We observed that call bells were being answered in a timely manner and did not observe a call bell ringing for any longer than three minutes. However the ward manager informed us that that the time taken to answer a call bell should not exceed two minutes, but at busy times such as breakfast and after breakfast, it often took longer to answer call bells.
- A learning disability hospital liaison nurse specialist was employed to provide support and advice to patients, relatives and staff.
- Support was available for patients living with dementia and learning disabilities. Despite some staff telling us in September 2014 that there was a specialist dementia team the trust has since confirmed that they do not employ a specialist dementia team.
- Some leaflets and patient information were available in different languages on request. Translation services were also available to be accessed 24 hours per day. Staff could demonstrate to us, when asked, how these services were accessed.
- In September 2014 most patients on Apple Tree Ward and Cherry Tree Ward said that they often did not know who their named nurse was, although this information was written above their bed. During our inspection in January 2015 we noted that patients named nurses were not recorded on the whiteboards above their beds.
- The Reablement Centre at the time of our September inspection the area was single-sex in each bay, because the ward was being used as an inpatient long-stay medical area, rather than as a rehabilitation service. This was due to capacity within the hospital, and capacity for beds within the community.
- The environment in each ward visited had been refurbished. Cherry Tree Ward had been refurbished with dementia-friendly themes, including different colours and signs to meet the needs of a person with dementia
- Pastoral care and multifaith support was available to people on the wards. There was a twenty four hour per day seven days per week chaplaincy service available to people to meet all faith needs.
- We viewed the food menus provided to patients on the ward, these contained options for vegetarians, gluten free and halal. One patient we spoke with requested specific foods that were lower in salt or sugar. These were provided with their preferred dietary option. This was supported by observing the food they were provided at lunch which was specifically created for them.

Learning from complaints and concerns

- The complaints process was outlined in information leaflets, which were available on the ward areas. In September five patients told us that they had been provided with information on how to raise concerns. However, this was not consistent practice on all ward areas.
- Senior nursing staff told us that complaints about their areas were discussed at their meetings. We saw evidence of this in the meeting minutes. Nursing staff told us that they were not always made aware of

complaints, and did not receive feedback about complaints, or learning from these. They also told us that providing feedback was difficult, as it was not possible for all staff to attend meetings.

- In September we spoke with two families of patients who were raising official complaints during our inspection. Both complaints related to missed medicines on medication rounds. They told us that they felt they were being listened to, and that action would be taken.

Are medical care services well-led?

Requires improvement

Following our September 2014 inspection we could not be assured that the delivery of high quality care was assured by the leadership and governance arrangements in place in the medical care services. We found that the culture of identifying, reporting and escalating concerns was not open. We found that teams were not engaged, or felt enabled to raise concerns. We identified serious concerns around the treatment and safeguarding of patients on Apple Tree Ward; when raised to the leadership team of the ward, they did not wish to raise it to a higher level, or through their reporting of concerns strategy called 'Stop the Line', as they felt it could be managed locally.

Prior to leaving the trust on 18 September 2014 we reported our concerns to the local safeguarding authority. The following day we informed the Trust Development Agency (TDA) and held a management review. We decided to request further information as we were considering taking enforcement action under our powers under Section 31 of the Health and Social Care Act 2008 to reduce the number of beds available on Apple Tree ward. However the trust took steps to do this and to improve care as seen during our two unannounced inspections. Since our inspection the TDA have given the trust significant support to address the issues highlighted in our letter of immediate concerns to the trust. We continue to monitor actions taken by the trust.

Locally, nursing staff were positive about the leadership of nursing on Walnut Ward; however, nurses felt that nursing leadership was lacking on Cherry Tree Ward and Apple Tree Ward. Medical staff felt that they were well supported by the clinical leads and consultants within the service. Junior medical staff had good access to leadership, education and development through the clinical teams.

We inspected Apple Tree ward on 2 January 2015 and found that a ward nurse had been placed as interim ward manager. This person provided support and leadership to the ward team and temporary staff on the ward. This nurse whilst having a good understanding of the management of the ward was not provided with support and their developmental needs identified. We found that systems and processes were in place to ensure that the ward was managed appropriately and issues raised with staff as necessary. The culture of the ward had improved with staff feeling more empowered following our September 2014 inspection. Whilst we found that the leadership of Apple Tree ward had improved the leadership of this ward was temporary and we could not be assured that the changes would be sustained over a longer period of time. We did not inspect other areas of this service.

Vision and strategy for this service

- In September 2014 the senior nursing staff we spoke with said that they did not feel involved in the decision-making processes within the hospital. The structure within the directorate, and within the trust, was clinically-led by medical staff, and lacked nursing engagement. In January 2015 we found that staff on Apple Tree ward felt empowered to raise issues of concern and were listened to by the senior managers within their service.
- All staff spoken with were aware of the vision and strategy for the service, and referred to the messages sent out by the trust management team and by Circle.
- The medical service has a five year strategy plan, which focused on community engagement, and the need to provide more residential support to the elder population.

Governance, risk management and quality measurement

- Wards used a quality dashboard and Safety Thermometer to measure their performance against key indicators. Where wards were consistently falling below the expected levels of performance, action was taken to improve performance by the nursing leader's clinical leaders and specialist nurses.

Medical care (including older people's care)

- There were regular governance meetings; however in September 2014, most junior staff we spoke with were unsure of how governance worked to improve patients care. For example, there have been concerns regarding the care of patients on Juniper Ward in the surgical service. Staff we spoke with were aware that there had been concerns, but did not know what was being done to improve the service. This meant that lessons learnt were not being embedded across the hospital. We did not assess this aspect of the service in Apple Tree ward in January 2015.
- Governance meetings covered areas for concern, complaints, nursing indicators, and plans for improvements in the safe delivery of patient care.
- In September 2014 we reviewed the risk register for the medical service and found that issues we had identified were not listed on the risk register.

Leadership of service

- All nursing and medical staff felt engaged in how the service could work together through the clinical lead for the service. Medical staff of all grades were positive about the clinical leadership shown by the clinical lead for medicine.
- In September 2014 senior nurses within medicine said that they felt confident in the director of nursing, who had been recently appointed within the previous three months. Nursing staff were supportive of the management demonstrated by the nursing leadership on Walnut Ward; however, other staff felt that the nursing leadership on the other medical wards was not as visible as they could be. We were concerned about the nursing leaders on Apple Tree Ward. When concerns regarding the safeguarding and treatment of adults on the ward were raised, the nursing leadership deal with the concerns that were raised locally, and failed to escalate the concerns appropriately to the senior management team to get additional support. In January 2015 we found that the new leader of Apple Tree ward was working well with the safeguarding teams both internally and externally to the hospital.

Culture within the service

- The trust has a whistleblowing policy, as well as the 'Stop the Line' procedure, for staff to raise concerns. 'Stop the Line' is a slogan borrowed from the manufacturing industry, where every worker on the shop floor has the power to bring the production line to a halt if they sense any risk to safety. In a hospital setting, this means that all staff have the power and responsibility to 'Stop the Line' on any activity which they think could harm a patient. 'Stop the Line' is one of four initiatives to improve hospital safety, as part of Circle's 16 point plan at Hinchingbrooke Hospital.
- At our September inspection we spoke with most staff about the 'Stop the Line' initiative, and all could give an example of when they would use the procedure; most scenarios involved safe staffing levels. Staff we spoke with felt that it would have to be a serious or significant event to invoke the procedure; we found that staff did not feel empowered or able to 'Stop the Line'. When asked why they would not use the procedure, no specific answers were given. We therefore felt that the culture of reporting concerns within the trust was not as open as it could be.
- We spoke with the senior nursing leads on Apple Tree Ward about our observation findings and our concerns, and whether they would consider this a case to 'Stop the Line'. We were informed that whilst it did meet the criterion, they would not 'Stop the Line' because they could resolve it locally. This is not in accordance with the trust's 'Stop the Line' procedure.
- We escalated our concerns to the executive team, including the chief executive. The chief executive declared that the CQC team had called a 'Stop the Line' into the concerns on Apple Tree Ward. A meeting was called to review the concerns, also known as a 'swarm'. 'Swarms' aim to gather all the relevant people together to discuss a matter of particular importance, This meeting was attended by the senior leads for the service and for the trust, to discuss the concerns. The meeting addressed points including staff exclusion and the need to increase staff levels on the ward. However, the meeting did not include the importance of the need to review the institutional culture on the ward. We were therefore not fully assured how effective the meetings were.
- At our January 2015 inspection we spoke with the new ward leader on Apple Tree ward who felt that she was supported to raise issues to the senior management team and confident that these were responded to appropriately. The ward manager was able to give inspectors examples of where they had raised concerns and actions that had been taken.
- We spoke to staff on Apple Tree ward in January 2015 who felt that since our inspection in September they

had more confidence in reporting issues of concern. One member of staff stated " one of the positives from the September inspection is that we are now able to raise issues and be listened to."

Public and staff engagement

- The medical care service regularly sought feedback from people who use the service. They demonstrated success in obtaining feedback, with achieving an above England average response rate to the Friends and Family Test, and the NHS inpatient survey.
- Each ward had a board displaying the latest response information, along with a 'you said, we did' message, responding to suggested areas of improvement.
- Staff were aware of the improvement plans and changes to be implemented within the trust. However, on a local level in September, some staff felt disengaged from the leadership when the focus was on capacity as they believed that the focus was on the targets rather than the delivery of care. At our January 2015 inspection the staff on Apple Tree ward felt that they were able to challenge decisions made about the service they provided.

Innovation, improvement and sustainability

- The refurbished improvements of Cherry Tree Ward, which were specific to those with dementia, were innovative to improve the care of older persons.
- There were plans to improve the cardiology care on Walnut Ward, with the service opening six beds specifically to provide monitored cardiology care. The plans included staff training and development in cardiology skills.
- Following the inspection, we returned to undertake unannounced inspections in September 2014 on Apple Tree Ward on two occasions. We noted that the management team had kept to their agreed bed numbers and had increased staffing numbers. We were also informed that the service did not plan to re-open beds in the near future. In January 2015 we saw that the curtain tracks had been removed form this area in Apple Tree ward thereby rendering a non in patient area.

Surgery

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

Information about the service

The surgery service at Hinchingbrooke Hospital includes surgical and orthopaedic wards. Operating theatres include main theatres, gynaecology and obstetrics, and the treatment centre. The treatment centre also accommodates the pre-assessment and day surgery ward. The hospital saw 18,106 patients in this directorate in 2013-14. Surgical service provision includes general surgery, orthopaedics, trauma care, ear, nose and throat (ENT), gynaecology, ophthalmology, and urology.

In September 2014 we visited all surgery services as part of this inspection, and spoke with five medical staff, four ward or team managers, 36 registered nurses, other health professionals and health care assistants. We also spoke with two specialist and lead nurses within the surgical service. We spoke with 30 patients, and examined 16 patient records, including medical notes and prescription charts, as part of this inspection.

On 2 January 2015 we inspected Juniper ward as we had significant concerns about the care provided on this ward. We did not inspect other aspects of this service. We spoke with eight members of staff including doctors, nurses and other care staff, reviewed five patient records and spoke with nine patients.

Summary of findings

In September 2014 the surgical services required improvement because there were significant risks and deficiencies evident across four areas of our inspection domains. The safety of patients was at risk due to delays in nurses attending when patients call for help. In Juniper Ward there was a clear consensus from many patients that they were not cared for safely because it took too long for nurses to respond, in particular at night time. However the trust produced data which demonstrated that the average response time in the week prior to our visit was on average four minutes, this meant that this may have been an emerging issue. We found that there were continuing problems of medication not being administered as prescribed. Nursing care records and plans did not always reflect the current needs of the patient, or have clear guidance of the care to be provided.

Patient outcomes were good in certain respects, such as low incidence of pressure ulcers, and low readmission rates indicating successful overall treatment. Many issues were evident and had been identified by the trust, but action had not been taken to improve the issues or actions taken had not been effective. It was not evident that staff could easily raise issues they were concerned about, either in their own teams or across professional boundaries.

In January 2015 we inspected Juniper ward in respect of the caring issues which we found in September 2014. We did not inspect this service in full nor did we review

other aspects of the service. Instead we focused on the area of significant concern following our September 2014 inspection. We found that the response times to call bells was on average 3 minutes during our inspection and patients reported that staff attended them appropriately.

Are surgery services safe?

Requires improvement

In September 2014 improvements were required in safety of the surgery service. We found that risk assessments were poor, there was a lack of changes made to care plans when patients conditions changed and children were not receiving appropriate care in the operating theatre as there were no dedicated lists or they were not grouped together at the start of a list. In ward areas, we found poor completion of documentation of care. Although risk assessments relevant to the patients were mostly in place, these were sometimes inaccurate, and there was no respective plan of care, or the plan was not reviewed as the patient's condition changed. We found that there were continuing problems of medication not being administered as prescribed. There were some areas in the care of children being infrequently carried out therefore some staff may not have been regularly practised in techniques; however, outcomes data has identified no area of concern in respect of patient safety.

There was an incident reporting system in place, and reports of the performance were displayed for staff, patients and visitors to examine. Safety checklists were used in operating theatres, and theatre staff were given feedback on quality of care. We found that in ward areas, the regular observations of patients were carried out, and early warning scores completed to identify patients at risk of deteriorating condition. Ward areas appeared clean and usually uncluttered. There was good use made of hand-cleaning systems.

We reviewed this aspect of care in September 2014 but did not re-inspect in January 2015.

Incidents

- Data for 2013-14 showed that the surgical service had low rates of pressure ulcers and falls, which are general indicators of quality of care.
- Data for 2013-14 showed that there were 10 serious incidents within this core service. These were mainly slips, trips or falls, and grade 3 pressure ulcers.
- In September 2014 we spoke with ward managers in three surgical wards. There were clear arrangements for reporting of incidents. Staff were informed of any incidents at ward meetings and handovers.

- In operating theatres, incidents were collated and discussed at clinical governance meetings every two months, but also at two weekly staff meetings, and on noticeboards at the entrances to operating theatres. Changes to practices or procedures, or recent serious incidents or near misses, were discussed at a team briefing session, as required.
- Mortality and morbidity meeting were held monthly to discuss recent cases where patients had died or care had not progressed as planned. Medical staff also attended governance meetings every two months. Risks and safeguarding issues were discussed and any key learning fed back to medical teams.

Safety thermometer

- We saw that safety reports were displayed for staff, patients and visitors to view in each ward area.
- Ward managers showed us the audit checks they made monthly on key indicators of patient safety and quality of care in September 2014. Staff in surgical services were given information about incidents and complaints, and staff confirmed this and knew the rates of infection or falls in their clinical areas. We saw that staff followed procedures and they recorded their regular checks on patient's position to prevent pressure ulcers or patient falls.

Cleanliness, infection control and hygiene

- There were sufficient hand-washing facilities, and supplies of cleansing lotions for hand washing at entry points to clinical areas, and within the wards and bays. We saw that ward staff used personal protective equipment, and washed hands at appropriate moments in providing care. We saw that all staff used the hand washing facilities provided on entering and leaving ward areas.
- In the ward areas there were sufficient side rooms to allow for isolation when necessary. Juniper ward had five side rooms out of the 30 beds. There were no patients on isolation at the time of our September visit but nurses described the precautions they would take. We spoke with one patient who had initially been isolated due to an unknown infection risk. The patient described precautions that nurses and visitors had taken on entering and leaving the room. We found these to be appropriate.
- Data for 2013-14 showed that the surgical service had low rates of catheter-related urine tract infections.
- We observed good cleaning arrangements and procedures in operating theatres. Staff cleaned areas and equipment between cases, and equipment and consumables followed a clear flow through from clean to dirty areas.
- There were inconsistent facilities for hand washing in different operating theatres. Staff were maintaining safety by using scrub sinks to wash hands where needed, but there were no alcohol gel stations outside some entry points to the department. Taps for hand washing and scrubbing up were 'non touch' in main theatres, but this was not the case in the treatment centre theatres. However the trust reported that these taps were compliant with current guidance.

Environment and equipment

- We examined checklists and resuscitation equipment in the surgical wards and operating theatres. Resuscitation equipment in each ward was checked routinely, and there were clear records to evidence that this had been completed.
- Ward areas had emergency resuscitation equipment trolleys easily available in main corridor areas. We examined these and saw they had been checked routinely and were safe and ready for use.
- In operating theatres, recovery staff checked and signed daily, to show key equipment and trolleys were safe and ready for use

Medicines

- In September 2014 we found that in Juniper Ward there were medication omissions which meant patients were not receiving the expected treatment, and their health and welfare could be at risk. One patient said they had been worried that they were not given their usual pain control tablet, and also missed a regular aspirin tablet for three days. The patient was known to have a risk of thromboembolism. We discussed the case with the pain specialist who advised that these tablets could and should have been given despite the order for clear fluids in this patient. Another patient's medication chart showed no record of a prescribed anti-embolism injection without any documented reason for the omission.
- We discussed the omissions with staff, who said that the specific omissions we noted in charts for the week prior to our visit had not been identified before our inspection and would be recorded on the trust incident reporting system.

- At both our inspections we examined storage areas for medication in ward areas and found appropriate security and temperature checking was in place. We observed that nursing staff were careful to keep medications locked safely when they were not in attendance.
- In ward areas we found there was good support of pharmacy. We saw that pharmacy staff visited the wards and checked through prescription charts to ensure appropriate supply of medication and advice to nursing and medical staff. Pharmacy staff were aware that medication omissions had been occurring in surgical wards and said that where this happened they discussed the recording issue with nursing teams.

Records

- In September 2014 we examined 16 patient care records in ward areas and operating theatres. We found that staff in surgical wards had completed standard documentation as appropriate for their patients. This included documents assessing the risk of pressure ulcers, nutrition, moving and handling, and venous thromboembolism. However, we found that risk assessments were not always reviewed as the patient's condition changed, and that respective care plans were not always detailed enough. Five records reviewed in Birch ward had no follow up review of the initial assessment of risk of venous thromboembolism when they should have been reviewed. However data provided by the trust showed that patients were not at an increased risk of developing a venous thromboembolism under their care. This meant that staff may not provide the appropriate care to meet the changing needs of patients.
- In September 2014 there were gaps in care planning for pressure ulcer prevention. We found that risk assessments for skin integrity had only minimal detail of the care to be put in place to prevent pressure ulcers developing. The trust had sufficient pressure relieving equipment available for staff to use. Risk assessments for skin integrity were completed on admission. We examined nine care records where an elevated risk of developing pressure ulcer had been identified but there was no plan of care completed for staff to follow that was related to the identified risk. We saw that staff entered a record of skin integrity checks and other personal care each shift. There were records on charts to show that the patient's position had been checked or changed. However it was not evident from care records that a clear plan had been decided following risk assessment. Staff told us that they were given information about key risks and the care to be provided at handover, and on handover sheets. This meant there was a risk that staff might not be aware of patient care needs to prevent pressure ulcers. However the trust had a low rate of pressure ulcers acquired in care.
- In September 2014 we found that there was good documentation of pre-assessment for patients preparing for surgery. Key risk information was also provided to the anaesthetist and surgeon as an alert, where this would improve patient safety. We saw that a risk of venous thromboembolism had been noted at pre-assessment for two patients who we spoke with. This information had been reported clearly in the care plan and medical notes.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We saw in patient records that consent to surgical procedures had been clearly discussed with, and signed for, by patients.

Safeguarding

- Staff in surgical services knew how to report safeguarding concerns to their manager to protect patients from abuse. Staff in ward areas were able to show us the policy and procedures for the safeguarding of vulnerable adults. Staff knew there was a safeguarding lead for the trust and would use this person for advice where needed. In operating theatres staff showed us the policy section on the intranet including safeguarding of vulnerable adults and children.
- In September 2014 we spoke with the matron in a ward area about a patient who considered that another patient who was confused and agitated had been handled roughly back into bed at night time by nursing staff. The matron told us they would take appropriate action to investigate, would inform the safeguarding lead and follow trust procedures for reporting. A patient in day surgery ward told us they felt they had been handled roughly by a junior member of staff. We found that the ward manager was aware of this, and was investigating the issue.
- In September 2014 we found that there was no dedicated operating for children or that they were placed on the beginning of an operating list. This meant

that there was risk to children that the appropriate staff were not available. There was no paediatric-trained theatre nurse employed since a nurse had retired in May 2014. Some staff had an interest in paediatric care, and had completed specific paediatric training courses, including safeguarding of children to Level 3. During our inspection only 16 out of 31 staff had undertaken Paediatric Intermediate Life Support training. When we raised this with the trust they took action to ensure that children were safe within the operating theatre department.

Mandatory training

- There were good arrangements to enable staff to attend mandatory training. Staff told us that they were supported to complete mandatory training by their managers. Some staff told us that they had undertook some computer-based training in their own time.
- Records for the year to March 2014 showed that staff across surgical teams had attended statutory training on moving and handling, safeguarding of adults and children, and information governance with around 90% of staff completed these sessions. There were comparatively low rates of attendance at basic life support ranging from 40% to 80% for the surgical teams. This meant that staff in surgical areas where patients could be at risk of collapse were not fully updated in basic life support.

Management of deteriorating patients

- We found there was accurate use of early warning scores on observation charts in the ward areas we visited. Staff in wards and operating theatres were aware of the procedure for early warning scores, and the process for escalating information and action to ensure prompt response to deteriorating patients.
- We saw that theatre teams were using the World Health Organization's (WHO) '5 steps to safe surgery checklist', which is designed to prevent avoidable mistakes; this was an established process with the teams. We observed effective communication during a team briefing prior to the surgical list. Audit results showed that post operation debriefs were completed only after 92% of operations. This meant that opportunities for learning could be missed. Overall audit results for WHO checklist from March to July 2014 ranged from 97 to 100%. The audit results shared with staff also highlighted issues such as the formality of team brief and that all staff questions had been addressed before the procedure went ahead. This meant that the theatre teams continually monitored and reported on processes to prevent avoidable mistakes.
- The patients paper section of the theatre record showing the time that a patient left the operating theatre was not being completed by theatre or recovery staff. This meant that individual records were not fully completed despite it being completed in electronic format.
- In operating theatres staff kept clear count of disposables and other items, to ensure that all items were accounted for at the end of the procedure. This was a clear visual safety procedure to prevent foreign bodies being left in the patient. Records were made in care plans and signed as accurate by two designated staff. Staff told us of a case where a patient had been required to remain in an operating theatre while checks were made. The remaining item was located and removed.
- Delicate airway procedures in the operating theatres were infrequently carried out on children. This meant that staff may not have been regularly practiced in the techniques due to low numbers of children using the surgical service. Staff told us that they were aware of the need to maintain competence. Since our inspection the trust reports that enhanced support for consultants dealing with emergency paediatrics has been put in place and a facility to provide mentored practice with elective paediatric anaesthetics offered.

Nursing staffing

- In September 2014 staff in surgery wards and operating theatres told us that they usually had sufficient staff. There were specified staffing levels for each ward area, dependent on bed numbers and types of patients. Staffing rotas that we examined showed staff levels had been maintained for the two weeks prior to our September inspection. On the night shift there were three registered nurses and two or three health care assistants on a 30 bed surgical ward. Additional staff were used where patients with higher dependency or were in the ward.
- However in September 2014, we found that many patients in wards told us there were not enough staff, in particular on night duty, which meant that patients had to wait too long for call bells to be answered when they required care or support. The majority of the patients

we spoke with on Juniper Ward told us of this issue. Patients were very clear that during the night shift it was often over 30 minutes before patients were attended to when they rang the call bell.

- In September 2014 patients in the acute trauma surgical unit also told us of delays in call bells being answered. We observed the call bell response time on two occasions during the daytime, and noted that it took ten minutes for a nurse to attend patients requiring the toilet.
- Ward managers told us that replacement staff were recruited to maintain the agreed safe staffing levels when there was vacancies. In operating theatres we saw that staffing levels met the guidance from the Association for Perioperative Practice, with two scrub personnel where required, one anaesthetic staff and one circulating staff member. Operating department practitioners told us that staffing levels were maintained at safe levels. The team would not allow operations to proceed without the required safe complement of staff.
- We saw that additional staff were arranged when a specific need was identified, such as several patients at risk of fall. Where an acutely ill or confused patient required constant supervision or monitoring, a member of staff was allocated. Additional staff, such as agency, were arranged when required. In September we spoke with an agency nurse who had been caring one to one with a patient who was agitated and confused and at risk of falling.
- In September 2014 we spoke with an agency nurse, who told us they had mandatory training checked prior to working in the surgical ward areas, and they had been given clear guidance about the ward area and procedures such as for emergencies when they arrived for work. The nurse said they had worked in the ward and other wards in the hospital on previous occasions.

Medical staffing

- Data showed that in surgery there was a higher proportion of consultant grade staff at 42% compared with the national average of 40%. There was lower proportion of registrar level staff at 8% compare to the England average of 38%. Junior and middle grade staff made up 50% of the medical staffing compared with 24% nationally. There was a total wte of 84 medical staff in surgical services.
- Patients told us that they had regular reviews of their care by medical staff, and were aware who the consultant was leading their plan of treatment
- We saw that consultant staff visited ward areas regularly to see patients, and ensure progress of patient pathways.
- There was support of specialists from the critical care unit if staff had concerns about a deteriorating patient.

Major incident awareness and training

- Staff in operating theatres showed us detailed plans and procedures to follow in the event of a major incident. There was a file of the major incident plan held in main theatres office and staff also showed us the full plan on the intranet in operating theatres. We saw that staff contact numbers had been updated as staff joined the team so that additional staff could be called to help in a major incident.
- Some ward staff were unsure of where the information was located about major incidents, but told us that contact numbers were kept by their manager, and they could be called to support if needed in a major incident.
- Operating theatres used an electronic system for operating lists. There were clear arrangements to use printed lists if the IT system failed.

Are surgery services effective?

Requires improvement

In September 2014 improvements were required in effectiveness of the surgery service. We found that there were a number of areas which required improvement including a lax approach to fluid management, gaps in care records, and ineffective communication between shifts. This meant that information about patients' needs was not always consistent. We saw an improving picture in January 2015 however there remained gaps in care records which require improvement. The multidisciplinary team worked well together but patients in September 2014 told us that the medical staff had not recognised the issues in nursing care. Patients said that medical staff were aware of lapses in communication leading to delayed diagnostic testing, and missed medications for example. We saw that managers were aware of trends showing missed medications and incident reports provided by teams about staffing levels. There were no plans in place to resolve the

issues with missed medication although these continued to be monitored by the pharmacy teams. In January 2015 we found that omissions of medication had improved on Juniper ward, however improvements are required in labelling bottles of liquid preparations to ensure that they are effective.

In general, the data showed that surgical admissions were successful, in that patients were discharged following treatment, and had not been readmitted. Pre-assessment of patients and planning of operations lists was effective in screening and preparing patients for surgery.

We reviewed this aspect of care in September 2014 but did not re-inspect in January 2015.

Evidence-based care and treatment

- We saw that NICE guidelines were followed for care of patients in the surgical service. Additional guidance was available to staff to ensure good practice in managing care.
- Specialist nursing staff described the NICE guidance that was followed for care of patients relating to pain control and hip fracture management. We saw that documentation in care records to guide staff each day post operatively for hip replacement followed NICE guidance for recovery. Therapy staff told us they followed guidance for mobilisation following surgery. We found that guidance was followed on good practice in stoma care in collaboration with local clinical networks.
- The operating theatre team used the intranet routinely for staff to easily locate and refer to policies and procedures.
- Infection control policies were clearly displayed including hand washing throughout clinical areas. In operating theatres the uniform policy was displayed to remind staff of infection control measures related to uniforms worn out to different parts of the hospital.
- Surgical staff held monthly mortality and morbidity meetings, and there were governance meetings every two months to learn from experience. Medical staff told us that risks and safeguarding issues were discussed. There was regular feedback from these meetings at staff meetings and daily briefings if required. Medical staff told us that they knew how to escalate issues if needed. The 'Stop the Line' procedure used to invoke if a serious concern was raised by any member of staff had been used by theatre staff. The successful use of the process had given staff confidence to speak out if they had any concerns for patient or staff safety.

Pain relief

- There was an established system to ensure post-operative pain of patients was managed effectively. A pain specialist nurse visited patients in ward areas to assess the pain with the patient, and support nursing and medical staff to revise pain control where required.
- We saw that pain control was managed, using agreed guidance in folders on each surgical ward, although this was only specified for patients following an operation. Patients on surgical wards who had not undergone surgery were not routinely referred for pain management advice but the trust reported that these patients were referred as required.
- In September 2014 we spoke with patients who had been assessed by the pain specialist nurse. Patients told us that their pain was well managed following surgery.
- In September 2014 two patients who had not had surgery told us that their pain had not been managed well. One person said that they had a syringe driver with pain control which had, on two occasions, become empty of the medication, leaving them for some hours without any control of their pain. Another patient with chronic back pain told us that they had to wait several times for over half an hour, for 'as required' medication. This was because nurses had not answered the call bell quickly enough.
- In September 2014 one patient told us that ward nursing staff had not administered some of their pain medication in the first two days of their admission, due to the patient being on clear fluids. However, the pain specialist nurse told us that part of the medication could have been administered in order to maintain the comfort of the patient. In January 2015 we spoke to three patients about the control of their pain symptoms all patients reported that they had received pain control in a timely manner and that their pain had been controlled on Juniper ward.

Nutrition and hydration

- We saw that risk assessments had been completed in care records, to check if patients required extra support

or monitoring for their nutrition and hydration. In September 2014 we found that fluid charts and food intake records were mostly completed and summarised accurately.

- However during our September inspection, in three cases where we had observed care in the ward, and spoken with relatives who had been in attendance, we saw that fluid intake had been poorly estimated. We saw also that calculations of total fluid intake were not always accurate.
- In September 2014 one visitor told us that they had been concerned about developing dehydration in their elderly relative. They said they had been asking for several hours for a doctor to review the patient's condition and to ensure adequate hydration. Another relative told us that they had been with a patient for four hours, trying unsuccessfully to get them to take a drink, and nurses had not offered any support. We saw that the ward was busy, with staff attending another acutely ill patient. We spoke at length with the relative and examined the care record. Charts of fluid intake had not been completed since the previous evening, the relative had been with the patient from 6am to 11am trying to get the patient to drink through the morning. We saw that the patient's position was difficult for drinking, it was only after nurses supported the patient with personal care and changed position that fluids were taken. We found that rough estimates of fluid intake were then added to a fluid intake chart.
- We saw that patients were usually offered drinks regularly during the daytime. Staff who undertook this task were aware of who was able to take drinks. We spoke with staff providing drinks and found that they were also part of the nursing care team and fully aware of patient's nutritional needs such as diabetic or supplementary diet. We saw that patients had water available with clean jugs and beakers. There were clear notices above the beds where patients were designated 'nil by mouth'.

Patient outcomes

- Data showed that in 2013-14 the length of stay for patients undergoing bowel surgery was worse than the England average. 83% of patients stayed in hospital more than five days compared with the national figure of 69%.
- Data showed that in 2013-14 the length of stay for patients undergoing hip fracture surgery was slightly worse than the England average. The mean length of stay was 22 days compared with the national figure of 19 days
- Data showed that in 2013-14 the ratio of observed readmissions was lower, which was better overall, when reviewing all types of surgical patients, at Hinchingbrooke than the expected rate compared to the England average. This is an indicator of effective treatment and discharge planning. However for elective orthopaedic and ophthalmology cases in 2013-14 the relative risk of readmission was slightly higher than the expected figure for the year. We saw that discharge checklists were completed in case records for the patients where we examined the notes of patients who had a complex condition or continuing need for support after discharge.
- The national audit of patients with bowel cancer in the trust had shown that 28% of patients were seen by a nurse specialist compared to a national average of 88%; however, this data related to a historical period when the specialist covered only part time hours. The specialist nurse role is now full time and 95% of patients know their specialist nurse, which is higher than the more recent national average of 91%.
- A high proportion, 54%, of patients who had bowel cancer had their surgery carried out as an emergency, compared to the national average of 18%.
- In the national hip fracture audit the service had worse than the England average of 96% performance for having a specific falls assessment as 75% of patients with hip fracture were recorded as having the assessment. A falls audit, undertaken by the trust in August 2014, did not specify the patient diagnosis but returned a falls risk identification rate of 91% across seven wards. Areas for improvement, together with planned actions, were included in the audit report.
- The trust had better than average performance for development of pressure ulcers at 1.5% compared to the national average of 3.5%.
- The trust had better than average performance at 91% for making bone health assessments of patients compared to the national average of 85%.

Competent staff

- In September 2014 we saw detailed documents that staff in operating theatres used to ensure competency in

specific duties. A competency booklet for scrub practitioners and theatre support workers covered the competencies related to perioperative care and specialist surgery, such as orthopaedics or ophthalmology. Staff completed competency checks for new skills, but told us that there was no review of competencies. This could mean that staff lose skills not practised and checked regularly, and may not undertake skills safely: however the trust told us that staff were issued with a revised competency pack between July and August 2014, which involves completing a separate annual review document.

- In a focus group in September 2014, including five theatre staff, we heard there was good access to training, they worked as a supportive team and staff felt able to ask for support if they required advice. New staff in operating theatres were employed under a probationary period, with checks on competencies at three monthly intervals for six months.
- In September 2014 two health care assistants we spoke with told us that they had annual training updates on key skills. This included taking observations and use of the early warning scores to ensure nursing and medical staff were alerted if patient's condition was deteriorating.
- Medical staff told us that they had good facilities and systems for personal development, and this had meant some staff developing in their career through to consultant level. Facilities included video links from operating theatres to seminar rooms, to enable observation and shared learning from current practice.

Multidisciplinary working

- Staff in operating theatres told us that there was effective working across paediatric services of the trust and the Cambridgeshire Community Trust staff, who managed the paediatric wards on the same location. There were meetings every two months to discuss collaboration on paediatric services.
- Staff told us that there was good multidisciplinary working in ward areas to plan care and promote effective discharge. We saw that there were ward team meetings early in the day at handover which included therapy, nursing and medical staff. Notes were taken and key care issues were noted in a communication book in addition to patient records.
- Specialist nurse advice was available to staff regarding infection control, and pain management. These staff provided clinical updates to link nurses for cascade within the ward teams.
- In September 2014 patients told us about communication issues that had caused delay in their diagnostic tests. One patient on a ward told us that they had waited four days for an ultrasound scan. They said they had been to the scan department three times, only to be turned away and sent back to the ward due to mistakes in bookings. Another patient told us they had been taken to a procedure room only to be told they would have go back to the ward and wait another three days until antiembolism medication had worn off. The trust supplied evidence which demonstrated a low level of delayed diagnostic tests, with eight incidents occurring in the previous 18 months.
- In September 2014 we found that there were some problems for patients regarding communication of care needs between shifts of staff. In Juniper Ward, one patient, and relatives of two other patients, told us that they felt there was poor communication about aspects of care. They said they had to remind staff of key aspects of care or treatment that had changed, but which the staff on a new shift had not been aware of. Two patients told us that they felt they had to manage their own care, remind staff for example about problems with infusions, to ensure treatment was consistent. One of these patients said there was a risk that other patients, who were not so aware, or able to articulate their concerns, may receive inconsistent care. In January 2015 we spoke with one patient who had been told that they could go home but this was not recorded in their patient records.

Seven-day services

- There were clear arrangements for medical staffing. Doctors of grades FY1 and FY2 told us there was consistent consultant cover when required, including for advice out of hours.
- Staff in surgical areas told us that patients needing urgent X-ray at weekends sometimes had to wait for several hours due to the availability of on-call radiography staff, in particular, if X-ray support was required in operating theatres. This was the case when we visited out of hours, staff in A&E stated that patients were awaiting x-ray due to the radiographer being in operating theatres.

Surgery

Are surgery services caring?

Good

In September 2014 the surgical service was rated in this domain as inadequate as, although many areas of surgical care provision were meeting or exceeding required standards, patients' basic needs were not being met in all cases. 17 out of 30 surgical inpatients told us that they had to wait unacceptably long periods when they called for assistance. This resulted in some patients not receiving care at the expected level required to protect their dignity. Two patients told us that they had been told to soil themselves and a further one patient stated that delays resulted in patients soiling themselves. Five patients told us that there was little time for nurses to provide emotional support and explanations about care to patients and relatives, although it is recognised that this is not a role limited to nursing staff. Fifteen patients also told us that they had had experiences of nurses being kind and considerate in providing care.

In January 2015 we returned to Juniper ward and found that patients reported that the response to their call bell was good. We witnessed that call bells on this ward were answered within approximately three minutes on average. We have rated this domain as good however we did not review the issue in respect of patients being transferred between wards at night time or that all staff provided support or explanations about their care in caring manner. We will review these aspects when we re-inspect the hospital.

Compassionate care

- Patients in September 2014 told us that most nurses and staff were kind and compassionate, but that there were many times when the care had been poorer quality than they expected. A comment that many patients gave was the delay in being attended to when calling for help. Patients also described a lack of attention to other issues such as keeping the bed area clear when patients were unable to get out of bed. One patient and relative said the bed had been surrounded by numerous urine bottles by the end of a day as they had been asked to keep samples for measuring.
- In September 2014 many patients across all surgical wards told us that they had to wait half an hour or longer when they were bed-bound but required a nurse to use the toilet. The trust provided evidence of a call bell audit undertaken by the trust on Juniper ward in the week prior to our visit that indicated that waiting times ranged from 2 to 8 minutes, with an overall average of 4 minutes from call to response. The concerns raised with us by patients may have been a recently emerging risk however this could not be confirmed. In January 2015 we witnessed that call bells were responded to on average within three minutes. Patients reported that on Juniper ward nursing staff attended them in a timely manner. However we did not inspect other surgical wards.
- In September 2014 two patients in surgical wards reported that care staff had responded briefly to the call bell, advised the patient to go to the toilet in the bed, and that they would be made comfortable as soon as they were able to attend the patient. The patients said that nurses were caring and supportive at these times but they could not attend quickly enough to help maintain the patient's dignity. Staff agreed that at night time they often found it difficult to respond quickly enough to calls from patients. They explained this might happen if there were staff on breaks and remaining staff were busy with other patients. In January 2015 during our inspection we did not see this happening.
- In September 2014 three patients in Juniper Ward told us that they had to go out of their bay to find a nurse to help patients who had been calling for help but the call bell was not answered. There were quiet sliding doors across bays which helped to maintain a quiet environment for rest in bays. Patients said this meant the nurses could not easily hear patients calling out for help when the call bell was not used; however, this was not substantiated via nursing staff. We reviewed this with patients at our January 2015 inspection and patients spoken to did not feel that this was an issue for them.
- In September 2014 there was agreement among the 12 patients we spoke with on Juniper Ward that the response of nurses to call bells was routinely poor at night time. They told us that they were aware nurses were busy with other patients at such times. As reported during our January 2015 inspection we saw call bells responded to within three minutes.

- In March, May and June 2014, the score of the Friends and Family Test of whether patients would recommend the service on Juniper Ward was between 61-66%. For other surgical wards where data was available, we saw the score was over 95% for the same months.
- In operating theatres we saw that the privacy and dignity of patients was protected. Curtains were used if patients were sharing the same bays in reception and recovery areas. Clear notices were used on curtains in these instances to designate the patients behind curtains to support good patient identification.
- In September 2014 one patient on the acute surgical and trauma ward said that they had been on seven wards in the first three days of admission, and had been moved at 12.45am, 3am and 5am on different days. The patient recognised the needs of more acutely ill patients, but said it had been disruptive to rest and sleep early in their admission.

Patient understanding and involvement

- Patients told us that nurses introduced themselves at the handover of shifts. In September 2014 patients told us that there was little continuity and there had been many different nurses across the shifts in the week.
- The views of patients were taken into account in operating theatres. Staff had used a survey to gather views of patients about anxiety and feelings through the procedure. As a result of feedback, more time was allowed for patients to talk with the anaesthetist or surgeon in the perioperative period. Additional patient satisfaction surveys were being undertaken at the time of our inspection.
- In September 2014 patients told us that the care provided by nursing staff was not effective, due to poor response to call bells and lack of continuity of information from day to day, meaning they had to ensure for themselves that staff were providing consistent care. One patient told us that they felt medical staff had not recognised or tried to address these issues in the nursing teams. In January 2015 we found that call bell response times had improved.

Emotional support

- In September 2014 patients in Daisy Ward told us they were cared for with compassion, and staff responded well to their needs. Two patients told us that in Juniper Ward the nurses had little time to provide emotional support. They said nurses were kind and supportive when they were able to attend patients. They told us that nurses only had time to provide the technical and physical care. One relative told us that they had to ask several times before staff found a person who was able to explain the treatment and plan of care. In January 2015 patients reported that the nursing staff were kind and attentive on Juniper ward.
- In September 2014 we saw that parents accompanied their children through to the anaesthetic room prior to surgery, and were able to be with children as they awoke from their operations.
- In September in the pre-assessment unit, patients were met by a member of the nursing team, and directed to the appropriate room for their appointment. Patients told us that this was reassuring and welcoming. We saw that patients were given adequate time to answer questions, and to ask if they were unsure about their forthcoming operation or procedure.

Are surgery services responsive?

Good

In September 2014 we found that surgical services were good, because we found examples across the service that showed flexibility and improvements to enable access to the service. Patients with learning disabilities were supported effectively to access surgical care. There was a good surgical pre-assessment service, which was designed to ensure time to capture relevant information, to promote safety, and to provide a seamless experience for patients. We found that patient feedback had not been used effectively to identify issues and plan improvements to basic care provision. We did not review this aspect of care at our inspection in January 2015

Service planning and delivery to meet the needs of local people

- The trust was meeting 18 week referral to treatment times (RTT) for all surgical specialities.
- There was an effective pre-assessment department, which supported patients in preparation for their operation. There was good flexibility in pre-assessment to provide this service in a way or place that was convenient for patients. Pre-assessment was being offered to some patients as a telephone service where appropriate. In the pre-assessment unit, the staff identified when clinic appointments were available, and

made these available to the outpatients department. This meant that some patients were able to have their pre-assessment for admission on the same day as the decision to admit was made in the outpatients clinic.

- Patients for surgical team care were regularly cared for on medical wards. Three patients in the orthopaedic ward told us that they had been moved several times before arriving on the surgical ward. This was a reflection of high occupancy of beds in the hospital and how patients were accommodated if admitted in an emergency. Although a nurse in charge of acute trauma ward stated it was rare to move patients at night we were told by patients that they had moved at night when beds were needed for emergency admission.

Access and flow

- There were clear arrangements and procedures for access to the surgical service. Patient booking for surgery and surgical lists was managed effectively. Operating theatre lists were managed by the consultant surgeons, with administration support, and in collaboration with surgical practitioners and theatre teams. This intensive planning meant that there were few cancellations of patient operations. Where theatre lists overran elective patients were operated on using the capacity of the emergency theatre teams. Since July 2013 any patients whose operations were cancelled had their procedure rebooked within 28 days.
- Data showed that in 2013-14, the delay from referral to treatment (RTT) was consistently better than the England average and national standard of 90%. All surgical specialties were meeting RTT standard of treating patients within 18 weeks. All specialties at Hinchingbrooke were over 90%. General Surgery 92.2%, Trauma & Orthopaedics 91.9% Plastic Surgery 97.0% ENT 94.4% Urology 99.7% Ophthalmology 95.4%.
- Ward managers and staff told us that discharge planning was reviewed regularly. The plans were discussed with patients during medical staff ward rounds. Progress on discharge arrangements was checked by the team in daily briefings, handovers and multidisciplinary meetings. This process was confirmed by therapy and pharmacy staff in ward areas. We found also that discharge checklists were completed in the care records that we reviewed.

Meeting people's individual needs

- The operating theatre team held a Saturday club for children to look round the facility prior to coming in for a procedure. There were bays decorated to help children feel relaxed within the clinical area.
- There was good flexibility in supporting people, such as vulnerable patients with complex needs. Patients who were identified as being vulnerable in any way, such as frail, confused or with learning disabilities, had specific attention paid through the use of a checklist, to assess capacity, the patient's understanding, and any anxiety about the procedure. Additional support was considered and planned at the pre-assessment stage with the patient and relatives where appropriate. Staff in the operating theatre described their flexibility in providing support for a patient who had a complex mental health condition. The patient had been anxious about anaesthetic and theatre rooms, and so had been anaesthetised in the recovery area before being taken through for the procedure. In January 2015 we found that the staff on Juniper ward were responsive to the needs of a patient with learning disabilities. This patient reported that they felt supported and well cared for by staff.

Learning from complaints and concerns

- Ward managers and staff in surgical wards told us that they used complaints to learn lessons and improve the service. However, we found that patients in all areas discussed problems with us, such as poor response to call bells, and lack of time to talk with patients. There had been clear indications that satisfaction was reduced for three months earlier in 2014 but the reasons for this had not been established or tackled in the relevant ward area.
- Patients knew how to complain and said they would speak to the nurse in charge or the ward Matron. They told us about some complaints they had made. One patient had complained about noise from outside the ward window which had not been stopped quickly at the time, but the patient had been reassured that the issue had been investigated and the cause of the noise had been dealt with.

Surgery

Are surgery services well-led?

Requires improvement

In September 2014 we found that surgical services required improvement because, although there were some systems in place to audit quality of care, they had not supported improvement. The staff and managers were aware of medication errors but a clear plan for improvement had not been developed. Documentation audits were being completed and reported but we found they were ineffective at identifying gaps in care planning. Patient feedback had clearly indicated a reduction in satisfaction from March 2014, but this had not been met with any plan to improve services. We found patients were still dissatisfied in some aspects of the service.

Although staff told us that they felt able to speak up if they were concerned, there were no comments from staff to the inspection team about the problems of responding to call bells in time, or having time to provide emotional support to patients. Staff raised concerns regarding the level of care they were able to provide by completing incident reports but it was not clear to staff that these were acted upon.

In January 2015 we found that on Juniper ward there was a new ward sister in place who had recently commenced her duties. However they were aware of the issues on the ward and had plans to address these. Patients we spoke with were satisfied with the level of care provided. Staff were still hesitant about raising issues of concern to them although they reported that the new sister was approachable.

Vision and strategy for this service

- Staff in the surgical service were aware of the trust campaigns to ensure staff provided individualised care to patients and visitors. Staff in wards were aware of the vision to provide 'better healthcare' for the local population.
- Theatre staff we spoke with in focus groups told us that they were aware of the 'Stop the Line' initiative. They had used the process successfully to protect a patient and this had given them confidence they would be supported. Theatre staff knew of plans for upgrading of operating theatres, they told us about investment already made to renew equipment, and were aware of continued move towards day surgery and keyhole surgery. They told us of intentions to provide local services where possible in the Trust and of the specialist surgeons that had joined the Trust.

Governance, risk management and quality measurement

- In September 2014 we found that there was a lack of action taken by managers to address known issues. An example of this was in respect of medication omissions which continued to be reported but little or no action was taken by managers to address these. However at our January 2015 inspection of Juniper ward we found that the new ward manager was a ware of the issues on the ward and had plans in place to address these. However we did not inspect other wards in this respect.
- In September 2015 although the ward managers had audited care records, the process had not identified weaknesses in risk assessments and the plans of care that we identified during the inspection. This meant that audit processes had been ineffective in improving the care records to promote better care. In January 2015 in Juniper ward we found that care records still required improvements to be made to documentation and individualisation to ensure that patients received appropriate care.
- We observed in operating theatres that there was good local leadership and flexibility of working to maintain safety. Where a patient had arrived late, the anaesthetist and surgeon agreed to have a mini briefing for that case prior to the procedure later in the session.
- In operating theatres, we saw that staff were supported by managers to focus on key areas of performance that maintained patient safety.
- Risk registers included an item about the environment in operating theatres which affected the ease of cleaning of some surfaces. There was a capital plan in place to improve the relevant parts of the premises.

Leadership of service

- 'Stop the Line' had been effectively used at team level in operating theatres. They felt assured that managers had responded appropriately to their request.
- In operating theatres, the absence levels of staff had been reduced by 50% in the year prior to our visit. This was due to clear monitoring, and support for staff, in collaboration with personnel and occupational health staff. Flexible contracts had been implemented where appropriate, to enable staff to continue in service.

- There was a new appraisals system in place which meant that rates of completion were 70% in operating theatres. It had been 85% before the new system. Managers said they were working on ensuring all staff were appraised using the new system.

Culture within the service

- Medical staff in surgical services told us they were well supported by seniors and considered it was a good working environment.
- Nursing staff told us they felt supported by their managers. They said they felt able to speak openly if they had a concern. In September 2014 there were clear problems raised by patients with inspectors, but there were no incidents reported that staff had raised concerns regarding the level of care they were able to provide. At our inspection in January 2015 we found that patients in Juniper ward were more satisfied with their care.
- Staff in operating theatres stated they felt it was a supportive work environment; they were encouraged to attend training and felt they could raise issues in the team or during procedures if required.

Public and staff engagement

- Data in September 2014 showed that patients on Juniper Ward were more willing than those in other areas to provide feedback on their experiences. The feedback from Juniper ward also showed that in March, May and June they were significantly less likely to recommend the service to friends and family. In our inspection we found many patients in this ward were dissatisfied with the care they had received. In January 2015 the latest friends and family test results for the hospital was 97% and patients on Juniper ward reported a good experience of care to inspectors.
- In September 2014 although there was clear evidence that patients were unhappy with the service on Juniper ward, it was not clear how staff of the ward or trust managers intended to tackle the issues of missed medication, poor emotional support and lack of continuity of care. This meant that managers had not responded to recent negative patient feedback and information that indicated the problems that could be leading to patient dissatisfaction at the time of our inspection. However in January 2015 we found that a new ward sister was in place and patient feedback was positive.
- Staff had been involved by the trust in developing the overall strategy. Two staff said they had attended workshop to discuss the 'better healthcare' plans.

Innovation, improvement and sustainability

- A survey in operating theatres, used to gather views of patients about anxiety and feelings through the procedure, had led to improvement in service. As a result of feedback, more time was allowed for patients to talk with the anaesthetist or surgeon in the perioperative period.
- The team in the pre-assessment department were providing a flexible and responsive service, and continuing to develop ways to enable easier access for patients. They told us they were planning provision of the service in rural areas, such as Doddington, to be more convenient for patients from that area.

Outstanding practice and areas for improvement

Outstanding practice

- In both maternity and critical care we noted good care, focused on patients' needs, meeting national standards.
- The paediatric specialist nurse in the emergency department was dynamic and motivated in supporting children and parents. This was seen through the engagement of children in the local community, in a project to develop an understanding of the hospital from a child's perspective, through the '999 club'.
- The support that the chaplaincy staff gave to patients and hospital staff was outstanding. The chaplain had a good relationship with the staff, and was considered one of the team. The number of initiatives set up by the chaplain to support patients was outstanding.

Areas for improvement

Action the hospital MUST take to improve

- Ensure all patients health and safety is safeguarded, including patient's nutrition and hydration needs are adequately monitored and responded to.
- Ensure that staffing levels and skill mix on wards is reviewed and the high usage of agency and bank staff to ensure that numbers and competencies are appropriate to deliver the level of care Hinchingbrooke Hospital requires.
- Ensure records, including risk assessments, are completed, updated and reflective of the needs of patients.
- Ensure that there are sufficient appropriately skilled nursing staff on medical and surgical wards to meet patients' needs in a timely manner.
- Ensure medicines are stored securely and administered correctly in the Emergency department and that liquid preparations are marked with opening dates in the medical and surgical wards.
- Ensure that all staff are trained in, and have knowledge of their responsibilities under the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS).
- Ensure that patients are treated with dignity and respect in the Emergency department.
- Ensure that all staff are adequately supported through appraisal, supervision and training to deliver care to patients.
- Ensure pressure ulcer care is consistently provided in accordance with National Institute for Health and Care Excellence (NICE) guideline CG:179.
- Ensure that catheter and intravenous (IV) care is undertaken in accordance with best practice guidelines.
- Ensure patients are treated in accordance with the Mental Capacity Act 2005.
- Ensure that the staff to patient ratio is adjusted to reflect changing patient dependency.
- Review the 'Stop the Line' procedures and whistle blowing procedures, to improve and drive an open culture within the trust.
- Standardise and improve the dissemination of lessons learnt from incidents to support the improvement of the provision of high quality care for all patients.
- Ensure that all appropriate patients receive timely referral to the palliative care service.
- Ensure action is taken to improve the communication with patients, to ensure that they are involved in decision-making in relation to, their care treatment, and that these discussions are reflected in care plans.
- Review mechanisms for using feedback from patients, so that the quality of service improves.
- Ensure that the checking of resuscitation equipment in the A&E department, and across the trust, to ensure that it occurs as per policy.

Action the hospital SHOULD take to improve

- Take action to reduce the over burdensome administration processes when admitting patients into the acute assessment unit (AAU).

Outstanding practice and areas for improvement

- Review intentional rounding checks to ensure that they cover requirements for meeting patient's nutrition and hydration needs.
- Involve patients in making decisions about their care in the A&E department.
- Review the training given to staff, and the environment provided, for having difficult discussions with patients.
- Provide adequate training on caring for patients living with dementia, to improve the service to patients living with dementia.
- Review the clinical pathways for termination of pregnancies in the acute medical area.
- Review the policy on moving patients late at night.
- Review the out-of-hours arrangements for diagnostic services, such as radiology and pathology, to ensure that patients receive a timely service.
- Review mechanisms for fast track discharge, so that terminally ill patients die in a place of their choice.