

James Paget University Hospitals NHS Foundation Trust

James Paget Hospital

Quality Report

Lowestoft Road,
Gorleston – on – Sea,
Great Yarmouth, Norfolk
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Website: www.jpaget.nhs.uk

Date of inspection visit: 11th, 12th and 13th August 2015
Date of publication: 12/11/2015

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

Ratings

Overall rating for this hospital

Good 

Urgent and emergency services

Good 

Medical care

Good 

Surgery

Requires improvement 

Critical care

Good 

Maternity and gynaecology

Good 

Services for children and young people

Good 

End of life care

Requires improvement 

Outpatients and diagnostic imaging

Good 

Summary of findings

Letter from the Chief Inspector of Hospitals

We carried out a comprehensive inspection between 11 and 13 August 2015 as part of our regular inspection programme. In May 2015 James Paget University Hospitals NHS Foundation Trust had been identified as having only one elevated risk and one risk on our Intelligent Monitoring system. This showed a decreasing pattern since October 2013.

The James Paget University Hospitals NHS Foundation is a university hospital providing the care to a population of 230,000 residents across Great Yarmouth, Lowestoft and Waveney, as well as to the many visitors who come to this part of East Anglia. The main trust site is in Gorleston and is supported by services at Lowestoft Hospital, the Newberry Clinic and other outreach clinics in the local area.

The James Paget Hospital officially opened on 21 July 1982, was established as a third wave NHS Trust in 1 April 1993 and became a Foundation Trust on 1st August 2006.

The trust has 458 inpatient beds and 26 day case beds located on the James Paget University Hospital. The trust provides critical, intensive and high dependency care, general and orthopaedic surgery and medicine, maternity, paediatrics and neonatal services.

We have rated this location as Good overall. We found that the staff were exceptionally caring and that they went the extra mile for their patients.

Our key findings were as follows:

- All staff were caring and compassionate. They treated patients, relatives and carers with respect and dignity.
- The trusts referral to treatment times (RTT) and four hour performance in the emergency department had improved since worse performance over the winter.
- There was mostly enough nursing and medical staff to care for patients and protect them from the risk of avoidable harm though it did not always follow national guidance in relation to the care of children.
- A number of medical vacancies had been identified, such as for consultant geriatricians which the trust had been unsuccessful in recruiting to.
- There was an effective recruitment and retention strategy in place for nursing and medical staff with gaps in nursing staff acknowledged in medicine.
- Clinical areas were visibly clean and we saw mostly good infection control practices. Infection control rates were low in the hospital.
- The environment in some clinical areas including theatres and recovery was dated. A comprehensive estates strategy was in place to address these issues.
- A new, purpose built day surgery unit opened during the course of our inspection which will enable more patients to be seen as day cases and potentially offer new pathways and services.
- The emergency department made excellent use of technology and pathways, including for stroke, to effectively manage the care of patients.
- For a number of clinical audits, the hospital performed in line with or better than the England average.
- The vast majority of staff felt supported in their work, had received training and appraisals and most were aware of the trust vision and values.
- Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) was not always consistently recorded or a care plan in place for patients receiving end of life care.

We saw several areas of outstanding practice including:

- Care of patients requiring thrombolysis in the emergency department, with trained consultants and telemedicine access to a consultant neurologist.

Summary of findings

- Patient pathways for GP referrals that resulted in 97% of GP referrals not requiring services of the emergency department.
- Spinal injuries nursing and state of the art equipment for patients with spinal cord injury was excellent.
- A charity funded Eye Clinic Liaison Officer raised awareness about support for patients with macular degeneration.
- The trust had been awarded integration status, with other health partners and social care to pioneer seven-day services. This included an Out of Hospital Team chaired by the clinical commissioning group involving social care, the mental health trust and the hospital to identify ways to avoid crises in communities leading to hospital attendance. Data was showing a reduction in admissions.
- The neonatal unit had developed a breastfeeding pack to encourage new mums whose babies were on the neonatal unit to hand express their breast milk. The pack contained information and tips on hand expressing along with a personal expressing log.

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

Importantly, the trust must:

- Ensure that all equipment is checked at a frequency as per trust policy including, but not limited to emergency resuscitation equipment.
- Ensure that all patient records are up to date and reflective of patient's needs.
- Ensure a named Non Executive Director for end of life care in line with Department of Health Guidance.
- Ensure that all Do Not Attempt Cardio Pulmonary Resuscitation forms are completed fully and in line with national guidance.
- Accelerate the implementation of the approved replacement for the Liverpool Care Pathway for people receiving end of life care

In addition the trust should:

- Review the application of the assessment under the Mental Capacity Act 2005 in end of life care.
- Review the storage of medicines in theatres to ensure that temperatures are consistent with trust policy.
- Review approach to the care of older people and the provision of senior medical staff in care of the elderly.
- Review audits in end of life care to ensure good practice is followed.
- Review staffing in children's services to ensure it meets national guidance.
- Review the environment within the outpatient area for gynaecology and paediatric patients to ensure that this meets their individual needs.
- The hospital trust should review the level of physiotherapists and pharmacists provided to the intensive care service as staff levels did not meet recommended levels of the Faculty of Intensive Care Medicine Core Standards for allied health professional staffing.
- Mortality and morbidity reviews within intensive care should be recorded in order to demonstrate lessons from any reviews are learned and these can be shared throughout the trust.
- The cover from specialist trainee/registrar doctors in the intensive care unit should be reviewed to ensure this meets recommended safe levels at all times.
- Intensive care should review the use of dementia-specific care plans for patients living with this condition. The trust should also review the provision of mental health support given to patients and their families who are or have been patients in the intensive care unit.
- The hospital trust should review and risk-assess the provision of the intensive care Outreach team service which was not being provided for 24 hours a day in line with national guidance.
- The intensive care team should review the governance within the unit and formalise the structure and meetings.
- Review awareness of the risk register process

Summary of findings

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service

Urgent and emergency services

Rating

Good



Why have we given this rating?

Overall, we have rated the accident and emergency department at James Paget hospital as good with an outstanding leadership team. The department ensured that people were protected from abuse and avoidable harm. Staff provided good care with outstanding elements for its effectiveness, which included patient care pathways and use of technology with evidence-based techniques and technologies, used to support the delivery of high quality care.

We heard from our discussions with staff a genuine open and transparent culture in the department. All staff use an incident reporting system. Incidents investigated were impartial with an ethos placed on quality and learning and improvement to the service offered to people.

We observed the leadership of the department, which was co-ordinated and was very well organised within the teams. Experienced leaders encouraged positive clear open communication and in particular, when the department was under pressure. There was a recurring theme of staff engagement within the department and between managers, which had a good impact on patient care, and staff morale. We saw outstanding evidence of a well led accident and emergency department and the Emergency Assessment and Discharge Unit (EADU) by the management team. We looked at equipment within the entire department, which was clean, serviced and suitable. Maintenance of equipment to the manufacturer's recommendations with service labels advising when the next service is due was evident. The environment was clean and designed to assist people with a disability.

We reviewed evidence that the department made full use of guidelines with over seventy guidelines in use that were available to all staff electronically. All staff within varied discipline levels was involved with local and national audits and staff leads ensured that education from audits took place across all teams.

Summary of findings

There were minimal nurse vacancies within the accident and emergency department and Emergency Assessment and Discharge Unit (EADU). We observed during our inspection that nurses and doctors demonstrated an understanding of individual patient needs centred on the patient. During our inspection, the department assessed patients' at periods of busy times arriving by ambulance within fifteen minutes of arrival. We noted that the ambulance median to initial assessment time to handover was consistently below the England average. There were only 197 ambulance handover delays over thirty minutes during the winter period of November 2014 to March 2015.

Medical care

Good



Overall, we found that medical care services at the James Paget Hospital were good. There were not always sufficient nursing or medical staff and mandatory training rates were variable across the division but patient outcomes were as good as, or better, than national averages.

Staff were competent, caring and professional and they had the information and training that they needed to provide effective care to patients.

There were some staff shortages but effective multi-professional team working helped maintain the quality of the services provided. Referral to treatment times exceeded the national target. The needs of different people, especially those in vulnerable circumstances were taken into account. However, there was a lack of a co-ordinated approach to providing care, support and treatment to elderly people. The trust was aware of this need and had tried unsuccessfully to recruit two consultant geriatricians. Work was progressing with social care and other health partners on the development of an integrated strategy to meet the needs of frail elderly people in the community as well as in the hospital.

Leadership was good, there was an open and transparent culture and the low staff turnover reflect the positive regard in which staff held the hospital and their colleagues. Effective governance and robust performance management was maintaining and improving the quality of the service.

Summary of findings

The trust was working in an integrated way with other local health partners and social care to develop a coherent approach to supporting elderly people in the hospital and in the community.

Surgery

Requires improvement



Safety in surgical services required improvement because the environment in some areas was in poor condition and medicines were not always stored securely in theatres. Nursing records were not always accurate or complete with inconsistencies in some records. Staff reported incidents and there were clear examples of lessons learnt. There had been a recent review of staffing within the division with increased qualified nursing staff in some areas. Surgical services effectiveness was good. Evidence based care and treatment was in place throughout the division, following National Institute for Clinical Excellence guidance and local audit. Pain assessments were completed and analgesia administered in a way best suited to patients need. National audit data showed the trust to be performing well in some areas and highlighting areas for improvement, particularly in hip fracture. There was good multidisciplinary working and staff applied the mental capacity act correctly. We found caring to be good across the surgical services. The friends and family test (FFT) for the surgical wards was positive, with a high proportion of patients saying they would recommend the ward they were received care on. We observed numerous examples of kind, compassionate and respectful care during the inspection. Patients received options for their care and treatment and that they and their relatives and carers, were kept up to date with their treatment and plans for future care. Surgical services were not always responsive to patient's needs. The division was failing to meet referral to treatment times (RTT) but had an improving performance in general surgery. Services were planned to meet the needs of local people including the provision of a new day surgery unit. The trust was planning a dedicated emergency theatre in line with national guidance to be available by spring 2016. There was good evidence of learning from concerns and complaints. Surgical services were well led because there was a clear vision and strategy for the service, with some

Summary of findings

Critical care

Good



clinic areas developing their own local vision. There was a robust system in place for governance within the surgical division with oversight of risks. Staff spoke highly of leadership at ward and division level. There was an open, transparent culture within the service was ongoing engagement with staff and patients through 'you said, we did' initiatives and staff survey and welfare committees.

Overall, we have judged the intensive care service as good. The service was providing safe, effective, caring and responsive treatment and care to patients. There were, however, elements within some of these areas requiring improvement. The overall governance of the service required improvement.

The service was delivered safely. There was a good track-record on safety with lessons learned and improvements made when things went wrong or should be better. There were low rates of infection and avoidable harm to patients. Staff responded appropriately to changes in patients' condition, although the intensive care outreach service (which provided support to staff caring for deteriorating patients elsewhere in the hospital) was not provided 24 hours a day. There were good levels of nursing and medical staff and agency nursing staff or locum cover was used infrequently. Patient records were clear and contemporaneous. Medicines were stored safely, were seen to be in date, and recorded accurately. The majority of staff mandatory update training compliance was high and most met trust targets.

The evidence of staff learning and sharing feedback from mortality and morbidity reviews was not well reported. There was insufficient cover to meet best-practice guidance from pharmacists and specifically physiotherapists. Some of the cover from the doctors at night did not meet the Faculty of Intensive Care Medicine (FICM) Core Standards guidance if the unit had a high number of patients. Care was effective. The majority of treatment and care by all staff was delivered in accordance with legislation, standards, best practice and recognised national guidelines. There was a holistic, multidisciplinary professional approach to assessing and planning care and treatment,

Summary of findings

although insufficient input to patient treatment and recovery from the under-resourced physiotherapist and pharmacist teams. Patient-centred care was the focus for intensive care services. The intensive care unit achieved good outcomes for patients who were critically ill and/or with complex problems and multiple needs. There was a strong commitment to the successful programme of organ donation.

There was respected and high quality training and development in the intensive care unit for trainee doctors. There were not, however, enough nurses with a post-registration qualification in intensive care nursing, which is an expectation of the FICM Core Standards. There were also incomplete records in relation to competency in equipment use having been assessed for the nursing team.

Staff were caring and compassionate. Patients were respected, valued and understood as individuals.

Feedback from people who had used the service, including patients and their families, had been exceptionally positive. Staff delivered care with kindness, dignity, respect and compassion.

Patient's cultural, religious, social and personal needs were respected and those close to them were involved with their care.

The intensive care service responded well to patient needs. The intensive care team were organised, flexible and ensured patients who needed a bed were admitted. Some patients were delayed on discharge from the unit or discharged at night, when this was recognised as less than optimal for patient wellbeing. There were good facilities in the intensive care unit for patients, visitors and staff, and these met the modern intensive care building standards.

Although there was good leadership and attention to a safe, effective, caring and responsive service, there was a lack of straightforward formal governance. There was no regular governance meeting for the whole intensive care service looking at a programme of audit; receiving and reviewing reports; developing shared action plans; and onward representation at key divisional governance meetings. The risks on the unit were mostly understood, but not being locally managed, or addressed by the board.

Summary of findings

Intensive care staff were committed to their patients and their unit with a shared purpose. A high level of staff satisfaction was found throughout the services. Many spoke highly of the positive culture and levels of constructive engagement, support and encouragement. There was a committed leadership from the consultants and the nursing team. The nurses were supported by an experienced matron who did, however, have extensive responsibilities beyond the intensive care unit.

Maternity and gynaecology

Good



The current safety of maternity and gynaecology services provided for patients requires improvement at James Paget Hospital. We spoke to midwives, specialist nurses, healthcare support workers, nursery staff, administration staff and consultants in focus groups and individually when we were able to during ward observation. Although very few of the staff we spoke to were able to describe the Trust's vision and values, they were particularly proud of the work to improve maternity services under leadership of a new head of midwifery. Staff were aware of incident and safeguarding reporting procedures and recording systems. Staff were able to describe how to escalate and or record untoward incidents. Senior staff had recently taken part in multi-disciplinary root cause analysis training (RCA) to improve investigation of untoward incidents. Further staff training in root cause analysis was identified for September 2015 to increase the numbers of staff with this skill. All areas visited adhered to infection control and prevention standards areas were clean; we observed staff wearing uniforms, were bare below the elbow and were seen wearing personal protective aprons and or gloves in line with infection control guidelines. Alcohol hand sanitizer was available on entering the wards, at the end of each patient's bed and reception areas. We saw that equipment was checked, signed and dated in line with portable appliance testing guidelines. We found that some daily checks for resuscitation equipment were inconsistently completed, resulting in gaps in the recording of these to show that the checks had been completed.

Summary of findings

The newly refurbished central delivery suite and the Dolphin suite were bright, clean and staff were welcoming. Electronic key pads, 'intercom entry and CCTV restricted access to some maternity services areas. We saw that the ante-natal clinic area was shared with the outpatient clinic for children and young people. A mixture of expectant women, young children some of whom had severe disabilities and their parents, overcrowded this area.

We found that medicines were appropriately secure to ensure effective management of these. We saw staff passing controlled drugs (CD) keys over to the senior staff and checking drugs.

We found the maternity records format was cumbersome. Information regarding some foetal abnormality checks in some records were not readily identifiable. However, we saw some good examples of individual risk assessments to meet the particular health or social needs of patients and their babies for example, risks associated with mental ill-health and or learning difficulties.

Midwifery and gynaecology staff were readily able to describe how to raise concerns and/or safeguarding issues. They knew who to speak to for advice including those pregnant women for which James Paget Hospital was not their booked hospital of choice. We found that patients from other specialities were regularly accommodated on the gynaecology ward (Ward 4) at the time of this inspection there were five gynaecological patients, 14 medical patients and nine surgical patients on a 28 bedded ward area. We found that some medical and surgical outlier incidents had been classified as gynaecology incidents because these patients were accommodated on the gynaecology ward.

We looked in 11 sets of obstetric patient notes and saw evidence of early warning scores being used to identify potential deterioration of mothers. There was no dedicated maternity IT system.

Inspectors visited central delivery suite (CDS) and labour ward on Tuesday 11, Wednesday 12 and Thursday 13 August and on each occasion we visited a ward the ward information showed there

Summary of findings

were midwife and maternity support worker shortages on central delivery suite on 12 and 13 August. We visited the gynaecology service on ward 4.

A maternity unit the size of the service at James Paget Hospital should have 40 hours of consultant cover weekly. The Trust maintained this level of cover and staff to which we spoke confirmed access to consultants was good, even out of hours.

Services for children and young people

Good



The children's and young people's service was good overall.

James Paget University NHS Foundation Trust delivered hospital based and community based services to children, young people and their families throughout Great Yarmouth, Lowestoft and Waveney.

The trust did not follow Royal College of Nursing best practice guidance (2013) in relation to nurse staffing levels for children's and young people's services. This was because there were insufficient experienced band six nurses employed over the 24-hour period to provide the necessary support to the nursing team on ward 10. However the trust ensured that an appropriate skill mix of nursing staff was available on the ward.

Although, risks to patients were assessed and managed, staff had not consistently monitored the emergency resuscitation equipment. We found gaps in the records used when checking this equipment and we also found equipment which had passed its expiry date in the resuscitation trolleys on ward 10. Patients received evidence based care and there were good examples of collaborative working in the multidisciplinary team. Staff were caring, compassionate and respectful. Staff were positive about working in the service and there was a culture of openness, flexibility and commitment to working as a team. Staff told us they aimed to provide family centred care and empowered parents to take some ownership of care to prepare for discharge. There was a culture of openness, flexibility and commitment. Arrangements were in place to minimise risks to children and young people receiving care, and there was effective monitoring of quality and outcomes.

Summary of findings

End of life care

Requires improvement



The safety of end of life services provided at James Paget University Hospital required improvement. The end of life services also required improvement across the effective and well led domains. We found that staff providing end of life services were caring and responsive to the needs of patients. Patients 'do not attempt cardio-pulmonary resuscitation' (DNACPR) forms were sometimes incomplete. Patients did not have a clear care plan which specified their wishes regarding end of life care. Introduction of the end of life care pathway in replacement of the Liverpool Care Pathway was slow and lacked oversight at the board level. Staff knew how to report concerns but these reports were not analysed and used to improve the service. The trust had scored much worse than the national average in the national care of the dying audit. The trust did not monitor the quality of the service effectively, for example no audits were carried out to check if there were any obstacles to patient's discharge and to ensure patients died in their preferred location. We also noted that the trust was proactive in developing links with local providers of end of life care and tried to influence how the services were delivered to the local population. Patients' complaints had been responded to by local team members and appropriate actions were taken in response. There was no routine audit of the palliative care team's response times and we were unable to fully assess the service to ensure the team was always responsive. The specialist palliative care team was poorly represented within the elective division and there was no non-executive director to who could provide representation of end of life care at board level. There was limited capacity to develop the service and undertake research due to recruitment issues. Staff across the hospital were respectful and maintained patients' dignity, there was a person centred culture. Specialist palliative care team members felt supported in their work and they worked well as a team. Staff were clear about their roles and their involvement in decision making. Patients said staff were caring and compassionate. They had appropriate access to pain relief and told us they were happy with the food and drink offered. Palliative care and end of life team members were

Summary of findings

competent and knowledgeable. There were examples of good multidisciplinary team working. The palliative care team was visible on all wards and nursing staff knew how to contact them.

Outpatients and diagnostic imaging

Good



Overall we rated the outpatients and diagnostic imaging services as good. Medicines storage and management was safe and robust in outpatients and diagnostic imaging services, clinical environments were visibly clean with regular auditing of cleanliness. Nursing staffing levels were well maintained to provide the level of care required. The reporting, managing and learning from incidents was well embedded and supported by an electronic system that was easily accessible for all relevant staff.

The auditing of equipment and clinical practice was well embedded across outpatients and diagnostic imaging services with sharing of learning happening at both local and senior level. Patients felt well cared for and respected in the outpatients and diagnostic imaging services, with patient's privacy and dignity being maintained by staff. Referral to treatment times (RTT) were better than the England average for outpatients and diagnostic imaging services and the waiting time for patients with suspected cancers was exceptionally good and there was dedicated provision for people with dementia in outpatients and diagnostic imaging services.

Local leadership was good within the outpatients and diagnostic imaging services. Staff were aware of the trust's values and there was good clinical governance monitoring and escalation, and there were service-level strategies for forward planning over the next three to five years. Outpatients and diagnostic imaging staff felt proud to work at this trust.

The use of both paper and electronic medical records introduced a risk of information being misplaced or not available within outpatients and diagnostic imaging services. The use of several different electronic systems for items such as medical records, investigations, reporting, patient note tracking, and cancer pathways was confusing

Summary of findings

and not robust. Systems were not joined up with each other which meant that all information regarding a patient may not be on one system or always accessible.

Staff compliance levels for mandatory training were on track to reach the trusts target level by March 2016. Auditing of clinical guidelines was not robust across all departments, meaning that good practice was not always being shared.

Some clinical areas were cramped due to the increased demand on services, which impacted on maintaining patient's privacy and dignity. However this was due to be addressed as outlined in a new estates strategy. Although some departments with outpatients and diagnostic imaging services had service development plans in place, this was not consistent across all departments.

The monitoring of complaints was done at local level and senior level, however the reporting of complaints was confusing and contradictory at times meaning that departments may not always be able to improve practice when complaints data is not robust. The senior executive team were visible to local leaders who knew how and when to contact them. However, senior executive visibility was not always present for front line staff.

James Paget Hospital

Detailed findings

Services we looked at

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

Detailed findings

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Background to James Paget Hospital

The James Paget University Hospitals NHS Foundation is a university hospital providing the care to a population of 230,000 residents across Great Yarmouth, Lowestoft and Waveney, as well as to the many visitors who come to this part of East Anglia. The main trust site, James Paget Hospital is in Gorleston and is supported by services at Lowestoft Hospital, the Newberry Clinic and other outreach clinics in the local area.

The James Paget Hospital officially opened on 21 July 1982, was established as a third wave NHS Trust in 1 April 1993 and became a Foundation Trust on 1st August 2006.

The Trust employs 3,000 staff, making it the largest local employer in the area. As a University Hospital, the Trust trains over one third of the medical students from the University of East Anglia.

The health of people in Great Yarmouth is varied compared with the England average. Deprivation is higher than average and about 24.9% (4,400) children live in poverty. Life expectancy for both men and women is lower than the England average. The health of people in Waveney is varied compared with the England average. Deprivation is lower than average, however about 21.8% (4,300) children live in poverty. Life expectancy for both men and women is similar to the England average.

We inspected in August 2015 as part of our ongoing programme of comprehensive inspections.

Our inspection team

Our inspection team was led by:

Chair: Leslie Hamilton, Consultant Cardiothoracic Surgeon

Head of Hospital Inspections: Fiona Allinson, Care Quality Commission

The team included CQC inspectors and a variety of specialists:

The team included nine CQC inspectors and a variety of specialists including a safeguarding specialist, a pharmacist, two medical consultants, a consultant in emergency medicine, a consultant obstetrician, two consultant surgeons, an intensive care consultant, a consultant paediatrician, a junior doctor, 10 nurses at a variety of levels across the core service specialities, a

Detailed findings

student nurse and an expert by experience. (Experts by experience have personal experience of using or caring for someone who uses the type of service that we were inspecting.)

How we carried out this inspection

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

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

The inspection took place between 11 and 13 August 2015 with an unannounced inspection on 25 August 2015.

Before visiting, we reviewed a range of information we held, and asked other organisations to share what they knew about the hospital. These included the clinical commissioning group (CCG); 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 11 August 2015, when people shared their views and experiences of

James Paget 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 11 and 13 August 2015. We also conducted an unannounced inspection on 25 August 2015. We spoke with a range of staff in the hospital, including nurses, junior doctors, consultants, administrative and clerical staff, radiologists, radiographers, pharmacy assistants, pharmacy technicians and pharmacists. We also spoke with staff individually as requested and held 'drop in' sessions.

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

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

Facts and data about James Paget Hospital

Beds 484

- 456 inpatient beds
- 26 day case beds

Staff: 2,508 WTE (April 2015)

- 274 Medical
- 800 Nursing
- 1,434 Other

Revenue £181,271

Activity Summary for 2014/15:

Inpatient Admissions: 23,896

Day Case admissions: 33,849

Outpatient attendances: 272,745

Accident and emergency Attendances: 71,400

Detailed findings

Our ratings for this hospital

Our ratings for this hospital are:

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

Notes

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

Urgent and emergency services

Safe	Good	●
Effective	Good	●
Caring	Good	●
Responsive	Good	●
Well-led	Outstanding	★
Overall	Good	●

Information about the service

The accident and emergency department at James Paget hospital provides a twenty four-hour, seven day a week service to a population of 230,000 residents across Great Yarmouth, Lowestoft and Waveney, as well as to the many visitors who come to this part of East Anglia.

The accident and emergency department saw around 70,174 patients of which about 20% were children between April 2014 and March 2015. The department consisted of five major and five minor treatment cubicles, a new four-bedded resuscitation area including a dedicated paediatric resuscitation area. There was a 'see and treat' assessment room led by emergency nurse practitioners and a dedicated room to support patients with a mental health need.

Patients present to the department by walking in via the reception area or arriving by ambulance. The hospital had a designated air ambulance helicopter-landing pad. The department had facilities for assessment, treatment of minor and major injuries and separate children's accident and emergency service.

Our announced inspection included two days in the accident and emergency department including the Emergency Assessment and Discharge Unit (EADU) . We spoke with reception staff, seven members of the medical team (at various levels of seniority), fourteen members of the nursing team (at various levels of seniority), including the leads for infection prevention and control, safeguarding and major incidents.

We also spoke with eleven patients and undertook observations of care in areas of the departments. We reviewed the medical and nursing notes of twenty-five patients and looked at audits of care provided.

The trusts performance concerning the four-hour waiting time has been consistently above the England average and required standard of seeing 95% of patients within four hours of arrival.

The accident and emergency department is a member of the regional trauma network and provides hyper acute stroke services.

Urgent and emergency services

Summary of findings

Overall, we have rated the accident and emergency department at James Paget hospital as good. The department ensured that people were protected from abuse and avoidable harm. Staff provided good care with outstanding elements for its effectiveness, which included patient care pathways and use of technology with evidence-based techniques and technologies, used to support the delivery of high quality care.

We heard from our discussions with staff a genuine open and transparent culture in the department. All staff use an incident reporting system. Incidents investigated were impartial with an ethos placed on quality and learning and improvement to the service offered to people.

We observed the leadership of the department, which was co-ordinated and was very well organised within the teams. Experienced leaders encouraged positive clear open communication and in particular, when the department was under pressure. There was a recurring theme of staff engagement within the department and between managers, which had a good impact on patient care, and staff morale. We saw outstanding evidence of a well led accident and emergency department and the Emergency Assessment and Discharge Unit (EADU) by the management team.

We looked at equipment within the entire department, which was clean, serviced and suitable. Maintenance of equipment to the manufacturer's recommendations with service labels advising when the next service is due was evident. The environment was clean and designed to assist people with a disability.

We reviewed evidence that the department made full use of guidelines with over seventy guidelines in use that were available to all staff electronically. All staff within varied discipline levels was involved with local and national audits and staff leads ensured that education from audits took place across all teams.

There were minimal nurse vacancies within the accident and emergency department and Emergency

Assessment and Discharge Unit (EADU) . We observed during our inspection that nurses and doctors demonstrated an understanding of individual patient needs centred on the patient.

During our inspection, the department assessed patients' at periods of busy times arriving by ambulance within fifteen minutes of arrival. We noted that the ambulance median to initial assessment time to handover was consistently below the England average. There were only 197 ambulance handover delays over thirty minutes during the winter period of November 2014 to March 2015.

Urgent and emergency services

Are urgent and emergency services safe?

Good



We rated the safety of urgent and emergency services as good.

There were systems to protect patients and maintain their safety. These systems consistently used within the patient pathways were available. There were adequate nursing and medical staffing levels and this provided care to patients that protected them from abuse and avoidable harm within the different areas of treatment.

We saw that staff at all levels including non-clinical staff received the necessary training to enable them to carry out their roles effectively. Staff displayed an awareness and practice of infection prevention and control, safeguarding of adults and children and supporting patients with a complex need.

We spoke with staff who confirmed incident reporting was common practice throughout the department and there were examples that staff learnt from incidents.

Departments managed risks and there was an environment that ensured patients received care and treatment in accordance with national and local guidelines. We looked at the storage and management of medicines, which was safe, and staff handled all medications in accordance with trust policy.

We observed and spoke with staff that demonstrated experience and an understanding of patients' needs. We observed care provided to patients, which were appropriate and followed guidelines. Care delivered was with empathy and compassion.

There was an appropriate separate adult and child waiting area within the accident and emergency department. The waiting areas displayed information for patients and their relatives or friends via an electronic system advising of the waiting time and demand on the department. There was also information available in a hard copy format.

Incidents

- The trust reported sixty-seven serious incidents to the National Reporting and Learning System, which occurred between May 2014, and April 2015. None of the sixty-seven reported serious incidents involved the emergency departments.
- There have been no recorded Never Events within the accident and emergency departments. (Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventable measures have been implemented).
- We looked at the safety thermometer incidents of pressure ulcers, falls and catheter acquired urinary tract infections between the periods of March 2014 to March 2015. The emergency departments had zero pressure ulcers reported. Two falls were recorded across a five month period. One in November 2014 and the other in March 2015. There were two catheter-acquired urinary tract infections recorded, one in March 2014 and the other in January 2015.
- We spoke with five members of staff around incident reporting and learning. All staff told us they had knowledge of the reporting system. Staff told us they received feedback on incidents they reported internally and that the senior band 7 nurse manager and lead consultant took responsibility to investigate and ensure feedback was provided. The department service manager supported this and we saw documents demonstrating that incident investigations were fed back to staff.
- The department monitored its safety performance against safety goals, reviewed weekly. Monthly meetings were held involving the multi-disciplinary team which included mortality and morbidity reviews
- Candour, openness, honesty, transparency, and challenges to poor practice were embedded within the departments. Managers' supported staff in their roles with duty of candour. For example, a doctor explained an incident whereby the protocol of the use of intra-venous paracetamol, was not followed and this was immediately explained to the patient and their family.

Cleanliness, infection control and hygiene

- Staff used hand sanitiser between patient care, moving around the emergency department, encouraging visitors to engage in the process, and explaining the procedure to children in a caring, supporting manner.

Urgent and emergency services

- There were hand-cleaning stations within treatment areas. Hand sanitiser was at each door entrance and within corridors throughout the emergency departments.
- All staff observed the 'Bare below the elbow' trust policy. This meant staff working in the emergency departments followed the required practice and understood safe infection prevention and control.
- Clinical waste bins were available. The person who assembled the clinical waste bin completed all sections on the bins. For example, date of assembling the bin and the name of the person who assembled the bin.
- Staff appropriately decontaminated patients' skin in line with trust policy, prior to insertion of venous catheters.
- Managers' supported infection prevention and control quality audits. Audit results discussed monthly, fed into governance meetings. Regular hand washing audits showed compliance to always be above 95%.
- There had been no reported cases of Methicillin-resistant *Staphylococcus aureus* or *Clostridium difficile* within the emergency departments in the last twelve months.

Environment and equipment

- The departments' had a range of equipment, which was clean and well maintained. 'I am clean' green labels were in use to indicate when items of equipment were clean.
- The resuscitation area included an increase to four resuscitation bays, which had clearly identified appropriate equipment. Emergency equipment trolleys' followed a system that adopted airway, breathing and circulation management approach within each resuscitation bay.
- We looked at emergency resuscitation trolleys' throughout the department and found all the trolleys' within the adult and children's accident and emergency department and Emergency Assessment and Discharge Unit (EADU) areas had been consistently checked daily with signatures of the staff that checked them recorded. We looked at past records over the previous three months and found no abnormalities within the audit of the checks.
- The adult accident and emergency department had a room dedicated to people who presented with a mental health problem. The room was away from treatment areas' and designed to offer people privacy and a

degree of security. There was a risk assessment in place for the use and design of this room. During our inspection we were unable to see the room as it was in constant use.

Medicines

- We checked the records and stock of medication including controlled drugs and found correct and concise records with appropriate daily checks carried out by qualified staff permitted to perform this task. During these checks, we observed two nurses carry out the correct procedure for a drug preparation for administration.
- Drug cupboards were secure and only those staff authorised via the use of their individual encoded identification card obtained access.
- Intravenous fluids were stored in a locked cupboard.
- When we checked, medication fridges were locked. Temperatures were recorded to ensure that medicines were stored as per the manufactures' recommendations.
- We spoke to a patient who told us that the medication they were given was explained to them and what the medication was for.

Records

- Within the accident and emergency department, individual care plans and records were managed within an information technology system. All staff used this system to record an entry into a patient's notes. The system recorded at the end of every entry a date, time and the author. This meant that there was no confusion around handwriting or signature. The system assisted any audit process and ensured records were stored securely.
- We accessed and reviewed eight electronic care records. This was to check the department routinely utilised risk assessments related to slips, trips and falls, mental capacity assessments, safeguarding and nutritional risk assessments. All records were complete and very well documented.
- The Emergency Assessment and Discharge Unit (EADU) used a paper record system, which had been in use for some time within the trust. The department ensured that all records were stored safe with access to those that only required access.
- We reviewed seven care records within the Emergency Assessment and Discharge Unit (EADU) and found all

Urgent and emergency services

records were complete, which included, body mapping for pressure areas, nutritional risk assessments and completed accident and emergency records if appropriate.

- Records in all departments were organised and easily defined between nursing and medical notes.

Safeguarding

- All staff across the departments' used the trust adult and child-safeguarding algorithm and the flowcharts were displayed across departments.
- The senior nurse in the accident and emergency department told us that should there be a safeguarding concern and they had to wait for the safeguarding team to come to the department they would admit the patient to support and protect them.
- We reviewed records and all staff have received level three safeguarding training.
- Staff had an understanding of their roles and responsibilities when reporting safeguarding concerns. We spoke with four nurses' and three doctors' who confirmed the training received and stated the process they would follow to alert a safeguarding concern to the trust.
- We looked at two previous governance meetings and saw that safeguarding was a fixed agenda item on all meetings.
- The previous staff meeting in June 2015 had a specific session delivered by child services on safeguarding and domestic violence.

Mandatory training

- Mandatory training was over two days throughout the trust. The training was known as the Collaborative Learning Action Workshops (CLAW). The first day focussed on practical elements. For example, moving and handling. The second day was a focussed clinical day and focussed on topics such as blood transfusion.
- All staff in the accident and emergency departments' had completed CLAW day one and we saw all staff were booked to attend CLAW day two training.
- We looked at staff training records and all staff had completed an immediate life support course and all band 6 nurses had attended a paediatric immediate life support course.
- We saw that there were eight band six nurses within the accident and emergency department and all band six nurses were qualified in advanced life support.

- Five qualified nurses across the department were qualified in advanced trauma life support.
- Security staff in the accident and emergency departments was included in CLAW training. They also received training in basic life support, level two child protection and conflict resolution training.
- Varied grades of doctors' told us the induction provided was exceptional. Three doctors' told us that the lead consultant was supportive with their training.

Assessing and responding to patient risk

- Processes were in place for monitoring patients. The use of the Modified Early Warning Score (MEWS) and Paediatric Early Warning Score (PEWS) allowed staff to monitor patients and to identify deteriorating patients. NEW scores were viewable on the electronic screen within the accident and emergency department so staff such as the nurse-in-charge or lead consultant were aware of any patient who may be deteriorating anywhere in the department.
- In the Emergency Assessment and Discharge Unit (EADU), the same early warning scoring system was in use and this was displayed on a white board, which provided a clear overview of patient acuity.
- Both the adult and children's' department operated a triage system. Patients' presenting to the departments either by themselves or via ambulance are treated in priority dependent on their condition.
- A pre-alert from the ambulance service occurred during our inspection. The forms used to record the information were completed with clinical observations, estimated time of arrival of the ambulance to the emergency department, and who took the details over the telephone from the ambulance service.
- We reviewed the previous months' pre-alert forms, which were completed to a good standard including all areas required on the form.
- The trust is one of the twelve trauma units within the East of England major trauma network supporting the major trauma centre at Addenbrooke's Hospital. A national peer review visit took place on 26 January 2015. Concerns rose that there were only twenty activations of the trauma team in the previous year, which was a 50% reduction. The trust plans to review why trauma calls were not initiated and identify any actions and with immediate effect, trauma team attendance will be documented and non-attendance to

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trauma calls, escalated immediately to the senior consultant. However, the reduced numbers appears to represent a changing service provision in the local health economy.

- The department held monthly clinical governance meetings where mortality and morbidity is one item on a regular agenda. Both clinical and nursing staff attends these meetings.

Nursing staffing

- Managers within the emergency department indicated that the establishment was operating at the required whole time equivalent. The department recently had four vacancies with five good applicants. The trust supported the decision to recruit above establishment with forward vision.
- In addition, the department provides six Emergency Nurse Practitioners' (ENP's) who provide a daily service. The ENP's support the advanced assessment and minor injury treatment to reduce the number of patients who may require to have waited for a doctor.
- The department had very little reliance on agency nurses and used three agency nurses who had received the trust induction and regularly worked in the departments.
- Registered nurses (child branch) worked in the children's accident and emergency department and nurses rotated with the children's ward to enhance skill retention. There was a children's nurse available in the ED in line with RCN guidance.
- Nurse staffing levels and skill mix were planned and met the needs of the departments.

Medical staffing

- The departments' currently operate at 25% whole time equivalent of consultant skill mix which is above the England average of 23%.
- There was 39% middle grade cover, which equalled the England average of 39%. However, the department had a 21% junior doctor cover compared to an England average of 24%.
- We spoke with doctors at various seniority including a junior doctor, middle grade doctor and three consultants. We were told that the induction was very comprehensive.

- Should a paediatrician be required for the children's department, the paediatrician rotates from the children's ward. There was also a bleep system in place. The department ensured that there was always a doctor trained in paediatric advanced life support available.
- Although the departments' did not have a twenty four hour, seven day a week consultant-led service, there was direct consultant cover available, seven days a week with 'on-call'
- The department employed locum doctors. When we reviewed the rota, we noted that the same doctors were used. Locums' received the trust induction programme and were familiar with the department and protocols.

Major incident awareness and training

- The department had a major incident plan, reviewed in 2015. The next review is due in 2017.
- We spoke with six staff, including switchboard staff that had a clear understanding of their roles and responsibilities concerning major incidents. Staff directed us to the major incident plan and switchboard staff discussed the action cards, which formed part of the policy.
- We reviewed the major incident plan, which had clear guidelines and procedures that followed the Joint Emergency Services Interoperability Programme (JESIP).
- The accident and emergency department had a unique set up concerning major incident preparedness and in particular decontamination. The department had hard standing linked units, which complied with the Department of Health decontamination requirements. The system recently tested through a live incident, which was commended in the speed of the department's reaction and management of the incident.
- The correct major incident equipment and quantity were in place. We spoke with the lead nurse on major incident, who had an excellent understanding of procedures and training. There was a live exercise every year, which included security and portering staff.

Urgent and emergency services

Are urgent and emergency services effective? (for example, treatment is effective)

Good



We rated the urgent and emergency services effectiveness as good.

There was an approach in the department to assessing, planning and delivering care with the safe use of innovation using technologies to support the delivery of high quality care. There were five doctors' within the department qualified to use thrombolysis treatment on patients' suffering an embolic stroke. Should these doctors' not be available, a direct link to a neuro consultant on call, via a computer on wheels (COW) and laptop was established to view live images to consider thrombolysis if appropriate.

This meant that there were systems to manage and share the information that was required to deliver effective care, which was integrated to provide real-time information across clinical teams.

The emergency department used a combination of the National Institute of Clinical Excellence (NICE) and Royal College of Emergency Medicine (RCEM) guidelines to determine the treatment they provided. Local policies were in line with this and updated as national guidance changed.

There was an approach to planning and supporting patients' discharge, transfer or transition of care to other services. The department attracted a high percentage of out of area visitors due to its location. We witnessed normal practice of an out of area discharge for a patient with a fracture. An electronic discharge letter was sent to the patient's GP and the patient had a hard copy. The doctor then telephoned the patient's local hospital and was able to arrange an appointment for them. This meant the departments' arrangements fully reflected patient individual circumstances and preferences.

Evidence-based care and treatment

- Departmental policies, procedures and guidelines were based on nationally recognised best practice guidance. For example, the National Institute for Health and Care

Excellence (NICE) and the Royal College of Emergency Medicine (RCEM). Examples included pathway management protocols for patients who present with suspected septicaemia.

- There was local audit activity whereby doctors' and nurses' participated. Three recent local audits included, the deteriorating patient, nurse protocols and competencies and equipment. These were yet to be analysed for results at the time of our inspection.
- There were five doctors' within the department qualified to use thrombolysis treatment on patients' suffering an embolic stroke. Should these doctors' not be available, a direct link to a neuro consultant on call, via a computer on wheels (COW) and laptop was established to view live images to consider thrombolysis if appropriate.
- Patients received appropriate care or early intervention as recommended by national guidelines such as the National Institute of Health and Care Excellence (NICE) and the Royal College of Emergency Medicine (RCEM).
- There was an audit plan in place for the emergency division that included the emergency department who undertook the

Pain relief

- In The Care Quality Commission A&E survey, the Accident and emergency department scored 'about the same' as other trusts with regards to the questions; 'How many minutes after you requested pain relief medication did it take before you got it? And 'Do you think the hospital staff did everything they could to help control your pain?'
- We spoke to a patient who told us that they received pain relief very quickly and that nurses came back to check that the pain had gone.

Nutrition and hydration

- Regular food and drink rounds took place twenty four hours a day, seven days a week and it was observed during our inspection that should patients require something to eat or drink then they were offered this.
- We reviewed a patient's notes that had catheter in situ, a fluid input, and output chart was completed.
- Nutritional needs and assessments were recorded within the nursing record on the electronic computer system.

Patient outcomes

Urgent and emergency services

- We looked at the department's Royal College of Emergency Medicine (RCEM) audits against two of the mental health fundamental standards. Standard one: Risk assessment taken and recorded in the patient's clinical record. The RCEM standard required is 100% and the department scored 80%. Standard two: Dedicated assessment room for mental health patients. The RCEM standard required is 100% and the department scored 100%.
- The unplanned re-attendance rate to the department within seven days was above the England average of 7%. The standard is 5% and the department between the periods March 2014/15 had a re-attendance rate of 8%. However, we looked at data and found that figures included the emergency nurse practitioner dressing reviews. For example, the same person returning four times for a change of dressing was included.
- The consultant sign off standard for patients prior to discharge was better than the England average at 23% (2013).
- We spoke with the lead consultant around the lack of Royal College of Emergency Medicine audit data submitted. It was explained that the department had dropped down to two consultants and they could not facilitate the audits. However, the increased department consultant levels meant this was now being facilitated. Audit plans showed that an audit schedule was now being maintained.
- The trust provided data to the Trauma Audit and Research Network (TARN). Numbers of total patients for 2015 was 36, with the last full data of 2014 showing 193 total patients. Most recent data from 2014/ 15 showed that survival rates for these patients was the same as expected (there were no additional deaths or survivors than would be expected). Data completeness at the trust had been 69.9% in 2014.
- TARN data for head injury patients showed that the mean time for patients to receive a CT scan was just less than one hour with the national average to be just over half an hour. This was for 24 patients between 2012 and 2015.
- Appraisals of both medical and nursing staff were undertaken and staff spoke positively about the process. One member of staff told us "They are of quality with protected time."
- Appraisals were led by the departments' and were up to date with 100% compliance. With exception of nurses on maternity leave and long term sickness.
- Junior doctors' told us teaching takes place every Wednesday afternoon between 2pm to 4pm.
- New nurses joining the department were given a buddy to support them through the competencies required.
- We saw records that demonstrated all medical and nursing staff had received appropriate refresher training in basic, intermediate and advanced life support.
- Each Band six nurse responsible for assuming the "in-charge" responsibility in the department had completed advanced life support training.
- Care was delivered against current based guidelines in a co-ordinated way by confident, competent staff within all grades.

Multidisciplinary working

- During our inspection we witnessed that staff worked together as a cohesive team in a way that assessed and planned ongoing care and treatment in a timely way when people were due to move between teams or departments, including referral, discharge and transition.
- The teams within the departments' demonstrated an excellent working relationship with the local NHS ambulance service.
- We observed the team working within the Emergency Assessment and Discharge Unit (EADU) on our second day of inspection work in cohesion with the accident and emergency and clinical decision unit staff, which enhanced a smooth transition of patient care that was seamless.
- On the first day of our inspection we noted that the mental health crisis team were in the department working collaboratively with the department team for the best patient outcome.
- We looked at three samples of discharge letters, which included a very comprehensive history, and treatment of the patient. This enhanced and improved the professional relationship with the patients' GP and the department.

Seven-day services

Competent staff

- We spoke with seven nurses of different grades who told us they felt the mandatory and supplementary training delivered, was beneficial and of a high standard, which kept them up to date.

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- There was a consultant out of hour's service provided via an on call system.
- Staff within all the emergency departments' said that there were limited external support services out of hours and it sometimes proves difficult to get the required support at weekends. For example, mental health assessments, social services and ambulance transport on occasions.

Access to information

- There was an electronic system within the accident and emergency department known as EDIS, which populates an analysis of demand on the department. This was in the form of a dashboard. The dashboard was quite unique in that it informed the nurse in charge and consultant different sections which included the amount of patients waiting for speciality doctors to see them, patients still to be seen, patients under the age of nineteen, patients in majors, minors, resuscitation and the waiting room. It also included the amount of patients waiting for beds.
- The operations centre also had this information.
- The department was engaged with the ambulance inbound screen and demand placed on them from the ambulance service. We saw the consultant regularly review the inbound screen and also the demand placed on other trusts in the area so that he could be pro-active with patient pathway management through the department.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff told us that a recognised assessment tool for people with who required mental health support. We saw there was a tool in place but did not see it used. It was not appropriate we saw people that required specific measures to be used in relation with mental health issues during our inspection. However, the process and policy was explained to us.
- We witnessed staff gain consent prior to treatment and care provided.
- We spoke with five staff who understood the requirements of a Deprivation of Liberty Safeguards (DoLS).

Are urgent and emergency services caring?

Good



We rated caring as good,

We observed staff treating patients with respect. Patients, relatives and carers told us that they felt well informed and involved in the decisions and plans of care. We saw that staff respected patients' choices and preferences and were supportive of their cultures, faith and background.

We found friends and family questionnaires on view within the departments' and reception areas. We found posters in the waiting room displaying information to the public of friends and family test results. %.

Compassionate care

- All staff, including reception, porter and security staff, respected confidentiality and dignity.
- The trust was submitting data for the Friends and Family Test (FFT). FFT is an important feedback tool that supports the principle that people who use NHS services should have the opportunity to provide feedback on their experience. It asks people if they would recommend the services they have used and offers a range of responses. The FFT highlights both good and poor patient experience. Figures demonstrated that the Friends and Family test score for the emergency department was displayed on posters throughout the department.
- The friends and family test results were above the England average between the period March 2014 to July 2014 with an average score of 87. The score dropped between August 2014 to January 2015 which was due to a system change in the way the department recorded results and increased to a score of 89 in February 2015.
- A and E survey was in line with the England average for 23 of the 24 questions. .

Understanding and involvement of patients and those close to them

- We observed bedside handover within the Emergency Assessment and Discharge Unit (EADU) ; we noted that patients and relatives were engaged in the handover and were able to ask questions and to raise any concerns.

Urgent and emergency services

- We spoke with four patients' and relatives' about whether they were provided with further information or offered the opportunity to ask questions about the care and treatment. All patients and relatives felt informed.

Emotional support

- Staff supported patients and their relatives as much as they could. Staff were very busy during our inspection but took the time to explain care and treatment. Patients and relatives thought that the staff was very helpful all the time.
- A chaplaincy service was available upon request.

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

Good



We rated urgent and emergency services responsiveness as good.

The emergency departments' were able to demonstrate that despite the increasing demands with increased attendances, they coped with the increased workload as well as being in a position to actively manage surges of activity across all departments.

All of the departments' had surges of activity, which occur on a regular basis. The departments' provided peoples' needs, which were central to the planning and delivery of care provided. The department provided good safe and effective care. All of the staff were flexible and provided choice where possible and appropriate to support the continuity of care in both the adult and children's accident and emergency department and Emergency Assessment and Discharge Unit (EADU) was evident. Thus providing good responsive care which reflected the needs of individuals.

The Emergency department management team reviewed complaints, investigations and response. We saw that improvements made as a result across the services provided included a consultant or senior nurse speaking to the patient at the earliest opportunity or visiting them.

Service planning and delivery to meet the needs of local people

- To ensure the service was delivered to meet the needs of patients', the consultants identified that they needed a front loaded model concerning junior doctor training and induction. This optimised their knowledge early.
- During periods of demand, the department managed patient flow through being pro-actively responsive in monitoring the ambulances inbound, reviewing patients regularly and all staff having clear roles.
- The nursing teams were coordinated and knew the priorities of care, which supported the needs of people within the department, ensuring people, were safe and care maintained at all times.

Meeting people's individual needs

- Regular attenders to the accident and emergency department we offered a meeting with a lead doctor and nurse. The meeting arranged a care plan for the patient for which the patient and department agree and meant patients attended less frequently.
- The department was coordinated and delivered care, which took account of people with complex needs. The emergency department had access to a permanent learning disability nurse and we saw that individual nurses championed dementia care and provided awareness and teaching to all staff.
- A room located in the major's area had been designed so as to allow the environment to be more appropriate to those patients attending the department who were receiving end of life care.
- Translation services were available through a dedicated phone system called INTRAN.
- We noted that the department had Red Cross volunteers that were supporting the department looking after patient and relative welfare. We spoke to one of the volunteers who told us they enjoyed being in the department and talking to patients'.
- We saw there were leaflets available within the department offering further information available.
- We saw an electronic notice board in the waiting room, advising people what the current waiting time was. A demand management tool updated the information on the board, which was 'live'. It also included information with how many patients' were in majors, minors and resuscitation area.
- Counselling services were available for both patients and relatives. We also saw that these services were available to staff if required. There was information available within the bereavement / family room.

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- We saw that staff responded in a timely manner to patients that requested help or required assistance. For example, we saw call bells answered in a timely manner.
- The trust performed in line with other trusts on three questions of the A and E survey including privacy and dignity when talking to a receptionist, length of stay in the department and privacy when receiving treatment.

Access and flow

- The emergency department was meeting the 95% target for patients admitted in August 2015 at 95.9%. Performance against the target. The department had performed broadly better than the England average since November 2014 and met the target for most months with exceptions in January 2015 (88%), March 2015 (91%) and May 2015 (83%).
- In August 2015, no patients waited longer than 12 hours for a bed once a decision to admit had been made.
- The percentage of patients' leaving the department before being seen is consistently below the England average of 3%. The departments average of patients' leaving between the period March 2014/15 was 2%, although it did fall to 1% between November 2013 and March 2014.
- The trust was performing above and maintaining performance against the England average concerning handover of patient care from the ambulance crew to the accident and emergency department. We looked at performance figures over the period April 2014/15, which demonstrated that compliance was consistently above the national Government target requirement of 95% of patients to have had their care handed over within 15 minutes. In July, September and October 2014 performance hit 99% and again in March 2015. However, there were fifteen occasions where performance dipped with a variance of 1% to 7% below the 95% standard.
- The emergency departments' were supported by an early intervention therapy team made up of physiotherapists, occupational therapists and further specialists dependent on people's needs. This assisted and supported people to be discharged safely with the correct support to avoid re-admission into the urgent and emergency services.
- Between the periods, November 2014 to March 2015 there had been 197-ambulance handover of care delays above thirty minutes, which is very low, compared to the England average.

- Within the waiting area, there was a 'meet and greet' room. Staffed by a qualified assessment nurse between the hours of 11am to 9pm. This supported streaming the care pathway route for patients' following initial assessment
- There was a designated ambulatory care bay within the adult accident and emergency department. This was within an area that did not impede on patient flow in other areas and enhanced the services provided.
- The department ensured a clinician-to-clinician conversation took place with reference to patients referred to the accident and emergency department. This resulted in 97% of GP referrals going to the Emergency Assessment and Discharge Unit (EADU) rather than the accident and emergency department pathway.
- The department held review clinics, which were consultant led, delivered on a Monday, Wednesday and Friday between 9.30am to 11.30am. These clinics were designed to see patients'. For example, review following a road traffic collision or frozen shoulder. The clinics saw an average of fifteen to twenty four people each week.
- The reception staff were positioned behind a desk that had an overview of the waiting area. During our inspection, we observed that the reception staffing levels met the requirements of the department. Reception staff informed us they were included and very much part of the complete emergency team and patient experience.
- There was an early intervention team from specialist nurses on a daily visit to the department.

Learning from complaints and concerns

- The emergency department advocates the patient advice and liaison service (PALS) available throughout the hospital.
- Information was available for patients to access on how to make a complaint and how to access the patient advice and liaison service (PALS). A dedicated member of staff within the emergency department teams reviewed all formal complaints received and concerns raised with PALS. All concerns raised were investigated and there was a centralised recording tool in place to identify any trends emerging. Learning from complaints was disseminated to the whole team in order to improve patient experience within the department.

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- There was an evident 'no blame culture' around complaints and staff told us they felt they could freely raise a concern.

Are urgent and emergency services well-led?

Outstanding



We have rated well led as outstanding.

The leadership used governance structures and culture to drive and improve the delivery of high quality person-centred care. Staff across all grades were proud working for the service. It was evident that staff within the department worked well as a team. The staff that we spoke with was aware of the trusts values and behaviours known as 'Our Vision'. The department was calm, organised through clear direction given by both medical and nursing leaders.

Clear governance structures were in place, designed to enhance patient outcomes. Robust governance frameworks were in place which were regularly reviewed. There had been a decrease in audit activity in late 2014 and early 2015 but data was again being submitted to the Royal College of Emergency Medicine. There was an audit plan in place for the department.

There were comprehensive and successful leadership plans in place to ensure delivery and succession to develop the embedded culture of collaboration and support across all areas of a clear vision and quality.

The leadership within the accident and emergency department had a shared purpose of focus to continually improve. The leaders were highly respected, not only within the department but within the hospital and wider health economy. Leadership was matured and had the capability and experience which we saw led the department effectively. The departments' were led by managers' with experience that strived to deliver and motivate staff to succeed. Turnover of staff was minimal and sickness levels were low.

The staff we spoke with demonstrated an attitude of commitment and told us they enjoyed working in the emergency departments'.

Vision and strategy for this service

- The hospital had introduced 'Our Vision' with a value statement of 'to be a well-led organisation delivering compassionate and safe patient care through an engaged and motivated workforce.' This was evident within the teams we met in the urgent and emergency services.
- The trust had a clear vision in the promotion of best practice across the emergency department and encouraged innovation from all staff. There was sustainable innovation in place with measurable outcomes. These objectives were stretching but achievable. For example, there were team away days where governance and learning objectives are proactively reviewed to reflect best practice.
- The leaders of the urgent and emergency services were able to clearly articulate the vision and values for the services and these were demonstrated throughout our inspection.

Governance, risk management and quality measurement

- A robust clinical governance system was in place in the department. One consultant was the governance lead, and regular monthly reports produced to demonstrate the effectiveness of the department. Where necessary changes to governance systems had been made to continuously improve the patient experience through robust monitoring of performance.
- These reports provided a balanced view of the department. The consultants we spoke with were clear about the challenges the department faced. They were each committed to enhancing the patient journey and were actively involved in some form of developmental working group within the department. The leaders of the services were actively working with other stakeholders in the local health economy to seek solutions to the issues they faced.
- Where the department had previously performed poorly in national audits due to not submitting data, the management team ensured that action plans were devised and timely re-audits were carried out to ensure improvements were made to enhance patient outcomes.
- Monthly meetings were held within the management teams. We reviewed minutes of the previous meetings. We were assured that risks were well managed within

Urgent and emergency services

the departments'. Managers were aware of the risks identified and there was a robust timeline of actions to address each risk. This meant that quality in risk management was measured.

- An electronic quality dashboard was displayed within the emergency department, for staff, patients and relatives to see at the nurses' station. This meant that people who used the service were informed and aware of the department's performance around the care delivered.
- There was information provided on notice boards with updates on any changes or amendments to the department's priorities and performance against those priorities. The information was relevant and up to date.

Leadership of service

- A clinical lead and band seven nurse headed the accident and emergency department. There was a similar model within the Emergency Assessment and Discharge Unit (EADU) . All staff told us that the management team was open, approachable and provided good leadership. Staff said that this openness gave them the confidence to challenge poor practice and raise concerns. They said they had confidence in the management team and that they felt that management would address issues or concerns in a timely manner.
- During our inspection, we saw that the departmental leadership had the capability and experience to lead effectively.
- We noted the band seven nurse in accident and emergency, each day had an open door policy for staff to 'call in' We saw this in practice which facilitated issues to be dealt with in a timely manner, supporting staff with decisions and did not allow problems to escalate.
- Staff told us that the nursing leadership in the department was excellent, encouraged learning with no limitations of where staff could develop. We heard an example of this, whereby a non-clinical member of staff was supported through college to gain qualifications to succeed into a nursing career.

Culture within the service

- The leadership engendered a culture within the department encouraged candour, openness and honesty. Complaints and concerns were not hidden and very much displayed for all to learn.
- There was a clear proactive approach to seeking out and embedding new models of care.
- We spoke with staff of various grades within the departments in clinical and non-clinical roles and it was evident to us that the culture within the emergency departments' was very much a 'no blame' culture.







Public and Staff engagement

- Staff felt listened to. The band seven-nurse manager listened and took action following staff comment or concerns and fed back to staff the outcome of any decision. Success was celebrated with internal department awards.
- The trust has a patient user forum. This meant people could actively engage so that views reflected the planning and delivery of services provided within the emergency department.
- During our inspection, we witnessed consistently high levels of constructive engagement with staff.
- One nurse came in on their day off to demonstrate the decontamination unit and major incident preparedness to the inspection team, as they were proud of what they achieved through autonomous ownership.

Innovation, improvement and sustainability

- Trainee and non-trainee doctors told us they felt very much supported with their learning and given teaching time with sessions taking place weekly in protected time. We looked at rotas that supported this. One staff grade doctor told us they had not had to pay for any training for three years.
- There was a visible consultant body, which strived for improvement and enhanced morale as the consultants' included all grades of staff within department changes and took staff views into consideration.
- Clinical leadership was evident by experienced consultants' and lead nurses' who demonstrated to all staff, an ethos of leading by example. We saw that the consultants and nurses were passionate about the department and there was very much an open door policy in place throughout all disciplines.

Medical care (including older people's care)

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

Information about the service

The medical care services at James Paget Hospital covered a wide range of specialities, including acute medicine, respiratory medicine, cardiology, gastroenterology and haematology. Medical care services also included a rehabilitation ward and a newly-introduced discharge lounge.

There were seven medical wards plus an acute cardiac unit and a short stay medical unit.

There were 22,001 admissions to medical care services at the James Paget between January 2014 and December 2014, of which 51% were emergency admissions, 4% were elective and 45% were day cases.

During our announced inspection we visited all of the medical care areas and wards and the discharge lounge. We visited the wards during the day and we conducted an evening visit.

We used a variety of methods to help us gather evidence in order to assess and judge the medical care services based at the James Paget hospital. We spoke with 58 patients, 13 friends and relatives, 7 doctors, including junior doctors, middle grade doctors and consultants, 22 registered nurses (one of whom was an agency nurse), 6 health care assistants, a focus group of allied healthcare professionals and a number of other support staff such as porters, cleaners and ward clerks. We interviewed the clinical leads, the deputy director of operations and the lead nurse for the Emergency division. We observed the care and the environment and looked at 28 sets of

patient care records and medical notes. We also looked at a wide range of documents including policies, minutes of meetings, action plans, risk assessments and audit results.

Medical care (including older people's care)

Summary of findings

Overall, we found that medical care services at the James Paget Hospital were good. There were not always sufficient nursing or medical staff and mandatory training rates were variable across the division but patient outcomes were as good as, or better, than national averages.

Staff were competent, caring and professional and they had the information and training that they needed to provide effective care to patients.

There were some staff shortages but effective multi-professional team working helped maintain the quality of the services provided. Referral to treatment times exceeded the national target. The needs of different people, especially those in vulnerable circumstances were taken into account.

However, there was a lack of a co-ordinated approach to providing care, support and treatment to elderly people. The trust was aware of this need and had tried unsuccessfully to recruit two consultant geriatricians. Work was progressing with social care and other health partners on the development of an integrated strategy to meet the needs of frail elderly people in the community as well as in the hospital.

Leadership was good, there was an open and transparent culture and the low staff turnover reflect the positive regard in which staff held the hospital and their colleagues. Effective governance and robust performance management was maintaining and improving the quality of the service.

The trust was working in an integrated way with other local health partners and social care to develop a coherent approach to supporting elderly people in the hospital and in the community.

Are medical care services safe?

Requires improvement



We rated service safety as requiring improvement as there were not always sufficient numbers of qualified nursing staff to fill shifts. The risk was partially mitigated by employing additional health care assistants. Mandatory training rates were variable with some in the low 70%. Not all staff were familiar with duty of candour requirements.

The trust struggled to recruit some senior medical staff. Some Consultant posts had been appointed to using a shared posts model but gaps still remained, notably in provision of specialist services to elderly people.

There was a culture of reporting and learning from incidents at all levels. People were kept safe and staff were clear about their responsibilities regarding the safeguarding of vulnerable adults. They felt they received the training they needed to safely carry out their duties.

There were suitable arrangements for the prevention and control of infection, and the safe management of medicines. Patients' records were generally comprehensive with assessments of people's needs and any risks to individuals completed promptly upon admission.

Incidents

- There were 39 serious incidents reported between May 2014 and April 2015 for medicine, including older people's care. Of these, 26 were classified as grade three pressure ulcers while eight were classified as slips, trips or falls.
- There was a culture of reporting and learning from incidents at all levels. Induction of new staff included training in incident reporting. A checklist reminded staff of what should be reported. All staff and managers that we asked were clear about their responsibilities in reporting and reviewing incidents.
- Incidents were reported electronically and any member of staff, including bank and agency staff could record an incident. Automatic notification would go to the ward manager, the consultant responsible for the ward, the lead nurse for the Emergency division and staff responsible for risk management and governance.

Medical care (including older people's care)

Incidents stayed on the system until closed by either the ward manager or doctor responsible for reviewing the incident and taking action. Incidents could be reopened if more information needed to be added, for example if a ward manager wanted to add details regarding an incident closed by the doctor. If the member of staff who reported an incident had requested feedback, this had to be given before the incident could be closed. Where possible this feedback took the form of a face-to-face conversation. Staff confirmed that they received feedback.

- There was readiness to report any incidents that could affect patients' safety, such as medication errors. We looked through the 712 incident reports that had been made between January 2015 and April 2015. While the number appeared high, nearly 30% of the reported incidents related to patients having pressure ulcers when they were admitted to the hospital - one nurse commented that they personally might record up to 10 such incidents in a day. We noted that staff would self-report if they had made a mistake.
- The procedures used assured us that suitable arrangements were in place to learn from incidents. Each incident was analysed to identify why it had happened and what action had been taken. The appropriate further action was identified and taken, for example the high incidence of pressure ulcers occurring on the heels of stroke patients, despite two hourly turns, was tackled by putting gel heel protectors on every stroke patient. This improved outcomes for patients.
- Incidents were reviewed at clinical governance meetings and staff gave us examples of changes in practice that had resulted. For example linen trolleys already had locks, but when sharps were found in one of these trolleys procedures were tightened to require the trolleys to be locked whenever unattended.
- Lessons learned from incidents were communicated verbally and via email. Recurring incidents were noted, for example drains getting blocked where the problem was identified as being due to patients putting pads in the toilet. This prompted a reminder to use the appropriate waste disposal units.
- When serious incidents occurred a root cause analysis approach was used and meetings were held (usually within 48 hours) with the head of governance and managers. The clinicians involved were fully debriefed and any necessary changes were made within a few hours.

Mortality and morbidity reviews

- Mortality and morbidity reviews enable clinicians to review the quality of care provided to people who had died or had suffered complications following treatment. Minutes of mortality and morbidity meetings and our conversations with staff confirmed that an effective process was followed:
- Meetings included consultants, registrars and senior nurses and were convened at least four times a year.
- Reviews of the care given to the patients (but not of cases that fell within their own speciality) were carried out by registrars or consultants. Any areas of learning were identified and action taken to ensure that this was disseminated to all staff.
- The minutes of the mortality and morbidity meetings were circulated to all physicians and findings were shared with any appropriate member of staff or group that could address the issues identified.

Duty of candour

- Duty of candour is the responsibility for NHS hospitals to be open and transparent and inform patients and/or family or friends where appropriate, when things have gone wrong and harm has been caused. Through conversations with staff we found that:
- Senior staff were aware of their responsibilities relating to duty of candour. In a focus group Consultants told us that the trust encouraged openness and honesty and had increased awareness of duty of candour requirements by disseminating information through meetings and mortality reviews. The root cause analysis proforma included duty of candour.
- However, understanding of duty of candour was less well understood by other staff. In a focus group of Band 5 nurses some, but not all, staff were aware of this responsibility.

Safety thermometer

- The NHS safety thermometer is a national initiative that provides a local improvement tool for measuring, monitoring and analysing patient harm and harm free care.
- Performance against the four possible harms (falls, pressure ulcers, urinary tract infection and venous thromboembolism) was monitored on a monthly basis.

Medical care (including older people's care)

- Safety thermometer performance was prominently displayed near the entrances of the medical wards and units we visited.
- Safety data provided by the trust for April 2015 showed mixed results. 4 of 7 wards did not fill 100% nursing shifts with 3 being as low as 74%. Other wards fill rate was above 95%. Falls on 6 wards had dropped compared to the preceding month with only 1 ward seeing an increase. 4 of the 7 wards showed either 1 or 2 incidences of pressure ulcers at grade 2, 3 or 4 reported.

Mandatory training

- Staff with whom we spoke said that they felt they received the training they needed to safely carry out their duties. They told us they received mandatory training in areas such as infection control, health and safety, safeguarding adults and moving and handling. However, staff told us that they sometimes found it hard to fit in the training due to staff shortages.
- Rates of completion of mandatory training were variable across the medical wards. Data provided by the trust for March 2015 showed that completion of this training ranged from 70% for Ward 15 (respiratory ward) to 88% in the rehabilitation ward (Ward 18). The trust's target was 95%. Ward managers we spoke with, however, stated that all staff were either booked on, or had completed their mandatory training to ensure compliance with the trusts target of 95% by March 2016. Completion of mandatory training was checked as part of each staff member's appraisal.
- We saw that training was adjusted and strengthened where needed. The trust had identified a risk to diabetic patients' safety from staff not adhering to the diabetic ketoacidosis (DKA) policy. Mandatory training included safe use of insulin, although it was noted that there was no DKA e-learning package available. The action plan noted that DKA training and education was being provided on the intranet, cards on drugs trolleys reminded staff of the correct procedure and incidents were to be reviewed in detail. Progress was being monitored.

Safeguarding

- Patients we spoke with told us they felt safe in the hospital.

- The adult safeguarding policy was regularly updated, having last been reviewed in July 2015. This policy clearly laid out responsibilities of staff at all levels in the trust in respect of safeguarding.
- Adult safeguarding training was mandatory throughout the trust. It was included in the induction programme for new staff and then updated three-yearly. Information provided from the hospital indicated that 88% of staff were up to date with this training.
- There was a named lead for safeguarding, and a safeguarding team. Staff told us that the procedure had been simplified and that all the information they needed was on hospital intranet.
- All of the staff we spoke with were clear about their safeguarding responsibilities and knew what actions to take if they had any safeguarding concerns.
- Staff told us, however, that there were only two 'fall beds' in the hospital. In the example of a patient who frequently tried to get out of bed unaided but was prone to falls, staff told us that one of them would sit by the bay opening at night and keep watch.

Cleanliness, infection control and hygiene

- Overall, we found that the Department of Health's code of practice on the prevention and control of infections and related guidance was adhered to within the wards providing medical care.
- Clinical areas were generally visibly clean. However we found a few items such as computer keyboards that were not clean.
- Cleaning regimes for some clinical equipment, such as blood pressure monitors, were not consistently carried out and checked.
- Bi-monthly hand hygiene audits and environmental cleanliness spot-checks were undertaken by the trust's infection control team. We looked at the outcomes of these checks for three wards. Two wards achieved 100% for hand hygiene, but the third achieved only 84% and staff had to be reminded about removing protective clothing, such as disposable gloves and aprons, between attending to patients. Uncleaned commodes were noted in two of the wards. The infection control team brought issues to the attention of the ward manager and made recommendations, such as weekly hand hygiene monitoring where performance had fallen below standard.

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- Antibacterial gel dispensers were available and appropriate signs reminded staff and visitors to wash their hands. We observed that staff generally followed good hand hygiene, although porters were less meticulous. Porters told us that they do not have a sink or hand gel in their base and have to use water from a container.
- There had been no reported MRSA infections in over two years and CDiff cases were below trajectory for the division.
- Patients with infectious illnesses such as clostridium difficile were kept in isolation and barrier nursing was used. Two patients being nursed on a ward had come into hospital with clostridium difficile. Although community-acquired this was recorded on the ward noticeboard. This indicated that staff were meticulous in their recording.
- Staff demonstrated a good understanding of infection prevention and control. There were supplies of personal protective equipment such as gloves and aprons available in clinical areas and we observed staff using them appropriately. Staff wore visibly clean uniforms.
- In the patient led assessments of the environment (PLACE) survey for 2014 the hospital had slightly higher or very similar scores to the England average for cleanliness and facilities.
- We looked at a sample of patients' prescription and medicine records. We saw arrangements were in place for recording the administration of medicines. These records were generally clear and fully completed, although the start date for treatment was not indicated on two sets of medication notes.
- Medicines requiring cool storage were generally stored appropriately with refrigerator temperatures monitored and recorded daily. However, in the Acute Cardiac Unit (ACU) we found that the safe temperature range of 5-8 degrees had been exceeded on most days for the previous two weeks. The refrigerator had been repaired and relocated but was still recording temperatures in excess of the required range. Intravenous fluids, which should not be exposed to temperatures above 25 degrees, were in a store room on the ACU where recent temperatures had reached 28.8 degrees. On the day of our inspection the thermometer in this room was recording 27.5 degrees. Staff said that if the temperature were to exceed 30 degrees on five consecutive days, they had been told that air conditioning would be installed. However the trust stated that the trust policy is that medicines stored in temperatures exceeding 30 degrees for 12 days are reviewed and expiry dates reset.
- Controlled drugs were appropriately secured in locked cabinets.
- We observed nurses administering medication. On one occasion we saw that only one nurse was administering medications that included oral morphine which was not in line with trust policy.
- There were regular antibiotic prescribing audits across the division. Results showed broadly good results and where a concern had been identified, for example inappropriate microbiology specimens sent, there was feedback to the ward regarding this and action taken.

Environment and equipment

- We did not identify any significant environmental risks or hazards.
- We saw that gel heel protectors and other equipment were used to help reduce the risk or severity of pressure ulcers. However, staff told us that sometimes air mattresses were not immediately available when needed, even where patients had high risks of developing or worsening pressure ulcers.
- We found that resuscitation equipment was readily available. Records showed daily checks were carried out to ensure that this equipment was complete and ready for use.
- There were separate, clearly labelled disposal bins for soiled waste such as pads and for general waste.

Medicines

- Medicines were prescribed electronically on Ward 16 throughout the medical specialities and the care of the elderly wards.

Records

- We saw that care records, medical notes and drug charts were legible, signed, dated and completed and in line with NHS guidelines on record keeping.
- There were individualised care plans for each patient and a range of assessments, such as risk of malnutrition, were carried out promptly on admission.
- Further specific assessments were carried out by a range of health professionals including physiotherapist and occupational therapists, usually within 24 hours of admission.

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- Regular (intentional rounding) checks by staff were documented in patients' notes.
- However, we found that observations regarding a patient's breathing were missing from the medical notes on ward 15 (the respiratory ward).

Assessing and responding to patient risk

- We selected a random sample of patients' records. From these we saw that assessments of risks such as falls, malnutrition and pressure ulcers had been carried out and measures put in place to reduce these risks. For example, a pressure ulcer risk assessment tool was used to assess the level of risk to individual patients of developing pressure ulcers. We saw evidence that the resulting specified actions, such as ensuring that patients were assisted to alter their position every two hours, were carried out and recorded on patients' care plans.
- One-to-one supervision was provided for patients who were at high risk of falling.
- An Early Warning score (EWS) system was used to identify patients whose health was deteriorating. Stickers in patients' notes indicated when EWS scores had triggered immediate referral to a doctor. We found evidence in patients' notes of staff responding to physiological changes, alerting doctors and changes in medication resulting. If a patient's condition deteriorated at night staff were able to get the level of support they needed, from junior doctors or registrars according to seriousness of situation. The on call consultant attended if needed. We were given an example given of a staff being able to go direct to a gastro-intestinal consultant when a patient had a bleed.
- Nursing handovers occurred at every shift change. Staff communicated any changes to ensure that actions were taken to minimise any potential risk to patients and to help their recovery. For example, in a handover that we observed the need to encourage a patient to get out of bed was highlighted.

Nursing staffing

- Information provided by the trust for March 2015 indicated that coverage of nursing hours across medicine wards was generally improving but ranged from 74.4% on Ward 15 to 96.5% (of shifts filled) on Ward 16 (gastro-intestinal ward). The ACU nurse staffing levels were 100%. Where nursing cover was stretched the data indicated that healthcare assistants (HCAs) had worked

extra hours in some wards, for example with 132.3% coverage in the cardiac ward (Ward 2) when nursing cover was at 89.2%. On Ward 15, 95.7% of the HCA hours had been covered.

- Between May 2014 and April 2015 there were some noted drops in qualified nursing. On Ward 15, filled qualified nursing hours fell to 64% for short periods and was mitigated by a shift fill rate of 165% for health care assistants indicating a greater number to support qualified nursing staff on the ward. A similar picture was seen on Ward 18.
- All the wards we visited displayed the number of staff (registered nurses and healthcare assistants) that were planned and that were actually present on each shift. During our visit there was generally the planned number of staff on duty, although we noted that one ward should have had four healthcare assistants on duty but only had three. Another ward only had two of the planned five healthcare assistants on duty. We were told by the ward manager that this was due to short-notice sickness and that two hourly bed meetings were being carried out to check that patient care was not being jeopardised.
- Across the emergency division, vacancy rates fluctuated between April and September 2015 between 9% and 12%. Nurses told us that it could be very stressful when they had to look after more than one bay and that, on occasion, agency nurses had walked out because of the pressures.
- Nursing staff told us that patient care was prioritised when there were staff shortages, but that it was sometimes difficult to fully meet all patients' care needs, for example on occasion the times between turns for patients who needed this assistance might extend to three-hourly.
- The trust had noted the risk to its ability to maintain patient safety due to vacancy levels in its registered nurse establishment and the lack of senior, experienced registered nurses to support development of junior staff. Actions being taken to tackle this issue included block booking of agency nurses, offering overtime and extra hours and increased matron and lead nurse input to support leadership development for ward sisters.
- Despite uncertainties about its future, the rehabilitation unit managed to remain fully staffed. We were told that there was significant loyalty to this unit, for example from nurses recruited from abroad several years ago. A health care assistant had been offered a more secure

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post elsewhere within the hospital but had chosen to stay with this ward, despite the risk of closure if the Clinical Commissioning Group fully implemented its plans to move rehabilitation work out to community organisations. This loyalty epitomised the response we received when talking to groups of staff, who expressed their enjoyment and commitment to their work.

- The service ensured that agency staff were competent. There was an induction for agency nurses, using a checklist with nurses providing explanations. We saw that an agency nurse who had been asked to come in to cover elsewhere in the hospital, but who was switched to a different ward at short notice was confident and aware of the ward routine and procedures.
- The trust had specialist nurses, for example in cardiology and respiratory care. We observed good, systematic assessment of a patient's pain levels by a specialist pain nurse. However there were no nurses that specialised in caring for elderly people.
- We observed an evening nursing handover between staff on two medical wards. Night staff told us that the information provided was informative and reliable and we saw that attention was paid to detail, for example reminding nurses coming on duty of the needs of a specific patient to have heel troughs to prevent pressure ulcers developing.
- We saw that the nursing skill mix and the number of staff required were reassessed, for example in the ACU where there was a planned increase to three trained nurses on afternoon shifts.

Medical staffing

- The trust had a similar proportion of consultants compared to the national average with 33% at this trust against an England average of 34%. There was a lower proportion of middle grade doctors at 36% against an England average of 45% and a higher proportion of junior doctors at 41% against an England average of 22%. Consultants told us that less than its fair share of senior juniors were being allocated to hospital and this was to the detriment of patients.
- There was infrequent senior medical supervision for medical patients who had to be placed on other wards due to lack of bed space on medical wards. We saw, for example that there were 15 medical 'outliers' on Ward 4 (surgical and gynaecological ward). All of these were respiratory patients and most were elderly and with

complex needs. Two junior doctors provided medical care for these patients, but there was no routine registrar cover and the two respiratory consultants only saw the patients every two days, Monday to Friday.

- Consultants acknowledged that management tried hard to recruit staff. The geographic position of the hospital and factors such as Norfolk's comparatively poor education results were cited as reasons for hesitation on the part of doctors to move their families to the area. However, in a focus group of 50 consultants there was a strong consensus that the James Paget was a good place to work.
- The Norfolk Health Overview and Scrutiny Committee recommended that the James Paget should urgently increase the number of stroke specialist consultants in its service. The hospital accepted the recommendation but it proved difficult to implement. While it had not succeeded in recruiting a specialist stroke consultant, a neurologist with a special interest in stroke and whose main commitment was to the stroke unit was added to the team. An additional middle grade doctor had joined the stroke team on a long term locum basis.
- Reduced medical capacity in dermatology was identified as a risk in the division's risk register. This was being tackled by exploring the scope for shared/joint posts with other hospitals in the region.
- Four consultants from the Norfolk and Norwich University Hospital reviewed patients at the ACU one day a week. The hospital had a shared post agreement in place to ensure senior cover and the registrar provided consistency in medical cover.
- Junior doctors we spoke with told us that consultants were contactable and supportive.
- There were efficient daily medical handovers.

Major incident awareness and training

- We found effective planning for, and response to, emergencies that could disrupt or place extra pressure on the service:
- Fire tackling equipment and procedures were in place. There had been fire drills and the staff whom we asked knew what action they would need to take in the event of a fire.
- There was a list of staff who knew where they needed to report and what action they needed to take in emergencies, such as a major traffic incident, where mass injuries occurred.

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- Emergency back-up generators were in place in the event of power cuts.
- When a failure occurred in the main oxygen supply, back-up cylinders were available.
- Staff told us that when lightning had struck the hospital and affected a number of systems. One of which was the internal telephone system. To mitigate this issue managers walked the wards every two hours to ensure the continued safety of patients.

Are medical care services effective?

Good



We judged that medical care services were effective. This was because care and treatment was based on detailed assessments of patients' needs and delivered in accordance with national guidance by competent and professional staff. Patient outcomes were as good as, or better, than national averages.

Pain relief and nutrition and hydration were well managed. However there was no dedicated nutrition team and some patients' dietary needs were not fully supported at weekends. Patients were cared for and treated by an effective multi-professional team, but the trust was unable to provide a full seven day service.

Staff were aware of the requirements of the Mental Capacity Act and understood when deprivation of liberty safeguards needed to be put in place.

Evidence-based care and treatment

- Clinical guidance was easy to access and was followed. The medical specialities provided care and treatment in line with guidelines from the National Institute for Health and Care Excellence (NICE) and Royal College guidelines. Local guidelines were on the intranet and had been produced in collaboration with the other two acute hospitals in Norfolk to ensure uniform approaches across the county.
- Protocols for the prevention of pressure ulcers were in place and were understood by healthcare assistants as well as by the nurses who carried out the assessments.
- A comprehensive range of assessments carried out on admission helped ensure that patients' needs were identified and care planned and delivered accordingly.

Nutrition and hydration

- PLACE survey results for 2015 had not been published at the time of our inspection.
- Patient menus were prepared in consultation with dieticians to ensure they were nutritionally balanced and met patients' nutritional requirements. Vegetarian and other options to meet specific dietary requirements were available.
- Menus complied with the Better Hospital Food initiative and 'protected meal times' ensured that there was minimum disruption while patients were having their meals.
- We saw that staff assisted patients who needed help to eat and drink.
- Elderly patients who lived on their own were provided with basic food supplies, such as milk to tide them over on their return home until their carer's next visit.
- However, there was no dedicated nutrition team, with reliance being on dieticians working with the pharmacists. There was a lack of nursing staff specialising in parenteral (intravenous) nutrition. Dietician coverage was only available Monday to Friday. This meant that there was reduced support at weekends for patients needing parenteral nutrition.

Pain relief

- Patients told us their pain was well managed.
- Patients were prescribed pain relief by doctors using the analgesic ladder approach (increasing pain relief in incremental steps if needed).
- There was a pain team within hospital with a specialist nurses on a bleep Monday to Friday from 9am to 5pm. Outside of these hours an anaesthetist would provide cover and doctors would be available.
- Pain management team assessments and management plans were documented in patients' notes. These included pain intensity scoring. A pain assessment tool was used for measurement of pain in people with dementia who were unable to verbally express how they felt. A daily record was made based on body language and physiological changes so that pain relief could be gauged accordingly.

Patient outcomes

- The trust submitted data to the Sentinel Stroke National Audit Programme (SSNAP), which aimed to improve the quality of care by auditing stroke services against

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evidence based standards and national and local benchmarks. For the period October to December 2014 the trust had an overall SSNAP score of 'C' (the lowest possible score is E).

- The trust participated in the Myocardial Ischaemia National Audit Project (MINAP). This is a national clinical audit of the management of patients experiencing a heart attack. MINAP provides hospitals with information about their management of patients experiencing a heart attack and compares the information with nationally and internationally agreed standards. James Paget hospital performed well in both in-hospital care and on discharge. The 2013/2014 MINAP audit showed that 99.5% of patients who presented with an nSTEMI (a less acute heart attack) were seen by a cardiologist against the England average of 94.3%. The percentage of patients admitted to a cardiac unit or ward was 83.1%, well above the England average of 55%. Similarly, 94.3% of patients had, or were referred for, angiography against the England average of 77.9%.
- The trust performed better than the England average in the National Diabetes Inpatient Audit (NaDIA) in 14 out of 21 of the major indicators audited. It performed worse than expected for patients being seen by a member of the specialist diabetes team, foot care and staff awareness of diabetes and emotional support.
- The average length of stay for elective patients was shorter than the national average, but longer for non-elective patients.
- Readmissions for elective patients were higher than the national average, but fewer for non-elective patients.

Competent staff

- Doctors confirmed that there was an effective system for training, professional development, assessment and revalidation of General Medical Council (GMC) registration.
- Consultants told us that there were strong teaching and training links with a local university and said that the medical director had given opportunities for clinicians to progress in careers within the hospital. One consultant stated that they had been attracted to work at the hospital because of the training atmosphere.
- We were told that all new staff attended an induction. Staff we spoke with confirmed they had received induction, which a junior doctor described as, "Really good" and which had included shadowing.

- We observed a ward round. This was a good learning experience for the junior doctors who were questioned well by consultants in a systematic and thorough but supportive way.
- There were specialist nurses, for example anticoagulation nurse specialists. Staff told us they knew how to contact these specialists and felt supported by them.
- Staff on the stroke ward told us that agency staff have to do training on intravenous infusion and blood sugar testing before they could work on the wards
- All senior nurses were advance life support trained.
- There were opportunities for career progression and development, for example assistant therapists being encouraged to undertake training and become qualified. They were encouraged to undertake foundation degrees, and well supported in being allowed time and having all the degree fees paid. This enabled them to progress from band 2 to band 4. Senior managers stated that therapy assistant practitioners at Band 4 could help reduce the problems caused by the shortage of therapists in some areas.
- In-house courses included stroke away days, training in tissue viability and a '16 Steps to Management' course for Band 6 staff which covered issues such as learning to deal with difficult situations.
- Staff could become mentors, for example a healthcare assistant with extensive experience in supporting people living with dementia told us that they had mentored a student through a dementia-based course of study.
- Student nurses on Ward 12 were participating in a pilot project to test whether the Collaborative Learning in Practice (CLiP) model used in the Netherlands had potential to support student learning. This included student nurses doing presentations, for example to consultants. Initial findings were positive, with the pilot being favourably viewed by the participants and by their managers.
- There were formative wards rounds where one consultant would review another consultant's treatments. About 65% of consultants had participated.
- Staff told us that there were no formal systems in place for regular supervision sessions with their line managers, but that any issues were addressed via informal support from managers.
- A cascade system was used for annual appraisals and staff confirmed that these were full and systematic and

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carried out on time. Training needs would be identified in the course of these meetings. Appraisers received regular training and an observer (one of new appraisers) would help ensure appraisals were consistent. We were told that an external team had reviewed the appraisal process and their report was awaited.

Multidisciplinary working

- Wards teams had access to the full range of allied health professionals and team members described good, collaborative working practices.
- Our review of patients' care plans confirmed that clinically agreed plans that included input from therapists were generally completed within the trust's target of 24 hours
- There was multi-professional working in the stroke ward and out into the community. Outreach into the community was also provided to enable early discharge and support for respiratory patients and a heart failure service was provided by the hospital into the community. Patients in the rehabilitation ward were seen by the mental health team and were followed up in the community. This joined-up outreach provided continuity of support and treatment for patients.
- Staff told us that length of stay for patients on the rehabilitation ward had reduced by two days per week compared to last year. Daily board rounds, Monday-Friday included physiotherapists and occupational therapists. Each patient's progress was reviewed and any further medical or therapeutic input was identified. This was then promptly followed through to enable the patient to be rehabilitated as soon as possible.
- Good team working was cited to us by many of the staff with whom we spoke, for example a healthcare dementia assistant commented that knowing who to ask and what their skills were helped secure positive outcomes for patients.
- The electronic patient management system and wards clerks were good at enabling therapists to know when patients had moved to different wards. We were told by staff that sometimes IT systems did not talk to each other, "But people do". This compensated, for example, for lack of access to the patient management system in some areas of the hospital.
- However, scope for improvement in communication was noted, for example in the legibility of some of the

radiology request forms. Radiologists also commented that junior doctors sometimes had unrealistic expectations of the speed with which services could be provided.

Seven-day services

- The hospital was working towards seven day service coverage. We found that at the time of our inspection:
- Seven day service was a hospital CQUIN (quality measure) for this year.
- A weekend plan was put in place each week so that staff knew which colleagues were working and so that any need for additional staff could be addressed, depending on the pressures on the trust at the time.
- The stroke service provided a seven day, 24 hour, access to stroke care including clot busting treatment and was trying to recruit second stroke consultant to further strengthen its weekend service. Telemedicine was being used to review patients at weekends.
- Anaesthetic cover is provided over the weekend and radiology is provided 24 hours a day, seven days a week for in-patients.
- Ultrasound is provided on weekend mornings and some extra sessions are provided on Saturdays and Sundays by the staff who also provide the on call service for CT scans. Other radiology services such as x-ray and CT scanning was available for inpatients on a clinical priority basis. Having sufficient staff cover is an increasing challenge especially in summer with the spike in population due to holidaymakers.
- There were no weekend physiotherapy or occupational therapy services, although some occupational therapists would volunteer to work at weekends and a physiotherapist came in on Sundays to see elective patients.
- There was no weekend tissue viability services to provide advice on dressings and treatment and dieticians told us they were stretched to cover Mondays to Fridays as they only had a small team.
- The 'hospital at night' covered weekends and bank holidays as well as 7.30pm to 7.00am each day.

Access to information

- Staff had access to the information that they needed to provide effective care and treatment.

Medical care (including older people's care)

- The hospital was using paper patients' notes. Records were then scanned to the patients electronic notes so that they were available to staff.
- Patients' notes were completed on admission. They were clear and provided the relevant information. When we reviewed a sample of patient's records from across the medical wards we found consistency and that the appropriate assessments nearly always fully and promptly completed.
- There had been a lot of clinician engagement in the development of a system for making electronic notes. These were colour coded to ensure easy access to the required information and included results from scans. Each page was bar coded to ensure that it found its way to the correct folder.
- Electronic prescribing had been piloted over the last months. This was a shared project with another provider which will manage pharmacy services in future.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We found that, where patients were able to give their consent to care and treatment, this was appropriately sought, for example use of devices such as catheters or back braces and when taking samples such as blood.
- Staff were aware of people's rights to refuse help with personal care. They would reason with them and showed sensitivity to patients' feelings, for example male members of staff would offer to assist male patients if they objected to being washed by female staff.
- Support was available from mental health professionals. A referral to the mental health liaison team helped an appropriate complex needs assessment to be made for an elderly patient. Another patient who had mental health issues was judged to have capacity. However, staff were concerned that the patient's main carer, their spouse, was elderly but refusing any assistance when the patient was discharged. A mental health nurse was asked to speak with the family and a re-enablement package was agreed.
- Where patients were suspected of being unable to give informed consent a doctor or nurse would carry out a mental capacity assessment. We saw that best interests' decisions were made, for example for taking blood samples. Green stickers in patients' records indicated those who were unable to give informed consent and

notes made of the source of information that had been provided for these people and that capacity should be considered when treating the patient or words to that effect.

- We saw that appropriate assessments were made, for example for a patient whose mental capacity had started to fluctuate but who needed an ascitic drain to relieve fluid build-up.
- Staff with whom we talked generally understood the requirements of the Mental Capacity Act (MCA), for example if a patient stated they wanted to go home. Annual mandatory training included MCA awareness. However, a health care assistant and a cardiology doctor could not recall this training and a junior doctor was unsure how to do a mental capacity assessment
- Guidance on dealing with challenging behaviour was included as part of the annual mandatory dementia training. Staff were given support by senior staff and porters could be summoned to assist in reasoning with patients who became agitated and potentially violent. staff told us that deprivation of liberty safeguards (DoLS) were applied for when patients were restricted in any way, such as the use of in mittens to prevent them removing tracheostomy tube. Procedures were in place for urgent DoLS referrals if restraint was needed.

Are medical care services caring?

Good



We judged that the caring aspects of the service were good. Patients and those important to them were positive about their experience of the care and kindness that staff showed towards them. We observed compassionate care from all grades of support and clinical staff, including doctors. Patient's privacy and dignity was respected. Where possible, patients were involved in their care and treatment and were given information to support their decision making. We found that patients were given emotional support when needed.

Compassionate care

- We spoke with 71 patients and relatives during our inspection and the comments we received were generally very complimentary regarding the quality of the care.

Medical care (including older people's care)

- Feedback was mostly positive about the way staff treated patients receiving care throughout the medical wards. One patient told us, "Everything is so good here".
- We observed professional and friendly care with patients being treated with compassion, dignity and respect. An example was the assisted feeding of a patient whose hands were bandaged. This was carried out in a caring and sensitive manner.
- We noted an instance where a patient insisted on discharging themselves. Staff maintained an interest in the patient's welfare and were happy to hear that the person had been seen in the community a couple of weeks later looking well.
- Confidentiality was maintained, for example shutters were closed over the white boards used to record patients' treatment and progress when the boards were not in use.
- Privacy curtains were pulled round beds when people were receiving personal care or treatment and a red notice requested that people's privacy should be respected.
- The trust used the NHS Friends and Family Test (FFT) to obtain feedback from patients. This survey asked patients whether they would recommend the NHS service they had received to friends and family who needed similar care or treatment. The average FFT response rate for the trust (from March 2014 to February 2015) was 32.7%. This was lower than the England average of 35.6%. The average response rates for medical wards varied from 34% to 62%. The percentage of patients who would recommend the service they received on their ward ranged from 92% to 100% in February 2015.
- The trust scored much worse in the PLACE survey for 2014 compared to the England average of 87% for privacy, dignity and wellbeing, seeing a drop from 91% in 2013 to 81% in 2014. Results of the 2015 PLACE survey had not been published at the time of our inspection.
- Several patients commented that doctors were good at explaining everything to them.
- Family members were able to come outside normal visiting hours and help with the care of a person with learning difficulties.
- However, there were some instances of poor communication. In one instance relatives were unhappy that a nurse had not taken time to explain the care and treatment being given to a patient. We also found an example of details of a patient's condition not being communicated to them as they were deaf and did not have hearing aids. The patient had mental capacity.

Emotional support

- Staff offered appropriate emotional support to patients and to those who were close to them.
- Patients could access a range of specialist nurses, for example in stroke and cardiac services.
- A person fighting addiction told us that everyone involved in their care was supportive and wanted them to get their life, "Back on track".
- We observed sensitivity in the way in which bad news was conveyed to patients and their families, for example diagnosis of a life-threatening illness. The consultant would talk with the patient and/or their relatives, accompanied by a member of staff. Staff would stay and check that the information had been understood and provide any support needed including practical help such as arranging accommodation on, or near, the hospital site. Open visiting access, where families were not restricted to usual visiting times, and concessionary car parking were offered where appropriate.
- There was a hospital chaplain who could be contacted to provide emotional support. There was a multi faith chapel in the hospital and a multi-faith/ multi-denominational team offered spiritual and pastoral care to all patients, visitors and staff.
- Dementia awareness, end of life and other in-house courses delivered by councillors helped staff to develop their skills in providing emotional support.

Understanding and involvement of patients and those close to them

- We observed that staff involved patients and those who were important to them in their treatment and care.
- Staff talked through what was happening with patients whilst undertaking care and treatment ensuring wherever possible that patients were aware of what was happening to them.

Medical care (including older people's care)

Are medical care services responsive?

Good



We judged that the responsiveness of medical services was good.

Patients generally had timely and appropriate access to the services that they needed.

The trust had exceeded the 90% national target for admitted referral to treatment times. Some delays occurred when transferring cardiac patients to the Norfolk and Norwich University Hospital. People's individual needs were taken into account and catered for. The service listened to any complaints or concerns and responded and any learning was shared with staff.

There was no specialist provision for elderly people, despite the high and increasing percentage of elderly people in the local area. This resulted in elderly patients being treated in specialist areas, but not being provided with holistic care. Some elderly people were placed in beds in wards not geared for their treatment, such as the female surgery and gynaecological ward.

Service planning and delivery to meet the needs of local people

- The 2013 Office for National Statistics mid-term estimate indicated that nearly half of the residents in the Gt Yarmouth area were aged 45 and over, with more than 22% of the population over the age of 65. The age profile is similar across the hospital's larger catchment area, for example the estimates for mid-2014 confirm that Norfolk's population has a much older age profile than England as a whole, with 23.4% of Norfolk's population aged 65 and over, compared with 17.6% in England. This shows underlying changes in the make-up of the population, with significant increases in the proportion of residents of pensionable age and the very elderly. The trust, however, did not have a clear approach or staffing to address the needs of older people.
- There were no specialist geriatric consultants. Senior managers told us that the hospital had tried to recruit two geriatric consultants, but had been unsuccessful. A stroke specialist provides a lead in geriatric care, but there is no annual leave cover for this consultant. When

we talked with a focus group of 50 consultants they agreed that lack of dedicated geriatric care was an issue, with the impact being lack of an holistic focus on elderly people and co-ordinated multi-disciplinary support for elderly patients. Senior managers identified the lack of a clear lead meaning that planning and preventative actions were not possible. They suspected that the length of stay might be reduced if the hospital had a frail elderly unit, but pointed out that mortality data did not indicate that patients are suffering poorer health outcomes.

- There were no specialist nurses for provision of care to elderly people, although there were two dedicated staff providing advice and guidance on caring for people living with dementia.
- There was no strategy in place for the care and treatment of elderly people. We were told that the trust was at an early stage of developing a strategy for integrated services for frail elderly people in collaboration with the clinical commissioning group and East Coast Community Healthcare. We were also told that two consultants (one of whom is an orthogeriatrician) were working on a model for frail elderly care.

Access and flow

- Patients generally had timely and appropriate access to the services that they needed.
- The trust had been above the 90% target for referral to treatment times (RTT) of 18 weeks from April 2013 to February 2015 (latest data) for all medical specialities. Cardiology, gastroenterology and neurology were 100% compliant with RTT.
- The average length of stay for medical care was below the England average for elective admission, although longer than the national average for non-elective admissions.
- Almost 90% of patients admitted as an emergency were seen by a consultant within 14 hours of admission.
- Thrombolysis treatment was available 24 hours a day, seven days a week, supported by telemedicine.
- The gastrointestinal Ward 12 which was normally a 25 bedded ward had a closed bay that could be opened to give extra capacity. We were told that this tends to be most of the time.

Medical care (including older people's care)

- Some delays were encountered when transferring patients with nStemi heart attacks to another provider. These transfers should be within 72 hours, but this was only being achieved for 70% of patients.
- Acute Cardiac Unit (ACU) nurses could refer patients to another hospital in some circumstances. Angiograms should be carried out within 72 hours but there had been instances of waits of up to seven days while waiting to access another hospital.
- We were told that ACU frequently had outliers placed on the ward including non-cardiac patients. [Outliers are patients under the care of medical consultants but placed on other wards due to a shortage of bed space].
- From April 2014 to April 2015, 27% of patient's experienced one ward move, 7% were moved twice, and 2% three times. These results show that nearly 40% of patients admitted to the James Paget Hospital were not treated in the correct speciality ward for the entirety of their stay. A patient who we talked with said that they had been moved five times, but they were satisfied with the continuity of the care they received. Some moves were made overnight, with examples given to us of patients sometimes being moved at 2am-3am when beds had been ready for them at 6pm.
- Consultants told us that there was no dedicated emergency theatre as it was used for elective operations to maximise use of resources. Inevitably this resulted in some postponements as lists would be interrupted for emergencies or for patients in severe pain. A new day case theatre is expected to ease the pressure.
- The respiratory ward was working with an external consultancy on reducing delays in discharge. The usual length of stay on this ward was about 6 days. Two hourly updates on the white board in this ward were used to identify any constraints to discharge. There was prompt communication with social care once patients had a date by which they would be medically fit so that the discharge date could be agreed. The planned next phase is the introduction of an electronic system.
- Continuing healthcare funded 7 community beds to help with discharge of medically fit patients.
- Senior managers told us that delayed transfers of care were down from about 40 to 10 a month. Delays were mainly attributed to waiting for appropriate social care support to be put in place.
- Patients had their needs assessed by medical and nursing staff and where required there was input from other members of the multidisciplinary team. We saw that care rounds were carried out to ensure that these needs were being met.
- Provision was tailored to patients' needs, for example separate en-suite rooms were provided for patients undergoing chemotherapy. The rehabilitation ward had a less clinical environment with a day room and a garden area to encourage greater independence.
- Patients were cared for in single sex bays and had access to single sex washing and toilet facilities. We saw that the new discharge lounge had separate male and female discharge areas with beds and separate toilets. The ACU was the only area where we were told that occasionally this was breached due to the limited bed space. Data provided by the trust showed 3 breaches of same sex accommodation between May and July 2015. All had been reported as an incident and a root cause analysis completed.
- Patients living with dementia were not in a specialist ward but had a yellow wristband so that they could be identified. There was a policy and guidance on dementia on the intranet and the internal training and advice on this area was described by staff as being very good. Relatives were encouraged to come in and provide support and if a patient with dementia liked to walk around they would be accompanied to ensure their safety.
- Rapid risk assessments were carried out for patients with learning difficulty or disabilities or autism. This was completed by staff supported by a learning disability liaison nurse.
- Staff told us that a range of bariatric equipment was available if they needed it.
- The hospital switchboard could provide language support via language line, although not all the staff with whom we spoke were aware of this facility. Staff told us they sometimes used family members to translate for them but this is not good practice as it can breach patient confidentiality.
- Ward areas were spacious, airy and looked well maintained. The rehabilitation unit had a pleasant garden area that had been created by volunteers from a contractor's workforce.

Meeting people's individual needs

Medical care (including older people's care)

- Although the trust had scored slightly worse for food in the 2014 PLACE survey, nearly all of the patients we spoke with told us that the quality and choice of food that was offered was good.
- Haematology patients had single rooms with en suite facilities and there was a specialist area for people undergoing chemotherapy. Several of the patients were well known to the staff as they frequently had to return to hospital. We saw that friendly and supportive relationships had been developed.

Learning from complaints and concerns

- Senior managers told us that they believed that the complaints system was robust and had become increasingly so with the involvement of a lead consultant in patient experience (which includes complaints).
- We saw examples of how complaints and concerns were investigated, responded to and learning shared. Where a discharged patient was inappropriately put on antibiotics, investigation showed that this was due to poor communication within the hospital and with the person's GP. Staff were reminded of the importance of checking that information was correct. When we talked with patients they told us that they were aware of how to complain, although few said that they had any concerns about their treatment and care.

Are medical care services well-led?

Good



There was good leadership at the service and at the trust level. Staff had confidence in their managers and felt well supported. This helped promote an open and transparent culture. Staff were proud of the hospital and of the services that they provided. Staff turnover was low and there was a welcoming and friendly atmosphere within the service.

There was effective governance and robust management of performance through regular audits. The resulting action plans helped to drive further improvement and progress was being regularly monitored. Risks were identified, mitigating actions were taken where possible and the risks were reviewed at regular intervals.

The trust was working in an integrated way with other local health partners and social care to develop a coherent approach to supporting elderly people in the hospital and in the community.

Vision and strategy for this service

- We were told that the trust's vision and values were discussed at personal development plan meetings.
- We found, however, that staff were generally unclear about the vision and strategy for medical services or for the trust. They were all, however, clear about their commitment to provide good quality care to their patient. When asked about their understanding of the service's vision and values several referred to the '6 Cs' of nursing (care, compassion, competence, communication, courage and commitment).
- We saw that the rehabilitation ward had its own vision displayed. This listed aims as providing a safe environment, two way communication, a friendly, welcoming atmosphere, and respecting privacy, dignity and equality.

Governance, risk management and quality measurement

- We saw that divisional clinical governance meetings took place with the agenda covering issues such as patient experience (which included complaints), patient safety, review of the risk register and infection prevention and control. Action logs assigned actions to named individuals and progress was reported.
- Governance meetings were also held within specialities, for example bi-monthly respiratory governance meeting at which issues would be reviewed outcomes and learning shared.
- There was a risk register for the division, which included risks relating to medical care. We saw that this risk register was regularly reviewed, actions agreed and taken and the register updated to reflect current risks and mitigation.
- The service participated in a range of relevant national audits, with accountability for ensuring these audits were carried out recorded in the annual clinical audit forward plan.
- Internal audits were carried out for example of safety thermometer data and antibiotic audits. These resulted in action plans where appropriate.
- Audit meetings for the division were held on a two monthly basis.

Medical care (including older people's care)

- Monthly staff meetings enabled sharing of information about incidents.
- Monthly consultants meetings were well attended and the chief executive attended alternate meetings. Issues were discussed, decisions made and there were presentations, for example on infection control.
- Staff were clear about their responsibilities, for example an accountability record was signed by nurses at the end of each shift to confirm accountability for care actions.

Leadership of service

- All of the staff we spoke with said they felt supported by their line-management and the division's senior managers. Comments were made that managers were very approachable and, "Always have time for you".
- Our observations of interactions between managers and their teams confirmed that their leadership was friendly and supportive.
- Senior managers appeared to be well known by staff and also knew them. They led by example and did not hesitate to provide assistance in patient care.
- Staff told us that the chief executive officer had a monthly blog and sent emails. She and board members were sometimes seen on wards. The chairman had visited the rehabilitation unit to check that staff were alright with the changes at the time when the future of the unit was unclear.
- There were regular emails about developments and screen savers that changed monthly and highlighted events such as dementia week.
- Staff were aware of how to raise any concerns and that there was an email address that they could use if they preferred not to approach their line manager.
- Junior doctors told us that they felt well supported by consultants and nurses. Mutual respect was evident, for example one junior doctor stated, "Nurses here are excellent".

Culture within the service

- There was a caring and positive culture. We received a lot of comments from staff about the friendliness and approachability of their colleagues.
- Staff were proud of the hospital and told us it was a happy place to work. Although there were some difficulties in recruiting staff, once at the hospital they

tended to stay and staff turnover rates were low at all levels. We were told that there was good camaraderie and staff who had come to the hospital as students returned because their experiences were so positive.

- Consultants told us that there was a 'no blame' culture and this was confirmed by staff who said that their managers were supportive if they made an error.
- The medical director, director of nursing and chief executive made an effort over last 18 months to engage with staff.
- Efforts to enable staff to get to know colleagues outside their immediate areas of work were appreciated. The summer BBQ was seen as a success in promoting useful conversations and contacts. All staff were invited and if they were working some of the food was delivered to them.
- When the rehabilitation unit was under threat of closure this was unsettling for the staff but they were reassured that they would all be offered jobs within the trust and their preferences would be accommodated as far as possible.

Public and staff engagement

- Staff were kept well informed and found the hospital's intranet, "Very good".
- Clinical governance meetings were opened up to nurses and junior doctors.
- Patient's experiences were shared, for example by the creation of videos that were then shown across the trust.







Innovation, improvement and sustainability

- The trust had been awarded integration status, with other health partners and social care to pioneer seven-day services. This included an Out of Hospital Team chaired by the clinical commissioning group involving social care, the mental health trust and the hospital to identify ways to avoid crises in communities leading to hospital attendance. Data was showing a reduction in admissions. A discharge 'hospital at home' was also being attempted but there were problems in recruiting appropriate therapists.
- The trust had already acknowledged the need for a co-ordinated approach to provision of services to elderly people. A strategy was being developed to provide support, care and treatment to older people in the hospital and also in the community in partnership with social care and other health providers. Discussions

Medical care (including older people's care)

had taken place with the local community service provider regarding how they could feed into a strategy both in a preventative and post discharge role to reduce admissions and readmissions.

Surgery

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

Information about the service

James Paget Hospital surgical services are within the Elective Division and provide surgical services to patients in Norfolk, Suffolk and Great Yarmouth and Waveney commissioning areas. Services provided include elective and emergency surgical care for trauma and orthopaedics, general surgery, colorectal, upper gastrointestinal (GI) and urology amongst others. During the period of our inspection, the division opened a new, purpose built day surgery unit. There were 25,363 episodes of care between January and December 2014.

We visited the theatre suite, theatre recovery area, day surgery unit, five ward areas, and the pre-admissions clinics. We spoke with patients and relatives, and junior and senior staff from a range of professions. We observed care being given, and reviewed records and information provided by the trust, stakeholders and individuals.

Summary of findings

Safety in surgical services required improvement because the environment in some areas was in poor condition and medicines were not always stored securely in theatres. Nursing records were not always accurate or complete with inconsistencies in some records. Staff reported incidents and there were clear examples of lessons learnt. There had been a recent review of staffing within the division with increased qualified nursing staff in some areas.

Surgical services effectiveness was good. Evidence based care and treatment was in place throughout the division, following National Institute for Clinical Excellence guidance and local audit. Pain assessments were completed and analgesia administered in a way best suited to patients need. National audit data showed the trust to be performing well in some areas and highlighting areas for improvement, particularly in hip fracture. There was good multidisciplinary working and staff applied the mental capacity act correctly.

We found caring to be good across the surgical services. The friends and family test (FFT) for the surgical wards was positive, with a high proportion of patients saying they would recommend the ward they were received care on. We observed numerous examples of kind, compassionate and respectful care during the inspection. Patients received options for their care and treatment and that they and their relatives and carers, were kept up to date with their treatment and plans for future care.

Surgery

Surgical services were not always responsive to patient's needs. The division was failing to meet referral to treatment times (RTT) but had an improving performance in general surgery. Services were planned to meet the needs of local people including the provision of a new day surgery unit. The trust was planning a dedicated emergency theatre in line with national guidance to be available by spring 2016. There was good evidence of learning from concerns and complaints.

Surgical services were well led because there was a clear vision and strategy for the service, with some clinic areas developing their own local vision. There was a robust system in place for governance within the surgical division with oversight of risks. Staff spoke highly of leadership at ward and division level. There was an open, transparent culture within the service was ongoing engagement with staff and patients through 'you said, we did' initiatives and staff survey and welfare committees.

Are surgery services safe?

Requires improvement



Safety in surgical services required improvement because the environment in some areas was in poor condition and medicines were not always stored securely in theatres. Nursing records were not always accurate or complete with inconsistencies in some records. Staff carried out sound infection control practice but were unsure when linen privacy curtains should be cleaned.

Staff reported incidents and there was evidence of learning from concerns. Nursing numbers had been recently audited that had seen uplift in qualified nursing staff on some wards. Safeguarding procedures were in place and followed and mandatory training rates were good with most staff having completed training or had training booked. There was some locum medical staff but the division used long term booking of locums to ensure consistency whilst recruitment continued.

Incidents

- There had been 10 serious incidents reported through STEIS between April 2014 and May 2015. 7 of the reports were for grade 3 pressure ulcers and 3 for falls.
- Hospital acquired pressure ulcers in surgical services remained low though there was a spike of 9 reported in December 2014. The number of falls was low and no trend could be identified in the low numbers. Catheter associated urinary tract infections were low in surgical services.
- Incidents were reported using an electronic system that all staff were able to access.
- 11 staff told us that they were aware of how to report an incident and were confident in doing so. They told us that they received feedback on incidents reported and any lessons learnt. On three wards, communication books and meeting minutes showed that outcomes of incidents were discussed with staff.
- Mortality and morbidity meetings (Surgical Mortality Review) were routinely held across the division every other month. Minutes showed that appropriate cases were discussed, that clinical and other factors considered and any lessons learnt clearly identified.

Surgery

- All staff we spoke with were aware of the basic principles of Duty of Candour. Professionally registered staff had recently received guidance from their regulatory bodies about their responsibilities in relation to the duty and all were aware.
- 4 senior staff we spoke with were aware of their responsibilities under the Duty of Candour regulation, the requirement to be open and honest and hold a meeting with patients who met the criteria. One member of staff showed us how they had identified a potential incident that may trigger Duty of Candour and escalated this so it was correctly addressed.
- There was personal protective equipment available. Different coloured aprons were used in different patient bays on wards so that it was easy to identify staff that may move between different areas without changing their aprons.
- Staff were bare below the elbows in clinical areas and we saw staff washing their hands correctly between patient contacts.
- Green stickers were affixed to equipment that was cleaned and ready for use. A number of staff told us that some staff used the equipment and replaced it without cleaning it or changing the label though we did not see evidence of this during our inspection.

Safety thermometer

- Safety thermometer data was displayed at the entrance to all wards and showed most recently available information. This also included the 'safety cross' diagram of the ward highlighting where there had been falls or pressure ulcers.
- Data shown was positive for wards. Day surgery data showed 1217 days since the last pressure ulcer, 10 days since last fall and no cases of C Difficile or MRSA.
- Ward 6 safety thermometer data showed 2 days since the last fall on the ward but did not show how many falls there had been in a given period. It also noted 39 days since a pressure ulcer and no cases of C Difficile and MRSA.
- Ward 7 safety thermometer data showed 0 C Difficile or MRSA cases, 50 days since the last pressure ulcer and 18 days since the last reported fall.
- There were action plans in place to address any concerns highlighted by the data and this was also discussed at division level meetings.
- Surgical site infection surveillance data for 2013/2014 (the last full set of audit results) showed the hospital to be performing better than the England average for surgical site infections in the categories of hip replacement, knee replacement and repair of fractured neck of femur.
- In theatres we saw that some plastic bumpers on doors had become cracked and these had been covered with adhesive tape. This tape was lifting in some areas and had not been recovered or the door repaired. We were concerned that this was an infection control risk.
- In theatres, we saw a member of estates staff wearing thin overshoes instead of usual theatre footwear. We were told it was because that group of staff were required to wear steel toecap footwear and that this was unavailable at the present time in theatres.
- Ward areas used fabric privacy curtains. We asked two ward managers when the curtains were changed. One manager had a clear knowledge of the cleaning routine but a second ward manager was unsure when they were cleaned or how to request they be cleaned. They also were unsure of when to request them being cleaned. We were concerned that this inconsistency posed an infection control risk.

Cleanliness, infection control and hygiene

- There had been two recent MRSA bacteraemia in before our inspection, the first recorded by the trust in three years. Root cause analysis showed one to be a contaminated sample in the intensive care unit. The second was found not attributable to the trust.
- C Difficile rates in surgery were below the agreed trust trajectory with three cases.
- Ward areas were visibly clean. Environmental audits showed that ward areas consistently scored in excess of 95% for cleanliness.
- There were adequate hand washing facilities available and alcohol gel dispensers were available throughout wards and corridors.

Environment and equipment

- Resuscitation equipment including bottled oxygen was available in all areas and were recorded as checked daily in line with trust policy. All staff were able to tell us the location of the emergency equipment.
- Equipment in ward areas such as hoists and infusion pumps were all tested and serviced in line with manufactures guidance and electrical testing requirements.

Surgery

- Records showed that oxygen and suction at bedsides were checked daily and recorded in ward areas. We observed a member of staff carrying this out during our inspection. However, on the day surgery unit 5 beds had suction catheters missing and one had oxygen tubing missing. These were replaced during our inspection.
- In theatres, resuscitation and difficult intubation equipment was available and in line with national guidance by the Royal College of Anaesthetists. All equipment had been checked daily from the beginning of June but records showed that prior to this, equipment had only been checked 36 times in the preceding 18 months.
- Environments in some ward areas was cluttered with trolleys and equipment.
- In theatres we saw that some of the environment was dated. There were two holes in plaster walls next to a drug cupboard. The plastic bumper on a theatre door had been repaired using tape which was peeling away from the door and showed a sharp edge on the plastic.
- In theatre recovery, we saw that the 'floating ceiling' was in poor repair, with numbers of old brown water stains on the ceiling. Staff informed us they believed a business case for the upgrade to facilities had been completed. There was a business case and plan in place for the refurbishment of recovery.
- We saw that most equipment was checked correctly but in recovery, on equipment relating to a drinking fountain, portable equipment testing (PAT) stickers on the plugs showed they had not been tested since 2013. Staff we spoke with in the area could not assure us that they had been tested correctly.
- Records showed that equipment had been properly maintained according to manufacturer's instructions.

Medicines

- Medicines were kept securely in ward areas with doors locked and a code required for entry.
- The hospital used a comprehensive prescription and medication administration record chart for patients which facilitated the safe administration of medicines.
- The pharmacy team were not able to provide a daily service to all wards so some prescription charts were not checked on admission. However we saw that where pharmacy staff had reviewed the charts, they recorded interventions which guided staff in the safe prescribing and administration of medicines. 'Get it on time' stickers were used to highlight those medicines where regular administration is important.
- A prescription chart adapted for the 'enhanced recovery' programme supported prescribers to follow the agreed protocol for these patients.
- We looked at the prescription and medicine administration records for 18 patients on four wards. We saw appropriate arrangements were in place for recording the administration of medicines. These records were clear and fully completed. The records showed people were getting their medicines when they needed them, any reasons for not giving people their medicines were recorded. This meant people were receiving their medicines as prescribed.
- Medicines, including those requiring cool storage, were stored appropriately. We saw controlled drugs were stored appropriately, but we noted a discrepancy in the record keeping. This was investigated and resolved immediately. Controlled drugs are medicines which are stored in a special cupboard and their use recorded in a special register.
- There was a pharmacy top-up service for ward stock and other medicines were ordered on an individual basis. This meant that patients had access to medicines when they needed them while in hospital. Pharmacy staff visited the wards to arrange medicines to take home, but nursing staff said there was sometimes a delay in getting medication on time.
- In theatres we found a main drug cupboard and a further drug cupboard in recovery to be unlocked and unattended. These cupboards contained a variety of medicines including bupivacaine for injection, antibiotics and anti-sickness medicines amongst others. We were concerned that they were left unlocked and unattended. The visitors' book showed that 17 people had been signed into the department over the preceding two weeks which meant that people, other than theatre staff, had access to main theatres.
- The temperature in the drug cupboard in theatres was recorded as consistently higher than 25c with a high of 27c and had been for some weeks. This is higher than the recommended storage temperature for some drugs being stored in the cupboard and outside of the trust policy of storage of medicines which permits 12 days above 30c in a month. We were told there was a plan in place to address this concern.

Surgery

Records

- Patient's records were kept in unsecured trolleys in the corridors of most wards. They were easily accessible for staff but would also be available to members of the public as they were not locked or secured. We looked at 18 sets of medical records.
- Three records we reviewed were not consistent with the patient's condition. For example one record assessment said a patient was living with advanced dementia and forgetfulness but this was not recorded in the medical notes or an MCA considered. On a further record the dementia assessment indicated a full assessment was required and this had not been completed.
- In six records, visual infusion phlebitis (VIP) scores had not always been assessed and there were omissions of date of cannula insertion making cannula management more challenging. In 4 records, Waterlow scores had been incorrectly calculated and had not taken a patient's condition into account, for example, one had not taken a patient anaemia into account. In 7 records Waterlow scores were not recalculated after a change in a patient's condition, for example following surgery.
- Malnutrition screening tool were completed for all patients but on one occasion we saw that a patient had been scored as at risk but it was not recorded as to whether they had been referred to a dietician as per protocol.
- Ward level dashboard data showed that for a number of wards that they regularly failed to meet the division target for nursing documentation with ward 4 scoring at 66, ward 6 at 84%, ward 7 at 81% and ward 9 at 69% in April 2015. Ward 5 scored 100% for the same period.

Safeguarding

- There were clear processes and procedures in place for safeguarding people at the trust.
- The majority of nursing and medical staff were trained to level 2 safeguarding with over 85% up to date with training.
- Information was available in clinical areas advising staff on which action to take in the event of a suspected safeguarding.
- Staff were aware of their responsibilities of safeguarding. 10 staff we spoke with were aware of local

safeguarding procedures and knew how to make a referral in the event of a safeguarding concern. Most staff had completed mandatory training in safeguarding or had the training booked.

Mandatory training

- Data reviewed pre inspection and in clinical areas showed that the majority of staff, typically greater than 80% were up to date with mandatory training or were booked to attend. For medical staff this was 91%.
- Mandatory training was completed in a variety of ways including face to face and eLearning.
- Training included cardiopulmonary resuscitation, moving and handling and infection control amongst others.

Assessing and responding to patient risk

- The trust used an early warning score (EWS) to identify patients who were at risk of deterioration
- Patients who scored a 3 or more on the EWS reviewed by the clinical team or the intensive care outreach team during working hours. Three records we reviewed showed that patients had been correctly referred to the outreach team and were reviewed with a plan of care recorded. This was usually recorded on a situation, background, assessment, recommendation (S-BAR) sticker affixed to the patient notes. However, in one record we saw that the observations requested by the outreach team had not been completed on three occasions.
- Out of hours, patients were reviewed by the on call anaesthetist. Staff told us they had no problems in ensuring patients they were concerned about were reviewed promptly.
- In theatres, the five steps of safer surgery was in place and being used. We saw that the WHO checklist was well embedded and correctly used with a good team briefing before and debrief following the procedure, led by the consultant/ primary surgeon.
- Audits completed showed that World Health Organisation 5 steps to safer surgery (WHO checklist) compliance was consistently greater than 98% for all theatres. Insufficiently detailed audits did not showing compliance with each step of the checklist. The audit was completed monthly.

Surgery

- There were clear procedures and processes in place for the transfer of unwell patients who required specialist treatment at another hospital. There were also contracts in place for additional services such as interventional radiology at a local acute teaching hospital.
- Morning trauma meetings were held daily at 0800 to prioritise patients for surgery according to clinical need.
- The elective division compiled a monthly patient safety report, identifying risks to patient care and providing actions to mitigate and address the risk. Risks identified included falls in one clinical area and the steps taken to address the risk.

Nursing staffing

- Nursing staffing had been reviewed in early 2015 using the safer nurse care tool to determine the acuity of different wards. This had meant an uplift in staff on a number of wards. One ward manager however told us they had not been involved with the audit
- Planned and actual staffing numbers were displayed on each ward for each day. They showed that on most wards during our inspection that staffing was maintained in accordance with the planned staffing level.
- Rotas reviewed showed for one ward that staffing was broadly maintained with gaps for staff sickness. Most ward areas reported small numbers of full time staff vacancies. Ward dashboard data showed that sickness rates were low.
- Vacancy was at 5%
- Induction programmes for agency staff were in place on the ward.
- Agency use stood at 8% for the trust and managers told us there was also the use of bank. The uplift in staffing had created vacancies that were being filled in the short term until permanent staff could be recruited.
- Information reviewed showed a low vacancy rate for registered nurses across the surgical division with 13 whole time equivalents across 6 wards and say surgery.
- We observed a nursing handover which provided the necessary, factual information for staff to be able to safely care for patients.
- In recovery we saw that there were 5 nurses whilst 7 operating theatres were in use which was not in line with national guidance.

Surgical staffing

- There was the same number of consultants as the England average at 41% of the medical work force. There were more middle grade staff and less registrar staff than the England average with a similar number of junior doctors.
- Surgical consultants worked a week on call rota with regular morning trauma meetings.
- There were clear on call rotas for consultants and registrars. Orthopaedic wards had a junior doctor dedicated to the wards with more senior cover when required.
- Surgical wards, out of hours, shared a junior doctor who also covered the emergency department. More senior doctors supported them. There were on call consultants always available on the rota.
- We spoke with 7 doctors who told us that they were busy but adequately supported by senior staff. They told us there were no problems in calling for senior help to review patients.
- There was consultant orthogeriatrician cover for emergencies only on Monday with a full round on Tuesday and Friday. There was middle grade cover on Monday and Thursday.
- A recent appointment of an additional general surgeon would support the planned dedicated National Confidential Enquiry into Patient Outcome and Death (NCEPOD) theatre in 2016.
- We observed a handover which was concise with relevant information.
- There were a number of vacancies for consultant grade staff with recruitment under way. Senior managers' mitigated this by block booking locum consultant's to ensure continuity of care. Locum consultants had an induction on commencement of their placement.

Major incident awareness and training

- There was a major incident policy in place relating to all services within the trust including surgical services.
- Staff we spoke with were aware of the major incident policy and the implications for its use in their area including procedures for cancelling elective and non urgent surgery.
- The division had business continuity plans in place to manage the service in the event of a major incident.

Are surgery services effective?

Surgery

Good



Surgical services effectiveness was good. Evidence based care and treatment was in place throughout the division, following National Institute for Health and Care Excellence (NICE) guidance and local audit. Pain assessments were completed and analgesia administered in a way best suited to patients need. National audit data showed the trust to be performing well in some areas and highlighting areas for improvement, particularly in hip fracture.

Staff were competent to carry out their role with many receiving additional training and there was effective multidisciplinary team (MDT) working and access to some services 7 days a week but this was not the case for all allied health professionals. The mental capacity act was appropriately applied and deprivation of liberty applied for in line with legislation.

Evidence-based care and treatment

- At the time of our inspection there was no dedicated emergency theatre. Instead, elective operations were planned for the morning in one theatre and the afternoon used for emergency cases. The elective operations were cancelled if there was an emergency case in the morning. This was not in line with National Confidential Enquiry into Patient Outcome and Death (NCEPOD) guidance. The opening of a day surgery unit in 2015 and subsequent reconfiguration of theatre services should allow for a dedicated emergency theatre by spring 2016.
- There were enhanced recovery pathways in place for some surgical procedures including for patients having bowel surgery which incorporated guidance for care of patients' pre and post operatively. There was also a pathway in place for patients with fractured hips.
- Elective patients were assessed for, and given information relating to deep vein thrombosis (DVT) and pulmonary embolism (PE) at pre assessment clinic in line with National Institute for Health and Care Excellence (NICE) guidance Venous thromboembolism in adults admitted to hospital: reducing the risk CG92. Emergency admissions, including those for trauma orthopaedics were also assessed to this standard.

- Pre admission clinic used a Wellbeing questionnaire to assess patients prior to surgery. We saw that this included assessments recommended and required by the Royal College of Anaesthetists.
- NICE guidance CG50 was in place including the monitoring and escalation of unwell patients with the aid of early warning scores.
- We observed a laser prostatectomy being carried out in line with NICE guidance IPG17.
- There were evidence based pathways in place for patients with fractured hips. There was also a pathway for acute spinal patients but there was no date for review on this document.
- There were clinical audit forward plans in place for the division which set out priority areas for audit and the clinician responsible. These showed a comprehensive programme of clinical audit across the division.
- Trust policies and procedures used in the surgical division were evidence based.

Pain relief

- Pain relief was prescribed and according to records reviewed, administered to patients in a timely way.
- We observed patients being asked if they required pain relief following surgery and were provided with it if required.
- An acute pain team was available during normal working hours and visited all patients post operatively or any that staff were concerned about.
- Outside of usual hours, pain management was led by the on call anaesthetist.
- Pain relief was provided in a number of ways post operatively including oral pain relief, patient controlled analgesia which is pain relief administered directly into the bloodstream and controlled by the patient, and by epidural.
- In day surgery patients were assessed preadmission for pain, on the return to the ward from recovery and before discharge with appropriate analgesia prescribed.
- Pre admission clinic staff discussed pain relief with patients and a pain assessment was completed with recourse to the acute pain team for patients with complex needs.
- On one occasion we observed a patient ask a domestic member of staff for pain relief. This was promptly reported to a nurse who arranged for the pain relief to be given.

Surgery

- Patients told us they were getting pain relief when they needed it. One person preferred to administer their own eye drops, and they were able to do this.

Nutrition and hydration

- Patients were supported with nutrition and hydration needs on the ward.
- Malnutrition screening tools (MUST) were available on wards for all patients as part of a comprehensive risk assessment though they were not always completed.
- Patients requiring additional fluid support or help with nutrition had fluid or food charts in place and were properly completed. .
- Nutritional requirements were met for patients who were unable to take food and drink orally by other means. PEG (percutaneous endoscopic gastrostomy) and total parental nutrition were both in use to support nutritional needs.
- Dieticians were available for patients who were considered at risk or had a complex condition. Record showed that dieticians reviewed patients promptly on receipt of a referral.

Patient outcomes

- The national hip fracture audit data from 2013/ 2014 showed that the trust performed better than the England average for five measures including case ascertainment rate, falls assessment and length of acute stay in hospital. The data also showed that the trust performed worse than the England average for five measures including admission to orthopaedic care in four hours, surgery on the day or day after admission, pre-operative assessment by a geriatrician and patients developing a pressure sore.
- Bowel cancer audit data for 2014 showed that cases discussed at the multidisciplinary team (MDT), patients seen by a clinical nurse specialist and computerised tomography (CT) scan being reported in time were all better than the England average with other measures all being in line with the England average. There were good ratings for case ascertainment and data completeness.
- National lung cancer audit showed that the trust performed worse than the England average for cases discussed at MDT with 82% against 96% but better than the England average for patients receiving bronchoscopy before CT at 94% against an England average of 91%.

- The national emergency laparotomy audit 2014 showed that the trust had a formal rota for diagnostic and interventional endoscopy and intensive care consultant cover but lacked an emergency theatre and round the clock intensive care outreach amongst others.
- Readmission rates for the trust were better than the England average for both elective and emergency surgery. Elective general surgery, ophthalmology and urology all had lower (better) readmission rates than the England average. Emergency general surgery and trauma and orthopaedics had readmission rates lower than the England average with emergency urology having a slightly worse readmission rate than the England average.
- The patient reported outcome measure (PROMS) showed that for most surgical categories surveyed the trust performed in line with or better than the England average for patient reported improvement following surgery.

Competent staff

- The majority of staff we spoke with in clinical areas and focus groups told us that they received regular appraisals.
- Ward data showed that the majority of staff had completed appraisals or that they were booked.
- On two wards staff told us they had access to clinical supervision but that this was usually unstructured and on an ad hoc basis. Staff were unable to provide records of these meetings. On another ward, one member of staff told us they did not have time for clinical supervision.
- Competency frameworks and assessments were in place in a number of clinical areas and we saw that they had been completed and staff regularly reassessed for competence when undertaking extended skills. For example, in one area we saw completed competency assessments for staff caring for patients with epidural analgesia.
- Staff had a full induction prior to commencing work and were assigned a colleague to work with during a supernumerary period. Completed induction programmes showed that new staff had regular meetings with managers during this period and that the supernumerary status could be extended if required.

Surgery

- The trust had recruited a number of staff from overseas who received a tailored induction programme and 6 weeks supervised practice before working autonomously. Surgical wards had a good retention of overseas nurses.
- Most staff were encouraged to take on new skills and gain qualifications. Ward records showed that staff had completed national vocational qualifications and staff we spoke with individually and in focus groups confirmed this was the case. Some staff had taken on additional skills such as ECG recording and we saw they had been assessed as competent before carrying out the skill.
- However, a focus group told us that health care assistants were not supported to take on additional skills within their role but could apply for clinical support roles to do this.
- Many staff took on a clinical champion role in their workplace. For tissue viability, link staff had three monthly meetings where further training was undertaken and competency also considered.
- Surgical first assistants in theatres had not all been formerly assessed for their competence for the role. All were now undertaking a competency assessment lasting for approximately 100 practice hours.
- Ward rounds continued over weekends but we were told by staff on several wards that emergency and post-operative patients were the patients routinely reviewed. However, they also told us that they could get any patient reviewed if they requested it.
- Theatres had commenced weekend lists, regularly undertaking two lists on a Saturday and two on a Sunday in addition to emergency work.
- Radiology was available out of hours and at weekends for inpatients on an emergency basis accessed via the on call radiologist. Three doctors we spoke with told us that they had not had any problems in requesting out of hours imaging. Radiology was available separately for theatres in the case of urgent need and could be booked for elective surgery over weekends.
- Some specialist services were Monday to Friday only including intensive care outreach and pain team though there were arrangements in place to cover these teams for example through the on call anaesthetist.
- There was no regular physiotherapy or occupational therapy at weekends though an on call physiotherapist was available for urgent care such as chest physiotherapy. In orthopaedics, ward staff told us that they mobilised patients immediately post operatively over weekends as there was no physiotherapy cover. We were informed that the trust was contracted to provide this level of service.
- Phlebotomy services ran 7 days a week for inpatient areas.
- There was no weekend trauma list; instead trauma patients were placed on the emergency list.

Multidisciplinary working

- There was effective MDT working in clinical areas. We observed wards rounds that consisted of medical, nursing and allied health staff. Specialist nurses routinely joined ward rounds.
- Board rounds, where patients are discussed at the ward name board were carried out daily and ensured members of the MDT were aware of the plans for patients' recovery and progress.
- On one ward we saw that a community nurse had joined a ward round to discuss the discharge of a patient with complex needs to facilitate an effective discharge.
- There was excellent MDT working in theatres from the team briefing at the beginning of the surgical list and through procedures. We saw talk to each other with an obvious rapport and respect.
- Allied health professionals provided care and support as a key member of the MDT however, we were told they did not always work on a Sunday.

Seven-day services

Access to information

- Records were readily available on wards and were split between medical notes kept in a central area and nursing notes kept at the end of patient's beds. Staff reported that they rarely had trouble locating notes.
- Radiology films and reports were accessed via an online system giving medical staff almost immediate access to unreported films and investigations.
- Blood results were also available online and were accessible to staff.
- The pre assessment clinic staff did not have access to the theatres IT system and so were required to fax information to theatres.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Surgery

- We reviewed 11 patient consent forms and found them all to be completed properly, clearly highlighting risks and benefits of the procedure and being signed by the patient.
- 4 patients we spoke with told us that they had been given adequate information to enable them to make a decision about their care.
- The pre-operative assessment clinic gave information to patients to take home prior to consent to allow them to make an informed decision.
- Mental capacity assessments were properly completed and best interest's decisions involved the relevant professionals and, in one instance, an advocate with the exception of one patient we identified.
- We reviewed two patients who were subject to deprivation of liberty safeguards and found that the proper authority had been received from the local authority. During our inspection we saw a decision reviewed to ensure it was the least restrictive option available.
- 96% of nurses had received training on the mental capacity act and 98% of medical staff.

Are surgery services caring?

Good



We found caring to be good across the surgical division. The friends and family test (FFT) for the surgical wards was positive, with a high proportion of patients saying they would recommend the ward they were received care on. We observed numerous examples of kind, compassionate and respectful care during the inspection. Patients told us that they were given options for their care and treatment and that they and their relatives and carers, were kept up to date with their treatment and plans for future care.

Compassionate care

- The friends and family test (FFT) response rate was 41% for the trust against a national average response rate of 37%.
- FFT response rates for individual wards between March 2014 and February 2015 varied between 37% for the Charnwood Suite and 53% for Ward 9.
- FFT responses between March 2014 and February 2015 for wards 5 and 9 were at or consistently above 90% for

patients who would recommend the ward. The lowest score for the period was 82% for ward 6 though all wards scored consistently highly for patients who would recommend the ward.

- Most recent results in day surgery showed that 91% of patients thought highly of the care they received.
- There was an obvious rapport between staff and patients. We observed interactions to be respectful with staff clearly aware of patients' preferences.
- Staff introduced themselves to patients before engaging in conversation. Curtains were always pulled to protect privacy and dignity.
- We observed numerous examples of kind and compassionate care provided by staff. Some patients required assistance with eating and drinking. We observed them to be helped in an unhurried way by staff that remained engaged with the patient.
- We spoke to 18 patients. All told us that they received excellent care and felt well looked after. One told us that "the staff are marvellous; there is nothing they wouldn't do for you".
- One relative we spoke with told us that they were unable to visit the ward during visiting hours due to transport problems but that the staff had supported them to visit their relative and also spend some time off the ward.

Understanding and involvement of patients and those close to them

- 5 patients we spoke with told us they had been given appropriate information to allow them to make decisions about their care. We spoke to one patient who had made a difficult decision about their treatment. They told us they had been well supported and been given enough information. It was most important, they said, was to talk over the decision a number of times and they had been given this opportunity.
- Records reviewed confirmed that patients had been given options and choices when planning their care.
- All but one relative we spoke to told us that they had been kept informed of the care their family member had received and the plans for future care or discharge.

Emotional support

- Patients with a religion or none were able to access the chaplaincy service for emotional support. Three people

Surgery

we spoke with told us they had visited by the service, with one receiving communion. One other person told us they had requested to see the chaplaincy team on a number of occasions but this has not happened.

- Counselling services were provided to some patients. Peer support groups, for example for patients requiring bowels surgery were also in place. A number of these groups we were told had arisen informally.
- There were a number of clinical nurse specialists who supported patient, relatives and carers through care and treatment. Two patients we spoke with told us they had received support from nurse specialists between periods of treatment and that they felt they could always contact them.
- In theatres, a member of staff described how they had shown an anxious patient around the theatre suite prior to their admission so that they could see where they would be cared for and so staff could answer any questions they had.

Are surgery services responsive?

Requires improvement



Surgical services required improvement as they were not always responsive to patient's needs. The division was failing to meet referral to treatment times (RTT) but had an improving performance in general surgery and a declining performance for trauma orthopaedics. There were small numbers of patients cancelled on the day and length of stay was broadly better than the England average. Services were planned to meet the needs of local people including the provision of a new day surgery unit.

There was no dedicated emergency theatre but a service redesign showed this would be available from Spring 2016. Patients' individual needs were met with some elements of outstanding practice including provision of care for patients with spinal injuries. The division demonstrated clear understanding of complaints and learning from concerns.

Service planning and delivery to meet the needs of local people

- During the period of our inspection a purpose built, three theatre day surgery unit was opened at the

hospital. This will allow a greater number of patients to be seen in a day surgery unit, aiming to reduce length of stay and increasing flexibility for new procedures and pathways.

- Meeting minutes showed that service design was considered along with commissioners so that the local health economy offered the right services.
- Senior divisional staff were aware of the need to work with other providers to manage services for patients, for example the provision of interventional radiology and some specialist surgery. Divisional risk registers showed that some the arrangements for some shared services such as out of hours ear, nose and throat team was by verbal agreement only but that there was work towards a formal service level agreement.
- There were development plans in place for specialties in the surgical division that highlighted plans required to meet the health and care needs of local people.

Access and flow

- There were 25,363 patients' admissions for surgical services between January and December 2014. 69% of those were for day surgery, 13% elective surgery and 18% emergency admissions.
- 32% of admissions were for general surgery, 26% ophthalmology and 23% trauma and orthopaedics.
- Theatre utilisation was consistently at or below 75% for all theatres for February, March and April 2015 with only two theatres reporting higher than this on one occasion each.
- Bed occupancy at the trust was at 90%, fractionally below the England average.
- The trust was failing to meet referral to treatment times (RTT) target of 90% for the 18 week admitted for treatment category for most specialties.
- Data for the most recent three months showed an improving trajectory for general surgery from 70% in March to 76% in May 2015. However, performance had deteriorated in trauma orthopaedics from 73% in March 2015 to 61% in May 2015. Urology and ENT performance was more variable but both failed to meet the expectations in May 2015 with urology at 73% and ENT at 72%.
- Ophthalmology was meeting its target in May 2015 with 91% patients admitted for treatment within 18 weeks.

Surgery

- The number of patients whose operation was cancelled and not rebooked within 28 days was low with three patients falling into this category between April 2014 and March 2015.
- Between January and December 2014, average length of stay for patients undergoing elective surgery was lower (better) than the England average overall at 2.7 days compared to 3.1 days however, for specialties trauma and orthopaedics and general surgery the average length of stay was higher than the England average with urology being lower than the England average.
- For the same period, average length of stay was longer overall at 6.2 days against an England average of 5.2 days. Non elective trauma and orthopaedics had a significantly longer length of stay at 10.6 days compared to an England average of 8.5 days. Emergency urology surgery had a lower average length of stay than the England average.
- Audit data showed that 65% patients admitted with a fractured hip in 2014 were operated on the same or following day compared to the England average of 74%. This was deterioration in trust performance from 2013 when 89% of patients were operated on in this time.
- There was no dedicated emergency theatre; instead an afternoon slot was routinely scheduled with non urgent patients cancelled to make way for emergencies of required. In the three weeks preceding our inspection this happened on only one occasion though senior managers told us that it was sometimes difficult to balance elective and emergency surgery. Emergency scheduling of patients remained the responsibility of the anaesthetist.
- Audits showed that overnight, only 17 laparotomies had been done overnight.
- Patients in day surgery who required an unplanned overnight stay were highlighted to bed managers who found them a bed. Staff we spoke with told us that there were no problems in getting patients an overnight bed.
- Some medicines for patients to take away were available on the day surgery unit which reduced delays in timely discharge from the unit.
- Nurse led discharge in day surgery against a fixed criteria ensured a prompt discharge for patients following surgery.
- Discharge planning was commenced at pre admission clinic, with care needs identified and plans commenced to meet those needs on discharge.
- The case manager for patient flow was responsible for liaising with all professionals to ensure timely discharge. An IT discharge system allowed the operations centre to monitor discharges across the trust.
- Prior to our inspection the day surgery area had been used for inpatients which had ceased in June 2015. Senior staff in the new day surgery unit were clear that they planned to protect the trolleys from 24 hour admissions. A number of incidents in the day unit when used for inpatients in early 2015 meant a desire to ensure the new day unit was used for day case patients only.
- In theatres, individual theatre performance was displayed by each. All showed that theatres lists started late – frequently more than 60% with typically 40% overrunning.

Meeting people's individual needs

- On one ward, any negative comments received from the friends and family test were reviewed and an action plan created to address the concerns.
- Staff had received training in caring for patients living with dementia. Staff felt confident supporting these patients and were aware of the dementia link nurse who would support them on the wards.
- The trust had a dedicated spinal injuries nurse who assessed and provided care for patients admitted with spinal injuries. The surgical division was one of only two trusts in the east of England with a full spinal bed which allowed full turning of the patient with minimum movement from staff reducing the risk of harm for these complex patients.
- On a number of wards, there were additional staff to care for patients who required additional attention and care. Staff told us there were no difficulties in authorising these additional staff.
- Staff had access to translation services via 'INTRAN' though they said they rarely needed to use it.
- The pre admission clinic planned a patient's admission so that if any specialist input or equipment provided it could be in place prior to admission.
- Occupational therapy staff could also be involved with the pre admission clinic to ensure a smooth discharge.
- Specialist equipment was available when required. Staff told us that they were able to order specialist equipment such as bariatric equipment and that it arrived promptly.

Surgery

- A fractured neck of femur keyworker nurse managed the patient pathway, provided expert information to patients, collected audit data and ensured suitable patients were on the fast track admission pathway. They offered a seven day service and reviewed all patients on the trauma round and reviewed outlier orthopaedic patients.
- Pre-assessment clinic gave patients information about their procedure and what they could expect in hospital. The pre assessment considered patients' preferences and their home and social situation when planning their care.

Learning from complaints and concerns

- There was positive learning from complaints and concerns within the service.
- Information on how to make a complaint was available in each area. Senior staff we spoke with could tell us of their most recent complaint and the themes arising from it. They were also aware of potential implications for duty of candour.
- Meeting minutes and communication books showed that complaints and concerns were disseminated and discussed with staff and any changes of practice highlighted.
- 10 staff we spoke with were aware of any recent complaints in their area and told us that they had received feedback regarding any investigations. They also told us they were confident in assisting people who wished to make a complaint.
- All areas we inspected were aware of their most recent complaints, what they involved and any learning that arose.

Are surgery services well-led?

Good



Surgical services were good for well led because there was a clear vision and strategy for the service, with some clinic areas developing their own local vision. Senior managers had recognised the need to address referral to treatment times and had a credible plan in place to address this. There was a robust system in place for governance within

the surgical division with oversight of risks and actions in place to address identified weaknesses. Senior division management had a sound knowledge of the service including risks to service provision.

Staff spoke highly of leadership at ward and division level. There was an open, transparent culture within the service/. Staff told us they were encouraged to report incidents and voice concerns. There was ongoing engagement with staff and patients through 'you said, we did' initiatives and staff survey and welfare committees.

Vision and strategy for this service

- There was a clear vision and strategy for surgical services at the trust from senior management to individual clinicians. The surgical services came under the Elective Division.
- The very recent introduction of a day surgery unit will increase the number of day patients whilst allowing the reconfiguration of existing theatre capacity and the introduction of a dedicated emergency theatre in spring 2016 in line with National Confidential Enquiry into Patient Outcome and Death (NCEPOD) guidance.
- A number of areas had their own vision for how they were going to develop their service and provide excellent care to patients. On one ward we saw the ward vision cascaded to staff.
- Staff we spoke to on the ward were aware of the ward vision as well as the wider hospital vision and strategy.

Governance, risk management and quality measurement

- Regular governance meetings were held within the service. There was a good attendance by staff at divisional board meetings. Key issues were discussed according to agendas and minutes. A divisional action log showed ownership for actions with realistic timescales.
- Divisional risk register showed key risks, mitigation and longer terms plans to address the risks. These also included issues where the division had identified it was not meeting national clinical guidance.
- Clinical governance meetings were routinely held in the division with good attendance from management, nursing and allied health professional staff. Minutes we reviewed showed limited engagement from medical staff.

Surgery

- Information was shared with colleagues in ward areas in a number of ways, through communication books and via email and staff meetings.
- There were peer reviews of ward areas by senior staff from other wards. This highlights areas for improvement and offered peer challenge to staff.
- Senior nurses were aware of a large number of falls on Ward 6 and the acuity of the patients. They had identified this ongoing risk, and conducted weekly reviews of all falls with matrons and the physician responsible to make changes to reduce the number of falls. This had led to an initiative entitled “Call don’t fall”.
- Minutes showed that senior nurses attended consultants meetings in the division to discuss clinical, governance and risk.
- Ward level information such as safety thermometer data was discussed at divisional level with appropriate challenge and oversight.
- The division’s specialties had development plans in place. Key milestones on the plan, such as opening the new day surgery unit demonstrated plans being met.
- The Combined Elective Divisional Audit Meeting (CEDAM) met monthly to discuss activity and consider the response to audit findings and other issues highlighted. Minutes were detailed with clear actions identified.
- There was a clear unit plan in place for the following 18 months which identified lead clinicians for each audit.

Leadership of service

- Leaders within the service were visible and all staff we spoke with told us they were approachable.
- The senior leaders within the service had a clear idea of the challenges and risks identified within the division as well as opportunities for development. Where they had identified risks, we saw that they had taken action to address them and plan future service provision.
- We were told some wards found it difficult to get good attendance at ward meetings so has instigated other ways of information sharing and cascading important information from email to ward bulletins.
- There were two interim managers in key positions within the division, specifically operations and theatres though appointment had been made for a permanent manager to theatres.

Culture within the service

- There was a very positive and open culture within the service. Staff were proud of the role they performed and the quality of the service they provided to patients.
- Staff told us that the culture was an open one. They were encouraged to report incidents and that they felt able to voice concerns to senior staff.
- A number of health care assistants told us that they did not always feel valued as they were unable to develop in their role and felt this was not recognised by senior staff.

Public engagement

- The friends and family test was carried out across the division with positive results in all areas.
- On some wards we saw that there were “You said we did” initiatives to address any issues raised by patients and their relatives or carers.
- There were reports every two months to the Carer and Patient experience Committee which highlighted friends and family test scores, patient advice and liaison service (PALS) contacts and complaints amongst others and any actions taken in response.







Staff engagement

- Staff survey was carried out across the division. Results were broadly positive and senior managers were aware of any areas of concern for example, around the number of staff reporting discrimination.
- The surgical division provided regular information to the Health, Safety and Staff Welfare Committee that considered these risks to staff, provided oversight and developed actions in response to concerns.

Innovation, improvement and sustainability

- The new day surgery unit that opened during the period of our inspection will allow the surgical services and trust to develop day case surgery, consider new pathways and ‘one stop shops’. The facilities were purpose built and offered an excellent environment for day case surgery.
- Plans for the refurbishment of theatres and a different utilisation pattern will mean that the trust has an NCEPOD dedicated emergency theatre in line with established national guidance.
- All staff we spoke with were keen to develop their services whether at division or a smaller specialist service. There was a notable enthusiasm amongst staff for improving services for patients.

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

Information about the service

James Paget Hospital provides a service to patients who need intensive care (described as level three care) or high dependency care (described as level two care). Patients were admitted following complex and/or serious operations and in the event of medical and surgical emergencies. The unit provided support for all inpatient specialities within the acute hospital and to the emergency department.

The intensive care unit (ICU) had 12 beds which were used flexibly by adjusting staffing levels in order to meet patient need. There were eight side rooms for single occupancy and four bays with side walls and curtains at their entrances. Two of the side rooms could be used with patients who required more specialist isolation. Each had lobbies to allow staff to change clothing before entering and leaving. The service was led by a consultant intensivist with support from the intensive care consultant team and senior nurses.

In the three months from January to March 2015, the department admitted approximately a third of its patients from elective (planned) and emergency surgical procedures and the other two-thirds were medical patients. Of the surgical procedures, around 9% were high-risk elective surgery and 21% emergency surgery. The number of patients treated had fluctuated over the past five years, but was usually between 150 and 175 per quarter with approximately 600 patient admissions per year.

The ICU contributed data to the Intensive Care National Audit and Research Centre (ICNARC, an organisation

reporting on performance and outcomes for around 95% of intensive care units in England, Wales and Northern Ireland). This is reflected in some of the statistical data used in this report.

On this inspection, we visited the ICU on Wednesday 12 and Thursday 13 August 2015 and returned for an unannounced visit on the evening of Thursday 13 August 2015. We spoke with a range of staff, including consultants, doctors, trainee doctors, different grades of nurses, healthcare assistants and a member of the housekeeping team. We met with the consultant clinical lead for the service, the matron who ran the intensive care nursing team, and three of the four senior sisters. We spoke with the lead physiotherapist, a lead nurse from the Outreach team, the lead pharmacist, one of the volunteers and a secretary. We met with patients who were able to talk with us, and their relatives and friends. We checked all of the ICU clinical environment, observed care and looked at records and data.

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Summary of findings

We have judged the intensive care service as good. The service was providing safe, effective, caring and responsive treatment and care to patients. There were, however, elements within some of these areas requiring improvement. The overall governance of the service required improvement.

The service was delivered safely. There was a good track-record on safety with lessons learned and improvements made when things went wrong or should be better. There were low rates of infection and avoidable harm to patients. Staff responded appropriately to changes in patients' condition, although the intensive care outreach service (which provided support to staff caring for deteriorating patients elsewhere in the hospital) was not provided 24 hours a day. There were good levels of nursing and medical staff and agency nursing staff or locum cover was used infrequently. Patient records were clear and contemporaneous. Medicines were stored safely, were seen to be in date, and recorded accurately. The majority of staff mandatory update training compliance was high and most met trust targets.

The evidence of staff learning and sharing feedback from mortality and morbidity reviews was not well reported. There was insufficient cover to meet best-practice guidance from pharmacists and specifically physiotherapists. Some of the cover from the doctors at night did not meet the Faculty of Intensive Care Medicine (FICM) Core Standards guidance if the unit had a high number of patients.

Care was effective. The majority of treatment and care by all staff was delivered in accordance with legislation, standards, best practice and recognised national guidelines. There was a holistic, multidisciplinary professional approach to assessing and planning care and treatment, although insufficient input to patient treatment and recovery from the under-resourced physiotherapist and pharmacist teams. Patient-centred care was the focus for intensive care services. The intensive care unit (ICU) achieved good outcomes for

patients who were critically ill and/or with complex problems and multiple needs. There was a strong commitment to the successful programme of organ donation.

There was respected and high quality training and development in the ICU for trainee doctors. There were not, however, enough nurses with a post-registration qualification in intensive care nursing, which is an expectation of the FICM Core Standards. There were also incomplete records in relation to competency in equipment use having been assessed for the nursing team.

Staff were caring and compassionate. Patients were respected, valued and understood as individuals. Feedback from people who had used the service, including patients and their families, had been exceptionally positive. Staff delivered care with kindness, dignity, respect and compassion. Patient's cultural, religious, social and personal needs were respected and those close to them were involved with their care.

The intensive care service responded well to patient needs. The ICU team were organised, flexible and ensured patients who needed a bed were admitted. Some patients were delayed on discharge from the unit or discharged at night, when this was recognised as less than optimal for patient wellbeing. There were good facilities in the ICU for patients, visitors and staff, and these met the modern intensive care building standards.

Although there was good leadership and attention to a safe, effective, caring and responsive service, there was a lack of straightforward formal governance. Intensive care staff were committed to their patients and their unit with a shared purpose. A high level of staff satisfaction was found throughout the services. Many spoke highly of the positive culture and levels of constructive engagement, support and encouragement. There was a committed leadership from the consultants and the nursing team. The nurses were supported by an experienced matron who did, however, have extensive responsibilities beyond the ICU. There was no regular governance meeting for the whole intensive care service looking at a programme of audit; receiving and reviewing reports; developing shared action plans; and

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onward representation at key divisional governance meetings. The risks on the unit were mostly understood, but not being locally managed, or addressed by the board.

Are critical care services safe?

Good



We have rated the safety of intensive care services as good as people were protected from abuse and avoidable harm. There was a good track-record on safety with lessons learned from incidents and improvements made when things went wrong. Some incidents were, however, not being reported as they should. Patients were cared for to avoid harm. Duty of Candour was understood and followed so patients or their relatives were treated with openness and honesty. Staff responded appropriately to changes in risks to patients. There was an intensive care Outreach team providing a hospital-wide support service, although this was not 24 hours.

There was high-quality well maintained equipment and a safe environment. The units were visibly clean and well organised and most staff adhered well to infection prevention and control policies and protocols. This led to low rates of infection. There were mostly safe staffing levels, and wide-ranging and appropriate experience and skills among the teams of nursing staff. There was a strong commitment by the consultant intensivists who worked collaboratively. The medical staff cover was good at most times, although the trainee doctors did not meet the expectations of the Faculty of Intensive Care Medicine Core Standards in terms of cover at night.

Patient digital records were comprehensive, well maintained, clear, and contemporaneous. Medicines and consumable stocks were managed, stored and used safely. Staff were trained and experienced in recognising potential abuse of vulnerable people. Systems were in place to raise a safeguarding alert and staff were aware of their duty to report to external organisations responsible for protecting vulnerable people.

Learning from mortality and morbidity reviews was not evident from meeting minutes. The provision for pharmacist and physiotherapist services did not meet the recommendations of the Faculty of Intensive Care Medicine Core Standards in terms of staffing levels and this led to a reduced service at times.

Incidents

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- There were relatively low numbers of incidents of avoidable patient harm, unit-acquired infections, and errors leading to patient harm. In the 12 months from May 2014, from around 600 patients admitted to the intensive care unit (ICU), there were three falls, one of which led to patient harm. There were six grade three pressure ulcers (the second most serious category) but none of the most serious grade four category. The grade three pressure ulcers had mostly occurred in 2014 and there was just one reported in the four months of 2015.
- Staff were open, transparent and honest about incidents and reporting them. All staff we spoke with said there were no barriers to reporting incidents or near misses and they were encouraged and reminded to do so. Staff we talked with said incidents taking place and some near misses were reported, although in the report we were provided with, these were not clearly defined as one or the other.
- In the ICU information from the electronic incident reporting system indicated a relatively high level of incident reporting when comparing the quantity against other similar units. This could indicate a good reporting culture within the unit.
- We saw examples of actions taken following incidents. This included extra training at staff induction as well as to existing staff. In response to a rise in patient acquired pressure ulcers, new equipment for positioning and securing tubes was acquired.
- Delays or night time discharges of patients were not always reported, although these would have been classified as a patient safety incident.
- Most staff felt they had good feedback from reporting incidents. This included one-to-one teaching and development with staff or group sessions, the ICU staff monthly newsletter, handover sessions, and through action plans.
- Serious incidents were rare in the ICU. A serious incident in mid-2014 which had been classed as a 'Never Event' (Never Events are serious, wholly preventable patient safety incidents, which should not occur) An investigation into the incident commenced which led to a detailed root cause analysis. An action plan had been produced and learning shared more widely than just the ICU.
- Staff we spoke with were aware of the new regulation to be open, transparent and candid with patients and relatives when things went wrong, and apologise to them. In the review of a root-cause analysis from April

2015, the circumstances of the avoidable harm was reported to have been discussed with the patient's family and documented in the records. The Duty of Candour was also referred to in the intensive care staff monthly newsletter to remind staff of the requirement to explain and apologise when something of the nature described above went wrong.

- Patient mortality and morbidity (M&M) went through a structured review, although documented minutes did not demonstrate accountability for sharing learning from reviews of M&M. The lead consultant told us patients' deaths were graded against the classification of care from the National Confidential Enquiry into Patient Outcome and Death. If the care was graded anything from B to E (where there was room for improvement in care, or at worst (E) care was less than satisfactory) the shortcomings were described. However, this was not documented in the minutes so any emerging trends were not being captured. Although consultants we spoke with talked positively about the quality and depth of the M&M reviews, the minutes we saw did not record if any learning had been identified, if any actions were required, and by whom. There was a good attendance of multi-professional staff at the M&M meeting.

Safety thermometer

- Harm-free care was slightly below (that is worse than) the national average. During a 12 month period from August 2014 to July 2015, the ICU had reported 100% harm-free care for six of the 12 snapshot days. The average for the NHS intensive care units for these 12 days was 92% of harm-free care. The ICU at James Paget Hospital was slightly below the average at 89%.
- In accordance with best-practice, the ICU published avoidable patient harm data within the unit for patients, relatives and staff to see. Other audit data, including cleaning results, was also displayed in public places in a spirit of openness and transparency.
- In the ICU in the twelve months from May 2014 to April 2015 there had been six pressure ulcers of the more serious categories, which was around 1% of patients. Other patient safety indicators were not reported in the ward dashboards. This included incidence of venous thromboembolism (VTE) and urinary catheter infections (UTIs).

Cleanliness, infection control and hygiene

Critical care

- Rates for acquired infections on the ICU were low. All rates of infection had mostly been below (better than) the national average over the past five years. There was one unit-acquired methicillin-resistant *Staphylococcus aureus* (MRSA) infection in the 12 months to March 2015 (the most recent data provided). There were two patients with acquired *Clostridium difficile* in the same period, which was just above (worse than) the national average.
- There had been one MRSA infection in blood reported for June 2015. This was being investigated by the trust. Previously there had been no MRSA infections for five years.
- The environment and equipment in the ICU were visibly clean, well-organised, and tidy. Cleaning audits performed with good results which were published on the noticeboard for patients and relatives just inside the main entrance to the unit. The housekeeper we met was an experienced member of the team. They said they had the appropriate equipment and facilities to do their job.
- Equipment was stored and sealed to prevent cross-contamination. All disposable equipment was in sealed bags and placed in drawers or cupboards where possible to prevent damage to packaging. Equipment at the patient's bedside, such as oxygen or other tubes were plastic-wrapped to protect them from cross-contamination. Equipment returned from the equipment stores or elsewhere within the unit was marked with a green sticker to show it had been cleaned, before being stored, to prevent cross-contamination.
- Staff followed hand sanitising and personal protective equipment rules. Audits from January to April 2015 showed 100% compliance with hand-washing. We observed a small number of nursing staff carrying out multiple procedures on a few occasions without changing their gloves. Staff followed policy by washing their hands on arrival to the unit, between patient interactions and at all times using anti-bacterial gel. All staff were bare below the elbow (had short sleeves or their sleeves rolled up above their elbow) when they were within the unit.
- Visitors were required to follow infection control protocols. Staff requested them to wash their hands and use alcohol gel on arrival and explained why. Personal protective equipment was also available for visitors.
- Patients' safety in terms of the equipment and the patient environment was a feature of regular nursing observations and during staff handover times twice per day. The electronic record system required checks of equipment and the environment to be recorded individually. For example, oxygen, suction, the ventilator, monitors, pumps, the bed and patient bed space were checked for different safety elements.
- The unit conformed to the Department of Health 2013 guidelines for intensive care facilities (Health Building Note 04-02). The only area which did not meet the full recommendations of the guidance was, due to the layout of the unit (a long narrow ward), was that not all patients were visible from the central nurses' station. Patients in intensive care were, however, given close supervision at all times by the nurses, so the risk from this lack of visibility was managed.
- The units had appropriate equipment for use in an emergency, although the checking of the 'difficult airway trolley' was not carried out consistently. There was a resuscitation trolley for adult patients and for paediatric patients. Resuscitation equipment was checked daily with records showing completion.
- The ICU had facilities for completing some patient medical tests within the unit. The 'near-patient' or 'point of care' services included testing of blood gases, blood glucose, and CO-oximetry. Staff said the services were used by trained staff in conjunction with hospital laboratory guidelines.
- All the equipment in the ICU was maintained in accordance with manufacturers servicing guidelines. We reviewed the maintenance records for equipment including ventilators, syringe pumps, infusion pumps, defibrillators and haemodialysis machines. Of around 230 different items of equipment, all had been serviced appropriately.
- Clinical waste was effectively and safely managed. Single-use items of equipment were disposed of appropriately, either in clinical waste bins or sharps-instrument containers. We saw staff using and disposing of single-use equipment safely at all times.

Medicines

- Medicines were stored safely and appropriately. They were kept in a room locked with a coded keypad and were well organised. The keys for the controlled drug

Environment and equipment

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cupboards within the locked room were held by the nurse in charge. Fluids stored here and elsewhere in bulk storage were also locked away as required for safety and security.

- Medicines required to be refrigerated were kept at the correct temperature, and so would be fit for use. We checked the refrigeration temperature checklists in the ICU which were signed to say the temperature had been checked each day as required.
- Controlled drugs were managed in line with legislation and NHS regulations. Medicines were recorded correctly of booking into stock, administration to a patient, and any destruction in the controlled drug register. Stocks were accurate against the records in all those we checked at random. The controlled drugs were audited every three months by a member of the pharmacy team.

Records

- Patient records were well organised and completed. The ICU had recently introduced a new electronic patient record system which contained and managed the majority of patient information. Staff told us they were getting used to the new system and were positive about its introduction. The five digital records we reviewed had areas for medical and nursing review with clear prompts to guide staff to consider all relevant aspects of care. Records demonstrated personalised care and multidisciplinary input into the care and treatment provided. The system had a wide range of sections and there was some confusion among staff as to where to put specific comments, data or records. Staff were copying and pasting some information into other sections to make sure they were completed, which resulted in some inconsistency in record-keeping.
- Each patient had risk assessments completed on admission and appropriately reviewed. These included assessments for venous thromboembolism (VTE), pressure ulcers, and malnutrition. These were up-to-date and all interactions had been recorded. Staff signed into the system so records made were attributable to the member of staff caring for the patient and automatically timed and dated.
- Audits of the completeness of patient records were undertaken with good results. These were completed mostly by staff from other wards as a peer review. A review of two patient's records was carried out monthly and the audits showed good results for completion with

January and March 2015 having 100% completion rates. February's report had a 94% compliance score due to a failure to complete a VTE assessment. This had improved to 100% in March 2015.

- Patient records were secure and kept confidential. The recently upgraded electronic system meant patient records could only be accessed by staff with authorised access. We saw that all agency and bank staff were able to use the electronic patient record system. At no time did we see confidential patient information left visible or unattended on any screens or boards.

Safeguarding

- Safeguarding training covered vulnerable adults and children. Training was delivered to all staff on induction then updated at intervals as required by trust policy. Mandatory update training was delivered to all staff and 95% of staff had completed safeguarding children and adults training.
- There were policies, systems and processes for reporting and recording abuse. There were clear checklists and flowcharts for reporting concerns for both adults and children. The checklists included reference to the local authority policies and procedures and relevant contact details.
- Staff were aware of their responsibilities to report abuse and how to find any information they needed to make a referral. Staff were able to describe those things they would see or hear to prompt them to consider abuse of the patient or another vulnerable person. Staff were aware of their statutory duty to report their concerns. Most were aware of the teams within the hospital to contact, and others demonstrated where the information could be found on the trust intranet. We observed how staff considered a family's social situation in the daily ward round to look for increased vulnerability for the rest of the family from the patient being in hospital.

Mandatory training

- Most nursing, healthcare and administration staff were up-to-date with the latest mandatory training refresher courses. There were twenty training courses for intensive care staff which were mandatory in relation to specific staff roles. Of the 20 update courses, 17 had been completed by more than 90% of staff with four completed by 100% of staff. Of these, 13 had met or

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exceeded the trust target of 95% of staff being compliant with mandatory update training. Only 49% had completed blood transfusion and 60% safe use of insulin training.

- All the consultant intensivist staff were up-to-date with their mandatory training. There were comments alongside the records of the medical staff suggesting some did not require some mandatory training including dementia training. .

Assessing and responding to patient risk

- The nursing team and medical staff assessed and responded well to patient risk through regular review. Ward rounds in the ICU took place twice daily in the morning and evening. These were led by the consultant on duty each day and included the doctors and the nurses caring for the patient. The supernumerary senior nurse (sister or charge nurse) would join the whole ward round. Outreach nurses would also join the ward round.
- We attended a ward round and found that all patients were discussed. There were various standard but also personalised discussions around patients' treatment and care. The patient notes were available on a projector screen in the meeting room during the ward round and analysed for each patient.
- Patients were closely monitored at all times so staff could respond to any deterioration. Patients in the ICU were nursed by recommended levels of nursing staff.
- The hospital did not provide a 24 hour intensive care Outreach team. When the Outreach service was not available the Hospital at Night team reviewed patients. The Outreach service was provided by experienced and skilled nurses from 7am to 7:30pm, 365 days a year. The Guidelines for the Provision of Intensive Care Services 2015 (Faculty of Intensive Care Medicine, Intensive Care Society, and others) recommended Outreach services be provided 24 hours a day.
- There was a hospital and trust-wide standardised approach for detection of the deteriorating patient. The Vital Signs Observation tool was based upon the Royal College of Physicians National Early Warning Score tool and referenced the National Institute of Health and Care Excellence (NICE) clinical guideline. When a ward-based patient triggered a high risk score staff took the appropriate action. One of the triggers would include a review of the patient by the intensive care Outreach

team or the Hospital at Night team. The Outreach team or the patient's medical team were able to refer the patient directly to one of the ICU consultants for support, advice and review.

- There had been a recent snapshot audit of the hospital's use of the Vital Signs Observation (VSO) tool by the Outreach team (September 2014). This showed that staff were using the tool correctly. Of the 132 records reviewed, the early warning score (EWS) was completed in 91% of the records. Of the individual patient observations, between 93% and 100% were fully completed.

Nursing staffing

- There were safe nursing staff levels in intensive care in line with professional standards. Staff levels were planned in accordance with the NHS Joint Standards Committee (2013) Core Standards for Intensive Care. Therefore patients assessed as needing intensive care (described as level three) were cared for by one nurse looking after that one patient at all times. Patients assessed as needing high dependency care (described as level two) were cared for by one nurse looking after two patients.
- The establishment numbers were those nurses required for a unit with eight level three and four level two patients. This would require 11 staff on duty including a supernumerary sister in charge of the unit. The rotas demonstrated this nursing ratio was met although very occasionally with the use of agency or bank staff.
- The staffing levels on the ICU in January to July 2015 showed the unit always met or exceeded the establishment for healthcare assistants. The unit endeavoured to have one healthcare assistant on each shift. This was usually achieved and would improve when the one vacancy was filled. There was an apprentice healthcare assistant also working in the team mentored by the other healthcare assistants.
- Patients were kept safe by limiting use of agency staff (or bank staff who were not the trust's own staff) to a minimum. Data showed that the rates were mostly zero with a peak of 1.0% in April 2014 and all other months were below 1.0% usage.
- In the 2014/15 year there had been a turnover of around 10% of the nursing staff team. In the period from 1 April to 10 August 2015 there had been just under 3% turnover. Sickness among the nursing team was around

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5%. The rate was also reducing. The unit had filled all the vacancies from staff leaving and three band five nurses were due to join the team shortly. This would increase the team to the full establishment level.

- There was good handover among nurses when changing shifts. Patients were discussed in relation to updates on their risks, including communication, hygiene, malnutrition, fluid balance, pain, elimination, psychological markers, sleep or ability to rest, and risk of falls. This included information related to any patients who wished not to be resuscitated in the event of a cardiac or respiratory arrest (not for CPR), patients living with a dementia or other cognitive impairment, and other essential information.
- Senior nursing staff were generally supernumerary in order for them to manage the unit and nursing teams. The FICM Core Standards recommended a supernumerary clinical coordinator on duty at all times for a unit of this size. The staff rotas demonstrated there was at least one senior supernumerary nurse on duty at all times.

Medical staffing

- The ICU was led by an experienced consultant clinical lead supported by a skilled team. The clinical lead was a consultant in intensive care medicine and Fellow of the Faculty of Intensive Care Medicine (FICM). All eight consultants working on the primary rota were consultant intensivists and therefore highly experienced in delivering care to some of the most critically ill patients in the hospital.
- The level of cover provided by consultant staff exceeded professional standards. There were eight consultant intensivists working in rotation in intensive care and on call. There was a good consultant to patient ratio. There was one consultant on duty or on call across the ICU for an absolute maximum of 12 beds, with usually a maximum of eight patients at the highest level of critical illness (level three). This was better than the core standards recommended ratio of one consultant for a maximum of 15 patients.
- One of the consultant intensivists was on duty from 8am to 8pm and a second from 7pm to 1am, unless it was risk assessed as safe for the second consultant to go home earlier and be on call.
- Consultants attended the units out of hours when needed and often took calls from staff. This arrangement covered seven days a week with no

difference in the level of cover on the weekends or public holidays. When consultant intensivists were on duty or on call, this was only for intensive care and not extended elsewhere in the hospital.

- The level of cover provided by the trainee/registrar doctors did not meet the guidance at all times, particularly if the unit had a high numbers of patients. From 7am to 10pm there were three specialist registrar doctors with two on duty at any time. This met the recommendation of the FICM Core Standards for there to be a trainee doctor for no more than eight patients, and the unit could admit up to 12 patients. At night, there was one specialist registrar in the unit from 10pm to 7am. Although they were often accompanied up until 1am by a consultant this did not meet recommended safe levels of cover when there were more than eight patients on the unit.
- There was an excellent commitment of consultant time on the unit. The consultants worked in seven-day block rotas so there was a consistent level of involvement on the unit among the small team.
- There was good induction for locum doctors. Although they were used relatively infrequently, there was a locum registrar on duty during our visit. They had worked on the unit for around two months. They said they were well supported from a good local induction to guidance from the medical staff and nursing team. They were confident to contact consultants or other allied health professional's out-of-hours and felt a valued and respected part of the team.

Allied Health Professional staffing

- There was not always an adequate level of cover to the unit from the pharmacist team and medicine incidents were increasing. The ICU was reliant on advice and guidance about medicines from the experienced and knowledgeable lead pharmacist.
- If the unit was full with 12 patients and the levels of care were high, the FICM Core Standard 1.4.1 recommended there be one senior grade (band eight A or above) whole-time equivalent pharmacist providing a full service to the unit. There was only one senior pharmacist working on the unit four days per week, and they were also providing services elsewhere in the hospital. The cover had been estimated by the unit as providing between 0.1 and 0.2 WTE pharmacists. The pharmacist team provided a routine on-call service to make sure advice was available and provided at all

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times. The pharmacist service was supported by technicians who managed unit stocks and ensured medicines were regularly checked and a safe level of supply maintained.

- The senior pharmacist endeavoured to review every patient on the ICU each day, but new admissions could wait several days to be seen. The lead pharmacist was not able to attend a multi-disciplinary ward round each day. This did not meet the guidance of the FICM Core Standard 1.4.5. There had been a request in September 2014 to elevate this issue to the hospital risk register. The report had concluded the risk would be mitigated by using more input from trainee doctors and close review of medicine incidents. Despite this review in September 2014 there had been an increase in the number of medicine incidents. Between October 2014 and April 2015, there had been 11 incidents, which had increased from five in the preceding six months.
- Intensive care units were recommended to have one physiotherapist for every four beds (FICM Core Standard 1.3.7). If the unit was full (12 beds), the department would need three physiotherapists. There were 3.76 whole-time equivalent physiotherapists working on the unit, but they also had responsibilities for cardiology and respiratory medicine, three surgical wards, and cardiac rehabilitation among others. The team tried to come to the ICU twice each day, but this depended on the pressures elsewhere in the hospital.
- The dietician visited the ICU to see all patients twice a week and would visit at other times when requested. An emergency parenteral nutrition protocol had been produced for staff to use on the weekends or out-of-hours should a naso-gastric regime need to be commenced and a dietician was not on site. Speech and language therapists did not attend the units unless requested, but were available if needed for a patient review.

Major incident awareness and training

- The trust had a major incident policy (Emergency Planning, Resilience and Response Strategy) reviewed in February 2015. The plan referred to action cards which gave written instructions for key staff who would be involved in the organisation and management of a major incident. There had been a desk-top exercise in 2015 to review planned procedures.
- There were standard operating procedures for managing beds in a major incident. These included

liaison with the local NHS ambulance service to arrange for redirection of seriously ill patients if no beds were available at the James Paget Hospital (JPH) ICU. The operating procedures stated patients who were closer to the JPH would still be brought to the hospital's A&E in a life-threatening situation. The ICU would also contact other hospitals within the local East of England Intensive care Operational Delivery Network to look for opportunities for clinical transfer of patients.

- The hospital had the ability to temporarily increase its capacity to care for critically-ill patients in a major incident such as a pandemic flu crisis or serious public incident. This would involve primarily using the recovery unit in theatres which was adjacent to the unit. In these areas staff were trained in caring for critically ill patients and would be supported by the intensive care team. There were also good relationships with the local Intensive care Network from where help, support and advice could be sought and provided.

Are critical care services effective?

Good



We have judged the effectiveness of intensive care as good. The majority of treatment and care by all staff was delivered in accordance with legislation, standards, best practice and recognised national guidelines. There was an excellent multidisciplinary approach to assessing and planning care and treatment for patients, although insufficient input to patient treatment and recovery from the under-resourced physiotherapist and pharmacist teams.

Patient-centred care was the focus for intensive care services. Patients were treated in accordance with their individual needs and the overarching priority for staff. Good results were achieved for patients who were critically ill with complex problems and multiple needs. Length of stay for patients was mostly just above average, but this was affected by issues associated with delayed discharge to full wards. The unit recognised the provision of rehabilitation for patients did not meet all the requirements of the National Institute of Health and Clinical Excellence (NICE) guidance 83.

The unit followed national guidance in for the provision of ventilation, sedation, screening for delirium, oxygen

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therapy, pain relief, nutrition and hydration. The intensive care unit (ICU) achieved good outcomes for patients who were critically ill and/or with complex problems and multiple needs. There was good access to patient information, including diagnostic tests and screening across all seven days. Patients were assessed for their ability to make their own decisions and consent sought in accordance with legislation and guidance. There was a strong commitment by staff to support the successful programme of organ donation.

There was respected and high quality training and development in the ICU for trainee doctors. We had overwhelmingly positive comments from all the trainee doctors we met on the unit. There was a dedicated training programme for the nurses from a fulltime clinical nurse educator. There were, however, not yet enough nurses with a post-registration qualification in intensive care nursing. Of the current nursing team, 42% had this qualification, against a target of 50%. More training sessions had been obtained for later this year which would bring the level to 50%. There were also incomplete records in relation to equipment competency assessments for nurses and the National Competency Framework for Adult Intensive care Nurses was not yet being used to assess competency.

Evidence-based care and treatment

- Patients were staying on the unit for an average length of time. The length of stay for all admissions in the intensive care unit (ICU) in the year from April 2014 to March 2015 was around five days, compared with the national average of around 4.5 days.
- Patients' care and treatment was assessed during their stay and delivered along national and best-practice guidelines. The ICU, for example, met most of the requirements of the key National Institute of Health and Care Excellence (NICE) guidance appropriate to intensive care units. The ICU had reviewed itself against these standards and most elements were being met.
- There was an element of NICE 83 not being met in relation to rehabilitation post discharge from the unit or hospital. This was in the area of providing patients with a structured and supported self-directed rehabilitation manual for use for at least 6 weeks after discharge from intensive care. However, there was a well-established nurse-led follow-up clinic for patients, although this was not being funded. This determined if patients needed further input after two to three months.
- The provision of rehabilitation did not meet best-practice guidance at all times. Due to a shortage of physiotherapist staff not all patients received a rehabilitation assessment within 24 hours. This initial assessment was often carried out by the medical staff and not a physiotherapist. Patients were not always receiving 45 minutes of each relevant active therapy each day for a minimum of five days per week. This was a recommendation of the Faculty of Intensive Care Medicine (FICM) Core Standard 1.3.4.
- The service had been collating evidence of how often this did take place and the results showed 50% had a review within 24 hours. The number of patients who had an entry in their notes each day was 48%. Rehabilitation plans had been produced for 65% of patients and 30% had goals. There were only 5% with both a plan and goals laid out. The physiotherapist team were also concentrating predominantly upon respiratory therapies and not musculo-skeletal or rehabilitative care. The senior team in the service were aware of these shortcomings in provision and a request had been made to raise this issue to the trust risk register.
- Patients were safely ventilated using recognised specialist equipment and techniques. The unit also used non-invasive ventilation to help patients with their breathing using usually masks or similar devices. All ventilated patients were constantly reviewed and checks made and recorded hourly.
- The ICU followed NHS guidance when monitoring sedated patients. In the ICU each sedated patient was assessed each day in line with the Richmond Agitation Sedation Scale (RASS) scoring tool. Sedation was then withdrawn, continued or adjusted dependent upon how the patient reacted to the change. The results were recorded in the patient's notes and able to be charted for an overview.
- Patients admitted to the ICU were formally assessed using recognised tools for delirium. The FICM Core Standards recommended all patients were screened for delirium with a standardised assessment tool (usually the confusion assessment method, often called CAM-ICU). Clinical staff recognised the need for delirium screening as the condition was often one of the first indicators of a patient's health deteriorating. Delirium assessments were being used in the ICU and part of the daily observations and patients were reviewed for any signs of not being completely themselves.

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- Patients in the ICU were assessed for risks of developing venous thromboembolism (VTE) from spending long periods of time in bed or immobile. There was a daily review of patients to ensure risks from developing VTE (also known as deep-vein thrombosis) were fully assessed. Where needed, patients were provided with preventative care such as compression stockings and sequential compressions devices.
- The ICU took advice and guidance in relation to best-practice for patients with Acute Respiratory Distress Syndrome (ARDS). This is a condition where the lungs do not provide enough oxygen for the rest of the body. Patients with this condition would be discussed with the local Extra Corporeal Membrane Oxygenation (ECMO) team as recommended by guidance from the National Institute for Health and Care Excellence (NICE) interventional procedure guidance 482.
- The ICU met best practice guidance by promoting and participating in a programme of organ donation led nationally by the NHS Blood and Transplant service.. As well as the experienced consultant intensivist leading on the work there was a specialist nurse for organ donation. They were employed by NHS Blood and Transplant, but worked with the hospital to directly support the organ donation programme and work alongside the clinical lead.
- As is best practice, the clinical lead led on organ-donation work for the trust. Referral rates in the year from April 2014 to March 2015 were 97%, compared with the UK average of 80%. The clinical lead for intensive care reported to staff there was a 100% referral rate of all potential organ donors in the month of July 2015. Staff were reminded when it was appropriate to refer patients and how the clinical lead was available 24 hours a day to provide advice and support for organ donation.
- There had been 25 patients eligible for organ donation during the previous year to March 2015. Of these, 13 families were approached to discuss donation. Eleven of these families (85%) were approached with the involvement of the specialist nurse, against a national average of 78%. Evidence has shown there is a higher success rate for organ donation if a specialist nurse is involved with discussions with the family. The average number of 3.8 organs donated per donor was better than the UK average of 3.4.
- Patients were given effective pain relief and strategies were based upon best practice. Patients' pain was observed or discussed and responses recorded by the nurses. Pain relief was adjusted in accordance with the response and the patient's prescription. Patients who were able to talk with us said they felt their pain was well managed. One patient we met said the nurses had, with the doctor's approval, reduced and then stopped giving them pain relief as they had decided they did not need it so frequently.
- There were protocols for safe use of pain-relief medicines. Clinicians were able to describe the use of different protocols for patients with differing needs.
- There was consideration for patients who were unable to communicate if they were in pain. This was carried out through subjective observation of pain (including movement or facial expressions or through physiological monitoring systems. For patients living with dementia, the Abbey Pain Scale tool was found helpful to identify pain. One of the consultant team spoke constructively and with compassion about assessing pain in people with cognitive impairment or communication problems. Following the administration of pain relief changes from observations of the patient were then recorded to allow a review of effectiveness.
- There was access to an acute pain team supported by a consultant and nurse qualified in specialist pain management. Staff in intensive care said they had a good relationship with and support from the pain team who were available during normal working hours for advice and guidance. Out of hours, the anaesthetists on duty could provide specialist pain advice and treatment.

Nutrition and hydration

- Patient nutrition and hydration needs were assessed and effectively responded to The patient records we reviewed in the ICU were fully completed, and safe protocols followed. Hourly fluid intake and output was measured, recorded and analysed for the appropriate balance, and any adjustments necessary were recorded and delivered. The method of nutritional intake was recorded and evaluated each day. Any required feeding through tubes or intravenous lines (enteral or parenteral feeding) was prescribed, evaluated and recorded.
- The unit had guidance, protocols and support for specialist feeding plans, although limited time was available from the dietician. A dietician attended the ICU on weekdays to support patients with naso-gastric

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tubes, total parenteral nutrition (TPN) feeding (nutrients supplied intravenously through a central line), and Percutaneous Endoscopic Gastronomy (PEG) feeds. TPN was kept in stock on the unit (in plain form) for use when required and the protocol was to commence feeding as soon as possible. There were dietician-designed and approved protocols for nursing staff to commence enteral feeding on weekends or when a dietician was not available. Nutrition care plans were drawn-up for all patients to identify patients who needed further supplements. Energy drinks and food supplements were prescribed and used for patients who needed them.

- Staff were competent in giving intravenous fluids. Adults receiving intravenous fluid therapy were cared for by staff competent in assessing patients' fluids and electrolyte needs, prescribing and administering intravenous fluids, and monitoring the patient.
- Patients could take their own food and fluids if they were able. For patients who could help themselves, particularly patients who were fit for discharge, drinks and any meals were available on bedside tables and within reach of patients.

Patient outcomes

- Patient outcomes were routinely captured and monitored against those achieved nationally. The ICU demonstrated almost continuous patient data contributions to ICNARC for at least the last five years. Due to problems with a new computer system, the data for the quarter October to December 2014 had not been submitted. This participation provided the ICU with data benchmarked against other units in the programme and units similar in their size and patient type. The ICU had been contributing a high standard of data: meaning the records submitted were mostly complete and could be evaluated and compared.
- Almost all patients were able to be admitted to the ICU at James Paget Hospital when they needed to be. Some ICU patients were transferred to other units for non-clinical reasons, although infrequently and much the same as the average when compared over time with other similar units. On the occasions this did happen it was usually due to a bed not being available when required in the ICU.
- Mortality levels of the three months from January to March 2015 were just above (worse than) the national average and expected levels, but overall similar to the

vast majority of intensive care units nationally. In the three month period from January to March 2015 there were 45 deaths. This was against a prediction of 40 deaths (ICNARC 2013 model). Over the past five years, the ICNARC data showed a relatively stable trend with mortality levels below (better than) the national average and expected rate.

- The unit participated in national and local audit and research. In national audit, the unit had contributed to the National Confidential Enquiry for Patient Outcome and Death (NCEPOD) 'On the right Trach': A review of the care received by patients who underwent a tracheostomy (2014); and the ICNARC National Cardiac Arrest Audit. The tracheostomy review was carried out in 2014 and updated in May 2015. Of the 25 recommendations, 18 were met, seven were partially met and one was not met. Those partial or unmet recommendations had action plans, timescales and staff names as responsible for completing the actions.
- The ICU was an active member of the East of England Intensive care Operational Delivery Network. There had been a local review in June 2015 with a peer review report. The report had made a number of recommendations in line with the Core Standards, but the majority of the review was positive on aspects of care, facilities and the environment.
- Patients were followed-up with any new test results once they had been discharged from intensive care. The service had developed a process to ensure patient results and reports, from non-standard investigations, were forwarded to the wards or a GP once a patient had been discharged. There was a whiteboard in use in the seminar room for reminding staff to follow-up and report upon tests which would typically take longer than normal and might return once the patient had been discharged. Staff said they had no problems with contacting the patient's parent consultant (the consultant who was responsible for the patient outside of the ICU) and these results being appropriately followed-up.
- Patients were given effective treatment without discrimination through the use of staff mandatory training and policies assessed and approved for equality and diversity. Staff spoke about respecting people's wishes, rights and beliefs. They were able to describe a wide range of different needs and would often talk about patients' individuality and right to be different.

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Competent staff

- Staff were assessed each year through appraisals for their competency, skills, and development. Staff in the service received appraisal. Overall, 86% of the non-medical staff in intensive care had been appraised by March 2015. 100% of the non-medical staff in the Outreach team had been appraised by March 2015.
- Medical staff were evaluated by their professional body for their competence. The consultants we met said the Revalidation Programme was well underway. Appraisals of medical staff were carried out each year and evidence demonstrated they were up-to-date. Consultants talked about good shared learning in the hospital and the service. Consultants shared learning from any courses or educational seminars they attended and articles they had read or contributed to.
- Nursing staff competence in the use of the specialised medical equipment was not being fully recorded. There were forms for nursing staff to complete indicating they had training and were competent with medical equipment used in the unit. These were then signed and dated by the assessor. Although these were completed and available for some staff, they were not for all the nursing team, so competence was not able to be demonstrated overall. The ICU was also not using the National Competency Framework for Adult Intensive care Nurses, although we were told there were plans to introduce this in the near future.
- The unit had admitted very few children, around one per month. The unit did not admit children unless there was an emergency or the child was being looked after while awaiting transfer to another hospital. We were told children had also been admitted to the unit for post-operative care before being returned to the ward. As there were no registered sick children's nurses (RSCN) among the nursing team paediatric anaesthetists, consultants and nurses from the children's service were used to provide support, advice and guidance to the unit.
- There was commitment to training and education within the ICU. The FICM Core Standard 1.2.6 was being achieved with the appointment of a full-time CNE. The CNE held monthly half-day training sessions for staff with sessions each other month for the more experienced or senior staff. There was one-to-one bedside training and development for all staff at other times. Staff said training and development was of a high standard.
- There was good support for new nurses, student nurses, and healthcare assistants in the ICU. There was a 'new starters' programme for the new nurses, who were supernumerary for six weeks. After the induction period, new nurses were paired with more experienced staff to provide guidance and support. They were required to complete workbooks and have these signed-off by their mentor. This ensured they were competent in the use of equipment and skills needed to safety care for patients. Nurses were provided with mentorship courses to ensure they were able to provide competent advice and support.
- Student nurses were provided with a welcome pack explaining their role, the names and roles of key staff, and an induction checklist. There was an introduction to the unit, but we noticed this was out of date, as it stated the unit had eight beds and not 12. The expansion had occurred around five years previously so this document was significantly out of date for review (although it had been updated in other documents such as the agency-nurse induction booklet).
- There was an induction for any agency nurses recruited temporarily to the unit. The use of agency staff was very low, but staff said the induction checklist and presentations on patient assessments and infection control were required to be understood before agency staff worked with patients.
- There was an experienced nursing team in the ICU in line with the FICM Core Standards, but the requirement for post-registration training did not meet recommended levels. As There were 42% of nurses in the ICU with this qualification but two intensive care training modules had been secured for nursing staff which would bring the unit up to the minimum recommended level by April 2016. More than 50% of nursing staff should have a post-registration qualification in intensive care nursing.
- Nurses had a range of link roles. They included nurses leading on such subjects as non-invasive ventilation, patients with learning disabilities, infection control, paediatrics, rehabilitations, bereavement, and skin integrity. There were also 'champions' among the nursing team who would look at broader subjects such as mental health.

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- There was excellent support to trainee doctors. The feedback we received from the trainee doctors was universally positive. The three we met said they felt valued members of the team and would recommend the hospital for training. The consultants were approachable and provided good supervision and support. There was a training programme for foundation year (FY) trainee doctors led by the clinical lead consultant with presentations by registrars. There was a programme of induction to the ICU for new doctors spread over two or three weeks. Those doctors we met said they had not been asked to work outside of their competencies. They said senior consultants and more experienced registrars were always available and willing to teach and support.
- Patients discharged from the ICU were reviewed by the intensive care Outreach team. The team also supported staff caring for patients on wards with tracheostomies, having continuous positive airway pressure management (for patients with breathing problems), central lines (for delivery of fluids, medicines, nutrients, or blood products), or receiving non-invasive ventilation therapies.
- An external review had commented positively on the multidisciplinary teamwork on the ICU. The East of England Intensive care Operational Delivery Network visited the unit in June 2015 to undertake a peer review. The report commented upon the “excellent ethos of multidisciplinary working and a collaborative approach to patient care.”

Multidisciplinary working

- There was good multidisciplinary working. All the different disciplines needed to provide effective care were involved with the patient care, although some was limited in scope due to staff shortages. This included input from the pharmacist team, physiotherapists, dieticians, speech and language therapists and other specialist consultants and doctors. The physiotherapists had a brief multidisciplinary meeting with the nurse in charge and consultant on duty each day to discuss treatments to be provided. There was daily support on a Monday to Friday from a microbiologist who completed a ward round and, we were told, proactive on-call arrangements. The microbiologist would review all level three patients each weekday with the consultant on duty. Other patients would be reviewed each day if required or as appropriate. Other members of the multidisciplinary team would be involved as requested or needed.
- There was good multidisciplinary team working with other services in the hospital. The intensive care lead consultant and matron said the surgery and medical teams were collaborative in their approach to the patient. They recognised the need to have a structured, formalised, timely and effective handover from intensive care. We observed a good example of the multidisciplinary approach when a consultant neurologist came to the unit to discuss a patient with one of the consultant intensivists. This was a good professional interaction and demonstrated an open and patient-centred approach.

Seven-day services

- A consultant intensivist was available across the whole week, and to lead the two ward rounds every day. When they were not on duty in the unit, there was good cover from the consultant intensivist team.
- There were arrangements for pharmacist services to be provided across the whole week for the ICU. During weekdays, the pharmacist team were available on the hospital site in the day time. Arrangements were in place for the supply of medicines when the pharmacy was closed. The pharmacist team worked to ensure those medicines used regularly or infrequently, but needed for a complex patient, were available for supply out of hours. A pharmacist was also available on call in the evenings, at night and on weekends.
- Access to clinical investigation services was available across the whole week. This included X-rays, magnetic resonance imaging (MRI) scans, computerised tomography (CT) scans, electroencephalography (EEG) tests (to look for signs of epilepsy), endoscopy, and echocardiograms (ultrasound heart scans). Consultants and registrar doctors said requesting tests was straightforward and there was a good service. The trainee doctors said there was no problem with them requesting and receiving diagnostic tests. Certain tests required consultant approval, and registrar doctors were aware of the protocols for ordering these.
- Therapy staff were available in person or on call across the whole week. If therapy staff were off duty, there was access to certain staff out-of-hours through on-call rotas.

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Access to information

- Information needed to deliver effective care was available and accessible. The largely electronic patient database in the ICU was almost fully established and accessible to the ICU staff where they were working throughout the hospital. Some staff, such as on-call consultant intensivists, were going to be provided access to the system from home in the future. The rest of the hospital used paper-based notes and these were used in the ICU for background information when a patient was admitted. Staff said records available at the hospital were provided relatively quickly in emergency admissions. Patient notes made in the ICU could be printed in varying degrees of detail to accompany the patient when they were discharged. Letters to GPs or other primary care providers were also produced from the system. The electronic notes meant the patients' records were easy to find, review and research.
- Access to patients' diagnostic and screening tests was good. The medical teams said results were usually provided quickly and urgent results were given the right priority. There was a range of 'near-patient testing' equipment on the unit to provide fast results for certain tests.
- There was good access to intranet-based guidance, policies and protocols. The trust intranet was open and available to all authorised staff. The data within it was locked so it could only be amended, deleted or changed by authorised personnel. There were protocols, policies and guidance for clinical and other patient interventions and care.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients gave their consent when they were mentally and physically able. Staff acted in accordance with legislation and guidance when treating an unconscious patient, or in an emergency. Staff said patients were told what decisions had been made, by whom and why. A review of consent in patient electronic records showed it had been considered and recorded by an appropriate member of the medical team. One of the consultant intensivists we met on our unannounced visit had a particularly clear and correct understanding of consent, the Mental Capacity Act and Deprivation of Liberty Safeguards and an interest in medical law.

- Staff had a good understanding of the Mental Capacity Act 2005. There was a mental capacity assessment record which was completed for all patients. This was used to determine if there were any reasons to suggest a patient did not have the capacity to make their own decisions. Staff told us there were arrangements within the hospital to provide an Independent Mental Capacity Advocate (IMCA) if a decision was needed in a patient's best interests and the patient had no family or friends to speak for them at the time.
- There was a good understanding among staff of the Deprivation of Liberty Safeguards (DOLS) and when to apply them. There was guidance, training and a checklist to direct staff in how to proceed where there was an indication of a patient being or potentially being deprived of their liberty at the time or in the near future. Staff described circumstances when this might be appropriate and how any decision would be made. The trust policy on DOLS was clear and followed the statutory framework of the Mental Capacity Act 2005 and supporting Codes of Practice. There was a folder with specific information and guidance for staff located at the nurses' station. A number of staff, both medical and nursing referred to it when discussing DOLS as a resource for guidance and direction.
- Staff understood the difference between lawful and unlawful restraint. The ICU had low-impact aids to protect patients if restraint was needed as a last resort. This could be used, for example, when a patient was assessed as at risk from pulling out their medical devices, such as tubes and lines. Details of the use or approval of any physical restraint techniques would be recorded in the patient's notes.

Are critical care services caring?

Good



We have judged the care given to patients using intensive care services as good.

People were supported, treated with dignity and respect, and were involved as partners in their care. Feedback from people we met in the intensive care unit (ICU) and who had written to the staff, including patients and their families, had been overwhelmingly positive.

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Patients said staff were professional, caring and compassionate, treated them with dignity and respect, and made them feel safe. Patients, their family or friends were involved with decision making. They were able to ask questions and raise anxieties and concerns and received answers and information in a manner they could understand.

We observed staff treating patients with kindness and warmth. The unit was busy and professionally run, but staff always had time to provide individualised care. Staff talked about patients compassionately with knowledge of their circumstances and those of their families.

Compassionate care

- All the patients and relatives we met spoke highly of the care and consideration they received. Patients we were able to speak with said staff were caring and compassionate. Those we spoke with said they were being well cared for. We also read cards and letters sent to the unit and comments from the surveys sent to patients and their relatives. Patients had commented on how the staff were “an incredible professional group” and “every nurse was dedicated and professional”. Another card said how the family was “supported at all times by the staff.”
- All patients and relatives said privacy and dignity was maintained. They said curtains were drawn around patients for intimate care or procedures. We observed good attention from all staff to patient privacy and dignity. There were signs on curtains asking people not to enter when they were closed unless they asked first. Voices were lowered to avoid confidential or private information being overheard.
- Patient’s preferences for sharing information were respected. When a patient was able to communicate, staff would review with them how, when and what information could be shared with the patient’s partner, family members, and carers. If a patient could not communicate, staff used their best judgement and previously available information to share information appropriately and sensitively. The unit had organised a password scheme with the relatives of some patients. This meant family members were able to call the unit by telephone and be able to ask questions and receive answers about their loved ones by giving staff their agreed password.

- All healthcare professionals involved with the patient’s care introduced themselves to patients, explained their roles and responsibilities. We witnessed this from many of the patient interactions we observed, even if the patient was drowsy or confused. Families we met also said they had been introduced to staff. They said the nurses looking after their relative would introduce themselves and explain their role. Relatives also said staff would tell them what they were doing and why. They checked with the relative if they were comfortable remaining at the bedside for some procedures, but would ask the relative to take a short break for intimate procedures.
- Visiting times were flexible to meet the needs of the patient and their loved ones. There was limited space in the units and visitors were asked to restrict numbers where possible, as too many visitors had been recognised as tiring for patients in intensive care. However, staff said they would accommodate visitors as much as possible at all times and those visitors we met agreed.

Understanding and involvement of patients and those close to them

- Patients were involved with their care and decisions taken. Those patients who were able to talk with us said they were informed as to how they were progressing. They said they were encouraged to talk about anything worrying them. They told us communication was good, and this had extended to talking with their families. We observed doctors and nurses in the intensive care unit (ICU) talking inclusively with patients and their relatives. They sought verbal consent from patients, discussing and offering care and treatment, and involving the patient to make their own decisions. A patient wrote recently to the ward after completing their treatment and said “thank you for all the care and attention given to me.”
- Staff communicated with relatives and friends of patients and sought their views with empathy. The views of relatives and carers were listened to and respected. We attended, with permission from the relative, a discussion about a patient with the consultant and a nurse. The consultant explained about the patient’s current condition and the need for an invasive procedure. The explanation was given in simple terms as requested by the relative. The consultant made sure

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the relative understood each point before proceeding to explain other things. Interactions from the nursing staff showed care and consideration for the family. Visitors were welcomed on the unit and encouraged to ask any questions that arose. A card from a family of a patient on the unit said how the staff had kept a family informed of changes in a patient's condition, and being open and honest with them about the prognosis.

Emotional support

- The ICU had introduced the use of the patient diary for longer-stay patients. Research has shown how patients sedated and ventilated in intensive care suffer memory loss and often experience psychological disturbances post discharge. Diaries have been shown to provide comfort to both patients and also their relatives both during the stay and post discharge. Diaries were usually started when the patient had been admitted for three days. Staff and visitors were encouraged to write in the diary with non-clinical entries.
- Staff understood the impact a patient's care, treatment or condition might have on their wellbeing and on those close to them both emotionally and socially. There was good support from the hospital multi-faith chaplaincy team who were on call at all times for patients, their family and friends and also staff. There was a team at the hospital who could be contacted to support patients and their families if the patient was recognised as at the end of their life or in need of palliative care. The trust also had a support from a palliative care facility, the Louise Hamilton Centre, based on the site. Staff spoke about the service having provided patients and families with, among other things, bereavement support, carer support, complementary therapies, counselling and specialist welfare advice.

Are critical care services responsive?

Good



We have judged intensive care services as good for responsive care. Services were planned and delivered to meet the needs of local people. There were good facilities for patients and relatives, although those for relatives were limited in what they provided. The service met people's individual needs and took account of best practice with the

provision of patient follow-up clinics (although these were not funded). There was, however, no provision of mental-health services if needed for patients or their families who had received intensive care.

Patients living with a dementia or a learning disability were well supported, although there was no specialist care plan for caring for those living with dementia. The unit was professionally run with a caring attitude, but noise on the unit was sometimes not recognised for its ability to disturb patients.

Patients were enabled to get a bed in the unit when it was needed. This was despite there being issues in the rest of the hospital leading to many patients being discharged more than four hours after they were deemed medically fit for discharge. Some patients were also discharged at night, although this was below the average when measured against similar units.

Service planning and delivery to meet the needs of local people

- The service had been designed and planned to meet people's needs. This unit had rarely been unable to provide a critically unwell patient with a bed and the care and treatment they needed. The ICU met the recommendations of the Department of Health guidelines for modern intensive care units as they related to meeting patient needs and those of their visitors. These included: Bed spaces were capable of giving good visual and auditory privacy, natural daylight for all bed spaces, use of a shower or a toilet. There were separate entrances to the unit from within the hospital corridors ensuring visitors did not observe patients arriving and leaving the unit and ceiling-mounted hoists for lifting patients.
- There was access to a Regional Home Ventilation and weaning unit. There were arrangements in place to transfer patients who needed long-term weaning treatment to a specialist centre, which could then arrange for home ventilation if this was appropriate.
- There was a policy outlining which patients would be suitable for admission to intensive care. This policy described those patients who would benefit from intensive care and thus be considered for admission. The policy went on to say how they wishes of patients who had an Advanced Directive to refuse intensive care would be followed. Early intervention by a consultant intensivist or the intensive care outreach team would be

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considered prior to admission to determine if the patient could remain cared for on the wards. Patients who were potential organ donors would be, nevertheless, be admitted to the ICU. There was a clear flowchart for staff to follow to determine if a ICU admission was appropriate.

Meeting people's individual needs

- The services reflected the needs of the local population. There were no apparent barriers to admission due to a patient's age or gender.
- Due to issues with patient flow on the wards, and the nature of intensive care services, the ICU was rarely able to meet gender separation rules for patients. Department of Health guidance recognised gender separation was difficult to fully manage in units like the ICU. Delays in discharge from intensive care to a ward bed (around 60%) meant that the unit on occasion breached the same-sex rules.
- The unit followed best-practice in providing follow-up clinics for discharged patients. This had been taking place for almost 10 years. Those patients who had been ventilated for more than three days, were invited for a nurse-led review two, six and 12 months after their discharge from intensive care. The nurses were able to refer the patients to other secondary care if appropriate. This included referral to speech and language therapists if patients were having difficulties with swallowing, for example.
- There were two relatives' rooms just inside the unit for visitors use. Drinking water was available and one relative room had a television. There was a toilet, but no shower facility if a relative had remained with the patient overnight. There were no facilities for visitors to make a hot drink, although there were café facilities within the hospital open in daytime hours. There was a small sofa bed for a visitor to sleep overnight on the unit. Otherwise staff would look for accommodation in the hospital if it was available or direct people to accommodation in the nearby area.
- Patients with a learning disability were supported by trained and experienced staff through a highly-regarded hospital liaison nurse. The ICU also had a link nurse who could provide guidance and advice to the team. Carers were encouraged to stay with the patient when and where possible to provide support. Patients who came to the hospital from a community care setting were asked to bring or produce a 'hospital passport'. This is a

recognised document used for people who live with a learning disability, so staff are able to know as much about them as possible including the persons preferred form of communication. There had recently been a multidisciplinary meeting held before a patient with a learning disability was admitted to the unit. This had helped to support staff and the patient themselves.

- Patients living with dementia were supported well, but without use of specific care plans linked to national strategies. All the staff we spoke with had good knowledge of the different needs of patients living with a dementia or any other vulnerable circumstances. There were liaison nurses within the hospital to provide support and advice and a link nurse within the ICU. Local strategies in the ICU included using bed spaces in quieter areas and or getting support from carers. Patients were identified with the use of specific coloured wristbands to make staff aware or remind them of the patient's different needs. The units did not, however, have specific care plans based upon national guidance, such as the Department of Health National Dementia Strategy 2009.
- Although recognised by the consultants for its importance, there was no support available to patients in intensive care with psychological problems or anxieties.
- There was limited awareness amongst staff of the level of noise within the unit. This may have disturbed patients who were trying to rest. We witnessed staff moving a noisy trolley through the unit. Once highlighted to staff they agreed the trolley itself was not constructed in such a way to move it quietly through the unit.
- Patients' needs around orientation and therefore the time, day and date were being met. Clocks were able to be seen from each bed and each side room had its own clock. The unit was above ground and there was natural light to help with orientation to day and night for patients.
- Patients and visitors were given good information about intensive care. There was a good range of booklets, leaflets and information for both patients and families, but very limited information about intensive care on the trust website. The leaflets available in waiting areas and rest rooms explained aspects of the environment and specific treatments. There were leaflets and booklets about managing disease and illness, prevention of conditions associated with hospital stays such as deep

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vein thrombosis and pressure ulcers, decisions relating to resuscitation, and information on 'After HDU Care' which was, however, very out of date for review. Most leaflets produced by the hospital trust contained instructions about how to obtain the information in another language or format.

Access and flow

- Patients were given access to the service when it was needed. Non clinical transfers were rare occasions. This was because there was good bed management, flexible staffing, manageable occupancy levels, and a determination to ensure a bed on the unit was kept available for use in an unplanned emergency.
- The ICU nursing staff were involved in daily hospital-wide bed meetings to discuss patient access and flow. Patients who were fit for discharge would be discussed at these meetings along with any patients who potentially needed an intensive care bed. The matron told us intensive care had been included in bed meetings about 18 months ago. This had helped to raise awareness of access and flow pressure within intensive care with the rest of the hospital.
- Delays in discharge from the intensive care unit was similar to the England national average of 60%. Delays were mostly less than 24 hours (64%) however 5% waited between three and seven days for discharge from the unit. Delays in discharge can lead to stress and other psychological problems.
- Delays to discharge, but also faster recoveries, meant some patients went directly home from the unit rather than stepped-down to a ward. This was due in part to delays in discharge from appropriate ward beds not being available elsewhere in the hospital, but also the faster recovery for some specific patients.
- The intensive care unit was below (better than) national averages for moving patients at night. In the first quarter of 2015 the out-of-hours discharges were 8% of all discharges (11 from 142 patients) against a national average of 7.5%. Rates had fluctuated in different quarters but for the last two years had almost always been below the national average.
- Occupancy rates within the ICU were in line with the national average. There were large fluctuations of occupancy rates at James Paget Hospital in January 2015 the occupancy was 92%, whereas in February and

March 2015 it was 50%. However whilst the recommended level is 70% the NHS average was 85%. James Paget Hospital was currently at 83% in June 2015.

- ICNARC data from January to March 2015 showed that there were fewer patients than average transferred into the unit from an high dependency unit (HDU) or intensive care unit (ICU) in another hospital, and this was usually the case. The rate of planned transfers was below the national average for similar units in the first quarter of 2015, and prior to this, had also been mostly below average.
- Patients were sometimes transferred to other units for clinical reasons. Usually transfers out were for patients to be accommodated closer to home or for specialist care. Transfers had been mostly below (better than) the national average for the last five years, and the rate had fallen to almost zero each quarter in the last two years. There were no patients transferred out in January to March 2015.
- There were some planned operations cancelled due to lack of an intensive care bed or enough staffing, although inconsistent information as to how many. Information provided to NHS England showed 54 elective operations cancelled between January and June 2015 (none were cancelled more than once) due to the lack of a bed in the ICU. The data supplied to the local East of England Intensive care Operational Delivery Network, however, showed no operations cancelled in this period. Nursing staff were able to demonstrate there were some operations cancelled, but not as many as were reported to NHS England.
- There were standard operating procedures for managing patient access and flow. The procedures for bed management when demand exceeded supply started with senior staff in the ICU contacting the site manager. They looked at ways to manage the problem within the ICU before discussing managing patients within the theatre recovery room. If this needed to happen, the patient would come under the care of the ICU consultant intensivist. The nursing staff cover would either come from the ICU nursing staff or arrangements would be made to allocate suitably skilled staff.

Learning from complaints and concerns

- There was information available in visiting areas and on the trust website outlining how to make a complaint and how it would be dealt with. The leaflet in the

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waiting room explained the purpose of the Patient Advice and Liaison Service (PALS). Patients, relatives, carers and member of the public were informed they could talk with PALS about any issues, even if they did not want to raise a formal complaint. Contact information and how to access an interpreter or person to communicate in sign language was included in the leaflet. The ICU staff said they would attempt to resolve any complaints or concerns as soon as they became aware of them. The senior sisters would be made aware of any concerns and got involved with resolving them quickly.

- There had been some complaints relating to intensive care services, although, we were told, a number of these had been wrongly attributed to the department. They were otherwise infrequent. We discussed the themes from the complaints with the matron. They had involved lack of communication to patients and relatives and some around the attitude of the nursing staff. All complaints were investigated by one of the senior sisters and reviewed by the matron. The clinical lead encouraged and supported the involvement of the consultants and doctors in any response or investigation.
- Complaints were addressed and learned from. They were discussed in the unit and at divisional governance meetings. A complaint received in April 2015 was mentioned in the newsletter and discussed in the consultant forum and divisional clinical board meeting. Staff we spoke with were aware of the complaint and talked about how they would look for opportunities to ensure the problem did not recur.

Are critical care services well-led?

Good



Intensive care services were good for well led. Intensive care staff were committed to their patients and their unit with a shared purpose. A high level of staff satisfaction was found throughout the services. Many spoke highly of the positive culture and levels of constructive engagement, support and encouragement. There was a committed leadership from the consultants and the nursing team. The nurses were supported by an experienced matron who did,

however, have extensive responsibilities beyond the ICU. The matron was supported by a team of four clinically experienced and committed sisters who were being developed to support the matron.

The service had good leadership but improvements were needed in the service due to a lack of formal governance. There was no regular governance meeting for the whole intensive care service with a collective approach looking at an approved regular programme of audit; receiving and reviewing reports on all aspects of the service and staff; development of shared action plans to make changes and improvements; and onward representation at key divisional governance meetings. The risks on the unit were mostly understood, but not being locally managed, or addressed by the board.

Vision and strategy for this service

- There was local vision and strategy for the intensive care unit (ICU). The service had a strategic five-year plan for the ICU first produced in 2014. This recognised some of the areas where the unit was not fully meeting best-practice or guidance; strengths and weaknesses of the service; developments in clinical practice for the future; and what was needed to achieve the vision and strategy.
- One of the visions for the service had already been achieved in the provision of the updated electronic patient record system. Although this had not been without initial set-up problems, the system was becoming embedded and providing advantages to staff. This included, for example, staff being able to access patient records if they were working elsewhere in the hospital. The pharmacists were able to check records from their department, and access was soon to be provided to consultants and other key staff at home.

Governance, risk management and quality measurement

- The unit contributed data to the Intensive Care National Audit and Research Centre (ICNARC) Case Mix Programme for England, Wales and Northern Ireland. ICNARC reported the data supplied was well completed and of good quality. Any issues or trends were discussed within the unit and actions taken.
- There was a structure for clinical governance in the trust, but some aspects of local work were not formalised. The medical governance responsibility sat

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with the clinical lead, and one of the senior sisters provided the overview of nursing governance. Unlike many other intensive care units, none of the consultant team had been given responsibility for governance. There were no formal unit meetings among the senior nursing and medical staff to review issues relating to intensive care. There were regular informal meetings, but these were not documented. Many issues, such as incidents and complaints were discussed at the mortality and morbidity meetings, but they were attended by between only two to four of the consultants at any time.

- There was a regular review of nursing elements within governance, but this was not fed-back as part of a formal departmental meeting. We attended a meeting with the matron and the sister responsible for the governance overview. Staffing (including levels of nursing cover, appraisals and training compliance), the budget, safety issues, avoidable harm to patients, incidents, infection prevention and control, patient surveys were discussed. Some of these issues were raised through the staff newsletter, but not at a formal unit meeting. Staff were not able to assure us how any actions raised from these reviews were communicated and staff made accountable for delivering change.
- Staff were not represented at all times at key divisional meetings looking at clinical governance. The ICU sat within the Emergency Division of the hospital. Minutes demonstrated the clinical lead had attended two of the four clinical board meetings for which we were provided with minutes (January to April 2015). There was an emergency division consultant forum held each month. There was, however, no presence from senior ICU staff in the meetings of January to April 2015 and the meetings were not circulated to the department. The meetings did, nevertheless, demonstrate how some of the key issues either directly or indirectly involving the service were discussed at governance meetings and actions raised if required.
- There was an intensive care standard operating policy but this was in draft form and not yet approved. The policy described consultants working in the department in 2012 and was therefore not recently drafted, but had yet to be approved and issued.
- The ICU recognised most of its risks, but, following trust policy, staff were not using a local risk register to capture, report upon and progress risks. Staff said the trust policy was to run one hospital-based register to

which staff could apply to have risks added. There were, however, at the time of the inspection, no direct risks on the trust register we were provided with pertaining to intensive care. Although the trust had decided none of the risks relating to intensive care met the criteria of the trust-wide register, the risks that existed nevertheless were not captured locally as there was no facility to do this. There were risks therefore being recognised but not reported and progressed. This included gaps identified from a review of the FICM Core Standards, such as not always meeting the recommendation for trainee doctor cover or physiotherapist provision; areas where the trust was worse than average when benchmarked by the Intensive Care National Audit and Research Centre (ICNARC), such as delayed patient discharges; and gaps identified from audits of NICE guidance or national audit, such as patients not receiving a rehabilitation programme when they were discharged from intensive care, or tracheostomy care.

- There was some audit and performance measures of aspects of care and safety within the units although not yet in accordance with an approved local audit calendar. The trust division in which intensive care sat (Emergency Division) had an audit calendar for NHS national audits, but only one of these related directly to intensive care. This was the national Actual and Potential Organ Donor audit, which was, however, produced by NHS Blood and Transplant and not the trust.
- There were risk assessments for major projects which had the potential to cause disruption. The recent updated electronic patient record system within ICU went 'live' in November 2014. The risk assessment recognised how this had the potential to be disruptive and cause errors in patient records. There was a plan acknowledging the known and potential issues with the rollout of the new system and actions to address these. These actions were owned by one or more staff and had review and completion dates. One of the actions taken was, for example, to provide information packs at the patient's bedside (from where the majority of the data entered to the system would be provided) and this had been achieved with good results.

Leadership of service

- The leadership team had the skills, knowledge, experience and integrity to lead the service. The medical leadership by the clinical lead consultant intensivist and

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the team of experienced staff was committed to patient care. The nurses we spoke with had respect for their medical colleagues and the allied health professionals, and worked as a cohesive and collaborative team.

- The nursing leadership of the service was strong although the matron had to manage an extensive area of the nursing within the rest of the hospital. There was an attempt to mitigate this workload by developing the non-clinical roles and responsibilities of the band 7 sisters. The matron and senior nursing staff demonstrated a strong commitment to their staff, their patients and one another and between them they had years of experience. There were plans to develop other grades of nurses, particularly band six nurses, to have specific roles and responsibilities.
- The leadership was fully supportive of their staff. The leadership of the service ensured staff were supported at all times and took the lead on making any changes to avoid errors in future.

Culture within the service

- There was a patient-centred and integrated culture within the ICU team. Decisions in the ICU were taken between the group of senior staff of doctors and nurses. Staff in the multidisciplinary team told us they felt confident to raise issues without concern, even if their views were at odds with the current approach. Most staff spoke positively about the culture of the ICU. Opportunities to peer review other wards and other staff to visit the ICU had extended and encouraged a good culture within the hospital. Nursing staff said this had given them and those reviewing the ICU a better understanding of one another's skills and experience, but also pressures and challenges. The housekeeper said they felt well supported and part of the team. They were able and encouraged to talk with patients and their families, and felt patients were well cared for and treated with respect.
- There were some aspects of culture that did not encourage staff to speak out at all times. There was a clinical incident (no harm arose) within the unit in March 2015. This incident revealed that the consultant involved did not follow hospital policy or best practice in two distinct areas.. They also did not acknowledge the deviations from policy or raise the matter as a more serious incident to be discussed at clinical governance. There were no actions taken and only a comment that

“guidelines and policies are not written in stone”, even though we were told the actions were deviations from hospital policy. The consultant's support for the deviations from practice were based upon opinion and not policy or best practice guidance.

- There were facilities for staff to work but also and rest in the ICU as there were staff offices and changing rooms. Senior staff often shared offices but they said they could always find somewhere for private conversations. In the ICU there was a reasonable sized seminar room within the unit used for ward rounds, handovers, staff training and meetings. There was a staff rest room which included a kitchen for staff with access to hot and cold drinks and food storage/ preparation areas. The location of the staff rest room was not directly within the main body of the unit This meant that staff were able to withdraw into some peace and quiet away from the unit, although able to return quickly in case of emergency.

Public and staff engagement

- People's views were gathered through surveys, compliments, cards and letters to the service. There was a quarterly report of scores from surveys where patients or their families were asked 28 questions about the care and treatment they received. In the reports from March to June 2015, 79% of patients who responded had said care was good either all or most of the time. The results and comments were circulated to staff. Where there had been criticisms of the service, we heard from staff about some the changes being made. This had included obtaining fans for the relatives' room, which had been identified as too hot. The supply of new chairs for the relatives' room was also being investigated as it had been recognised they were uncomfortable, particularly for longer stays.
- The unit demonstrated to visitors what changes it had made from listening to concerns. There was a 'You Said: We Did' notice just inside the entrance to the unit. This demonstrated what visitors had said about the unit, and what actions had been taken. It included visitors not being sure who staff were and who they could speak with. A photo board of staff had been produced to show who the senior staff were on the unit and that they could be approached at all times. New uniforms had also been provided to enable patients and visitors to tell the difference between staff.
- There were internal reviews of the service with good results, although no clear action plans from areas







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needing improvement. These reviews were completed mostly by staff from other wards as a peer review, and staff from intensive care would carry out the same reviews on other wards. Reviews included the NHS '15 Steps Challenge'. This was a tool designed to offer an insight into how a ward or unit felt for a patient or visitor. The 15 Steps in the ICU included whether the reviewer was welcomed to the unit, whether staff were helpful, was the environment free from treatable odours and clean and tidy. The reviews provided from January, February and March 2015 showed good results, but there were areas on each report of failure to check either refrigeration temperatures or resuscitation trolleys. These failures continued each month and therefore no action had been taken to address this.

- There was a clear understanding of the financial position of the hospital trust and the budgets for the departments. The budgets were managed by the clinical lead and matron (with the senior sisters) who had a full understanding of the figures. Both the clinical lead, one of the intensivists, the matron and two of the senior sisters said they could not recall any circumstances where financial pressures had compromised patient care or safety.
- There were good links with the local East of England Intensive care Operational Delivery Network (ODN) with evidence of coordination of patient pathways over a wider area. There had been a recent peer review prior to our inspection which had commented upon the positive and open attitude of the ICU team.

Innovation, improvement and sustainability

Maternity and gynaecology

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

Information about the service

The Trust provides maternity and gynaecology services to the populations of Great Yarmouth, Lowestoft and Waveney. James Paget Hospital Maternity service consists of a maternity ward (ward 11) which provides ante-natal care; the central delivery suite which provided consultant led care and the Dolphin suite, a midwife-led birthing unit for women with a low risk of complications in labour. All of these services are located on the first floor of the hospital. There is also an early pregnancy assessment unit co-located within the gynaecology out-patient department on the ground floor.

Community Midwifery Services are provided in GP surgeries and children's centres across the area served though were not inspected at this inspection. The annual delivery rate has steadily declined from 2270 in April 2009 to 2079 by April 2014. In year to April 2015, there were 11 complaints, 12 serious incidents including five hospital acquired pressure ulcers and three falls. In the Friends and Family test this Trust scores more highly than the national average for patients recommending ante-natal, post-natal and postnatal community provision by this Trust. There were no 'never events' in maternity services between April 2014 and March 2015.

The inspection team consisted of two inspectors, a specialist midwife, a nurse and a consultant obstetrician. During the inspection we spoke to specialist nurses, midwives, health care support workers, administration and nursery staff, obstetricians and gynaecology staff as individuals on ward observations and in large numbers in focus groups.

We visited the central delivery suite (Delivery Suite), maternity ward (ward 11), Ante-natal clinic, gynaecology outpatient's clinic and the ward where gynaecological patients are treated (Ward 4). We received comments from our listening events and from people who contacted us to tell us about their experiences. We used information provided by the organisation and information that we requested, which included feedback from women using the service about their experiences. This information included information from staff concerned about the medical leadership of gynaecology services.

Maternity and gynaecology

Summary of findings

The current safety of maternity and gynaecology services provided for patients requires improvement at James Paget Hospital.

We spoke to midwives, specialist nurses, healthcare support workers, nursery staff, administration staff and consultants in focus groups and individually when we were able to during ward observation. Although very few of the staff we spoke to were able to describe the Trust's vision and values, they were particularly proud of the work to improve maternity services under leadership of a new head of midwifery. Staff were aware of incident and safeguarding reporting procedures and recording systems.

Staff were able to describe how to escalate and or record untoward incidents. Senior staff had recently taken part in multi-disciplinary root cause analysis training (RCA) to improve investigation of untoward incidents. Further staff training in root cause analysis was identified for September 2015 to increase the numbers of staff with this skill.

All areas visited adhered to infection control and prevention standards areas were clean; we observed staff wearing uniforms, were bare below the elbow and were seen wearing personal protective aprons and or gloves in line with infection control guidelines. Alcohol hand sanitizer was available on entering the wards, at the end of each patient's bed and reception areas.

We saw that equipment was checked, signed and dated in line with portable appliance testing guidelines. We found that some daily checks for resuscitation equipment were inconsistently completed, resulting in gaps in the recording of these to show that the checks had been completed.

The newly refurbished central delivery suite and the Dolphin suite were bright, clean and staff were welcoming. Electronic key pads, 'intercom entry and CCTV restricted access to some maternity services areas. We saw that the ante-natal clinic area was shared with the outpatient clinic for children and young people. A mixture of expectant women, young children some of whom had severe disabilities and their parents, overcrowded this area.

We found that medicines were appropriately secure to ensure effective management of these. We saw staff passing controlled drugs (CD) keys over to the senior staff and checking drugs.

We found the maternity records format was cumbersome. Information regarding some foetal abnormality checks in some records were not readily identifiable. However, we saw some good examples of individual risk assessments to meet the particular health or social needs of patients and their babies for example, risks associated with mental ill-health and or learning difficulties.

Midwifery and gynaecology staff were readily able to describe how to raise concerns and/or safeguarding issues. They knew who to speak to for advice including those pregnant women for which James Paget Hospital was not their booked hospital of choice. We found that patients from other specialities were regularly accommodated on the gynaecology ward (Ward 4) at the time of this inspection there were five gynaecological patients, 14 medical patients and nine surgical patients on a 28 bedded ward area. We found that some medical and surgical outlier incidents had been classified as gynaecology incidents because these patients were accommodated on the gynaecology ward.

We looked in 11 sets of obstetric patient notes and saw evidence of early warning scores being used to identify potential deterioration of mothers. There was no dedicated maternity IT system.

Inspectors visited central delivery suite (CDS) and labour ward on Tuesday 11, Wednesday 12 and Thursday 13 August and on each occasion we visited a ward the ward information showed there were midwife and maternity support worker shortages on central delivery suite on 12 and 13 August. We visited the gynaecology service on ward 4.

A maternity unit the size of the service at James Paget Hospital should have 40 hours of consultant cover weekly. The Trust maintained this level of cover and staff to which we spoke confirmed access to consultants was good, even out of hours.

Maternity and gynaecology

Are maternity and gynaecology services safe?

Requires improvement



We judged the safety of maternity and gynaecology services at James Paget Hospital as requires improvement because equipment that should be checked daily was not always checked appropriately. Staff fill rates for maternity and gynaecology were variable with a significant proportion of health care assistant shifts not filled at night on the central delivery suite and some unfilled shifts for nursing and midwifery staff. Staff mandatory training on the labour ward was at 78% and below the trust target. The Trust had taken steps to protect people from harm and or abuse. Staff knew how to use the reporting and recording systems for escalating and managing incidents or concerns. Staff had been trained in safeguarding and in managing incidents.

Maternity and gynaecology services were benefitting from changes in the governance structure brought about by the new head of midwifery. The head of midwifery had rejuvenated governance and taken steps to improve safety of the service.

We spoke to staff that were aware of reporting concerns processes and were able to describe remedial action taken following incidents. The central delivery suite had recently been upgraded and provided a good environment for patients.

On each day we visited the ante-natal clinic, it was over-crowded and the Trust was not protecting pregnant women or vulnerable young people from the potential risk of exposure to diseases which commonly occur in childhood and which can be harmful to adults and unborn babies.

Incidents

- There were 12 serious incidents assigned to maternity and gynaecology services; of which five were grade 3 pressure ulcers; three were falls and the rest were a variety of reasons. Eight of the serious incidents occurred at ward level and two in the ante-natal clinic. We found that the Trust had taken action, for example to

prevent recurrence of the incident in the ante-natal clinic by identifying a lead clinician to manage and monitor this. There were summaries of the actions taken and work ongoing or completed.

- We followed up the pressure ulcer incidents at ward level and discovered these had been coded to a gynaecology ward for medical patients with long term conditions. The gynaecology ward accommodates patients from other specialities including medicine and surgery. This practice is known as medical/surgical outliers depending on the service speciality responsible for treating the outlying patients.
- We looked at minutes of mortality and morbidity meetings that had regularly taken place, and were well attended by medical, diagnostic, and midwifery staff. Minutes showed that lead clinicians presented details of issues. The presentations included anonymised patient histories, outcomes and recommendations. The Trust has guidelines for care of pre-term babies under 26 week's gestation that was also presented at one of the recorded mortality and morbidity meetings.
- Staff were aware of how to report incidents and raise concerns. The 'Duty of Candour' was not identifiable in the Trust's incident reporting policies or procedures. Staff were open and honest in their explanations of incidents and how to record and report these within the Trust. Staff told us they had a debrief service for traumatic incidents and that development of this approach had partly been in response to a national report. This was good because it showed the Trust compared their approach to incident reporting and learning to events with national significance and local relevance.

Safety thermometer

- The central delivery suite (CDS) environment had recently been upgraded and staff had moved back to this area earlier in the month. There was a variety of patient information including staffing levels pinned to notice boards on the wards near the entry points in maternity ward (Ward 11), central delivery suite and the ante-natal clinic. There was information about the Friends and Family test, (FFT) but no information about for example hand hygiene audits, vaginal versus caesarean section delivery rates or commencement of breast feeding for new babies.

Maternity and gynaecology

- The Trust showed that this Trust had obtained Clinical Negligence Scheme for Trusts (CNST) Level 3 for maternity services which is the best achievable level.
- Information showed the Trust's rates for the following hand hygiene audits, vaginal versus caesarean section delivery rates; ratio of midwives to number of births; or commencement of breast feeding for new babies were as follows: hand hygiene in 2013/2014 was 100% compliant; the proportion of vaginal deliveries to caesarean section delivery 25.7%; the ratio of midwives to births was consistently better the England average 1 midwife to 25 births (England average for May 2015 1:27); commencement of breastfeeding for new babies is below the target of 75% at 71.4%.
- In the gynaecology ward staff showed inspectors an electronic database for the ward showing patient safety thermometer information including staffing levels compliance. At the in-patient ward entrance (ward 4) we also saw 'patient safety crosses'; a colour coded ward display indicating for example numbers of available staff, days since patient falls (three days), days since last pressure ulcer occurred on the ward (45 days) and hospital acquired infections. This was good because it showed the Trust makes information available to patients and relatives about some measures of safety.
- Mandatory training for the Trust included infection control training. However, the information also showed us that not all staff that were required to do so, had completed infection prevention and control training up to the end of April 2015.
- We were told by staff that on another day earlier this year a child infected with chickenpox had attended the ante-natal clinic at the same time as pregnant women. Our inspectors were concerned because chickenpox contracted during pregnancy can cause complications, both for the pregnant woman and her unborn baby. Our inspectors were concerned that the Trust was not protecting pregnant women or vulnerable young people from the potential risk of exposure to diseases which commonly occur in childhood and which can be harmful to adults and unborn babies. The Trust was asked to urgently review use of this space.

Environment and equipment

Cleanliness, infection control and hygiene

- The ward areas visited were visibly clean, tidy and staff were appropriately dressed in uniforms and personal protective equipment such as plastic aprons or disposable gloves as required. With the exception of domestic services staff, plastic aprons were white; domestic services staff who were serving food were wearing blue plastic aprons. It was easy to identify that domestic staff were not responsible for clinical care.
- Information provided by the Trust showed that there had been no reported occurrence of known infections such as *Clostridium difficile* or methicillin resistant *Staphylococcus aureus* (MRSA) in maternity and gynaecology services. This information also showed us that staff regularly washed their hands in between seeing patients on the maternity ward (ward 11), but not always on central delivery suite. Inspectors saw staff washing their hands or using alcohol hand sanitizer during our visits to ward areas. We saw dated and signed 'I'm clean stickers' on equipment that regularly had to be decontaminated so clean equipment was easily identifiable.
- Throughout central delivery suite, we observed appropriate use of disposable blinds and curtains. These were labelled to remind staff and anyone entering that they should first seek permission from the patient. This was good because staff and visitors were reminded to respect patient privacy.
- On the first day of the inspection we looked at adult and new-born resuscitation equipment on central delivery suite, the Dolphin suite and maternity ward (ward 11). We identified gaps recording that daily checks of this equipment had been done in the coral and wave rooms of the Dolphin suite and rooms 5 and 6 on central delivery suite. We drew this to the attention of ward managers.
- We looked at this equipment again on the second day of the inspection. We found that gaps in recording daily checks identified the previous day remained. We found this to be the case on central delivery suite, the Dolphin suite and maternity ward (ward 11). We found that the resuscitation equipment on central delivery suite and maternity ward (ward 11) did not secure emergency drugs because the plastic tag intended to secure these did not close.
- We identified gaps in recording daily checks in the adult resuscitation equipment on central delivery suite had consistently occurred on two particular week days. We looked at the daily checklist for the central delivery suite trolley as far back as 14 July 2015. This showed us that

Maternity and gynaecology

this was not an isolated occurrence. We asked staff about this and were told that during the refurbishment of the central delivery suite they had shared equipment with another ward.

- We looked at Cardiotocography equipment (CTG) on central delivery suite. CTG equipment can be used to monitor a baby's heart rate and a mother's contractions while the baby is in the uterus. The CTG equipment we looked at had been checked and labelled when the date of the next maintenance check was due.

Medicines

- We checked storage of medicines in central delivery suite, maternity ward (ward 11) and ward 4 and records of controlled drugs (CD's). In each case medicines were stored securely, refrigerated where required and CD's had been correctly signed and accounted for by two members of qualified staff.
- We asked staff on labour ward about disposal of unused IV fluids and were told these were disposed of as clinical waste. We saw that medicines were locked and stored securely. Staff managed medicines in line with legal requirements for safe administration, security and disposal.

Records

- We looked at two sets of hand held notes (HHN) in the ante-natal clinic. The hand held notes (HHN) were recorded on an 83 page A4 sized booklet. The templates contained good information of what should be checked. Not all the foetal abnormality checks on page 9 of the booklets had been recorded in the allotted space. We asked the manager about this and she directed us to another part of the booklet that contained this information. It showed these checks were recorded under consent to the procedure. Hand held notes also included a template learning difficulties screening tool, assessments of social circumstances, mental health and information about referrals that had been made to other agencies such as mental health services. Risk assessment templates included factors such as weight, pregnancy history and circulatory problems.
- We looked at three set of notes on maternity ward (ward 11). The notes were accurately completed including hourly observations, medicines administered and CTG records. All entries were signed and dated.
- We looked at 15 sets of notes on the early pregnancy assessment unit (EPAU). The EPAU accommodates the

termination of pregnancy clinic; patients had consented to treatment, contraception had been discussed and risks of circulatory disease assessed. All notes were signed and dated.

Safeguarding

- We spoke to staff about safeguarding. Midwifery staff told us they had completed Level 3 safeguarding training and named the lead safeguarding midwife. We saw evidence that 83% (87) of staff that are required to; have completed Level 3 safeguarding training.
- Staff confidently described how to escalate a safeguarding concern and knew who they needed to speak to for information or advice. Staff were aware of potential safeguarding concerns for women for which James Paget Hospital was not their booked hospital of choice.
- The Trust had a Safeguarding Adults (Vulnerable Adults in need of Protection) policy which was last reviewed in February 2015 and cross-referenced national guidelines including 'No Secrets'. The Care Act 2014 (effective 1st April 2015) has replaced 'No Secrets' with additional mandatory requirements for safeguarding. The policy also included a flow chart which included contact numbers for the local authority safeguarding team.

Mandatory training

- Records of training showed that not all staff that were required to do so had attended mandatory training. Target attendance was 95% and staff in maternity services had regularly been unable to attend due to clinical needs and 81% of maternity staff on central delivery suite and 78% of staff on the maternity ward (ward 11) were up to date with mandatory training.
- Mandatory training included for example Safeguarding, Mental Capacity Act and Deprivation of Liberty safeguards, consent and infection control. The attendance at mandatory training was 78% for the maternity ward (ward 11) and 81% for central delivery suite. Practice development midwives showed inspectors a schedule to ensure that staff attends mandatory training within the next 12 weeks to increase this to ensure as many staff as required were up to date with mandatory training.

Assessing and responding to patient risk

Maternity and gynaecology

- Evidence of risk assessment for factors such as weight, pregnancy history and circulatory problems were included within the hand held note template.
- On the delivery suite we looked at three sets of patients notes and saw evidence of the use of 'fresh eyes' for CTG hourly observations ('fresh eyes' is the approach which ensures a colleague reviews foetal monitoring readings as an additional safety check to prevent complications being missed.) Patient notes included evidence of early warning scores being used appropriately for adult patients.
- The head of midwifery had implemented a daily report identifying numbers and acuity of patients across maternity services. The coordinating midwife completed the daily report and emailed it to the head of midwifery at the start of her shift. On 12 August the daily report included patient numbers, staff and skill mix and clinical risks that required escalation.
- We visited the gynaecology ward (ward 4) and on the occasion we visited there were five gynaecology patients, 14 medical patients and nine surgical patients. Ward staff had an easily identifiable method for assessing and responding to patients at risk of falls.
- The head of midwifery confirmed in an interview that midwifery staffing was a challenge owing to the geography of the hospital. She also confirmed the Trust had completed a Birth-rate Plus assessment. This was an externally assessed staffing and skill mix audit and results are anticipated early in September 2015. The head of midwifery also confirmed some shifts had been covered by bank and agency staff.
- We observed the evening handover between maternity day staff and their colleagues. The handover covered key risk information in sufficient detail to alert the labour ward to anticipate arrival of labouring women and any increased risk factors.
- James Paget Hospital has a better midwife to birth-rate and supervisors of midwife ratios than the national average at 1 midwife per 25 births versus national average of 1:27.
- The ratio of supervisor of midwives was 1 supervisor of midwives to 12 midwives versus the recommended ratio of 1:15. The purpose of supervision of midwives is to protect women and babies by actively promoting safe standards of midwifery practice. Supervision is a statutory responsibility that provides a mechanism for support and guidance to every midwife practising in the UK.

Midwifery and gynaecology staffing

- Staff and skill mix was recorded on the head of midwifery's daily risk report. During ward observations we saw notice board information identifying staffing numbers required and identified shortfalls. There were shortfalls in required midwives on central delivery suite, during the night on 12 and 13 August and maternity support workers for am and pm shifts on both days.
- Dashboard information provided by the Trust showed that there had been regular shortfalls in shifts on the central delivery suite between May 2014 and April 2015. Data showed a shortfall in nursing and particularly health care assistants on night shifts with less than 60% of shifts filled for healthcare assistants. Data for ward 11 showed a more consistent staffing level with some exceptions including April 2015 when 86% of nursing shifts were filled.
- We spoke to midwives in a focus group and they were keen to point out that the head of midwifery had undertaken recent recruitment and had completed a Birth-rate Plus assessment. (Birth-rate Plus is a workforce planning tool for midwifery based on NICE guidelines and supported by the Royal College of Midwives as good practice).
- All of the patients we spoke to said they had felt safe and well cared for by midwifery staff.
- We saw in the gynaecology speciality service meeting April 2015 that recruitment to a band 7 nursing post had been unsuccessful.
- The Trust monitors the numbers of staffing hours covered one each ward and we saw evidence that there were regularly shortfalls of up to 25% of night time shifts on the gynaecology ward (ward 4).

Medical staffing

- Information held about this Trust shows consultant cover meets good practice guidelines at 40 hours weekly. This information also showed that there are higher numbers of junior and middle grade doctors and higher numbers of senior doctors than the national average for this Trust.
- Trust information provided showed that there was just under 25 medical staff required to cover obstetrics and gynaecology and they had a vacancy rate of just under five vacant medical posts.

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- Obstetrics and gynaecology has an establishment of eight medical consultant posts, with a vacancy rate of 2.58 whole time equivalent posts.
- The divisional director told us that the Trust had worked hard to attract junior doctor trainees. Trainee feedback had been good and the deanery had recently agreed an increase in trainees from 3 to 4. Middle grade doctor recruitment remained challenging.
- Junior doctors had had a mixed experience of availability of senior colleagues out of hours. One junior doctor had told us they had experienced difficulty getting an assistant for an emergency caesarean section. Others had told us support was good, consultants are friendly, accessible and approachable.
- Minutes of the Midwifery and Obstetrics Risk Meeting held in February, May and June 2015 showed that medical and midwifery staff attended, Terms of reference were discussed and agreed including that this group would oversee the maternity risk strategy.

Major incident awareness and training

- Midwifery and medical staff told us about multi-disciplinary training known locally as Collaborative Learning Action Workshop (CLAW) and which included 'skills and drills' simulation to give staff experience of responding to high risk incidents. All disciplines of staff with whom we spoke about this training were proud of the way they had worked together. Practice development midwives (PDM) provided evidence in a report that attendance at this training was good at 61% since January 2015. The practice development midwives had a stated aim to train 100% of staff by year end.

Are maternity and gynaecology services effective?

Good



We judged the effectiveness of maternity services at James Paget hospital to be good because patient treatment is planned and delivered in line with some evidenced based practice. Patients have their needs assessed, reviewed and care is monitored. The Trust provides training and development opportunities for medical, midwifery and nursing staff.

We saw evidence in the maternity service dashboard that the maternity services are monitored and statistics compared with national figures to determine how James Paget hospital performs. For example, the number of patients booked for maternity service at 12 weeks and the amount of consultant hours versus Royal College of Obstetric guidelines.

Midwifery and medical staff described multi-disciplinary root cause analysis training that had taken place to improve working between professional disciplines for investigations. We spoke to midwifery and medical staff who all confirmed this training had been useful and they had enjoyed working jointly with colleagues from other disciplines.

There were gaps in the evidence to support effective working particularly in gynaecology. For example staff on ward 4 told us that evidenced based policies and guidance required review and we saw evidence that local and national audits were not all commenced or completed. We saw evidence in the Board assurance framework that the Trust is aware of the out of date guidelines and had a plan to review these.

Evidence-based care and treatment

- Staff to whom we spoke told us that policies and guidelines were out of date and were being revised. Staff accessed policies on the staff intranet. The trust had identified these concerns and had a plan in place to review all policies and procedures with more than 20 already reviewed.
- There were policies and procedures on the Trust intranet that had previously been updated, but were overdue for review. For example staff showed us that the extreme pre-term policy had been reviewed. However, we observed that a previous version had not been removed from the intranet. This was a concern because staff may not be using the most up to date, evidenced based guidance. The Trust removed the out of date version from the intranet upon request.
- The Trust had a database of over 100 policies for maternity services and at the time of our inspection was in the process of reviewing some of these. For example, later termination of pregnancy, which was last reviewed in 2010 was being updated and merged with late miscarriage or medical termination of pregnancy and medical termination of pregnancy >21 weeks, both of which were overdue for review.

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- The Trust database of policies showed that 21 policies had been reviewed this year, including infant feeding, consenting to treatment in obstetrics and gynaecology and transfer from dolphin suite to delivery suite.
- The Trust had identified a new process for ensuring National Institute for Health and Care Excellence (NICE) guidelines are received by the Clinical Audit and Effectiveness Group and cascaded to be reviewed by relevant clinical divisions.
- The Trust has a maternity and gynaecology forward audit plan for 2015/16 and which included Maternal, New-born and Infant Clinical Outcomes Review Programme (MBRRACE) and clinical guidelines for example: Ectopic pregnancy and miscarriage and fertility assessment for people with fertility problems.
- The Trust has a separate maternity audit plan that included drug administration and supply in midwifery practice. This plan showed all activity to commence in September 2015.
- On all the areas we visited staff had followed medicines management, safeguarding and incident reporting policies and procedures.
- On ward 4 (the gynaecology ward) risk factors such as falls were highlighted to alert staff of patients at high risk of falling. For example, through use of a blue patient at risk of falls sticker. Ward staff attached the sticker to the patient board above the bed space. There was also evidence of assessment of support with basic needs such as eating and drinking on ward 4 through use of colour coded trays, for example red lidded water jugs and red trays for people who required assistance eating.

Pain relief

- The information booklet given to women at the first booking appointment explains the types of pain relief available during labour. The booklet includes a section about the choices of pain relief both natural and drugs available including Entonox, pethidine, epidural or birthing pool. The booklet explains the options and side effects of these options.
- We spoke to five patients on the post natal ward, one patient in the early pregnancy unit and two patients on the gynaecology ward. None of the patients who spoke to us identified difficulties obtaining pain relief. We saw evidence that pain relief had been given to patients in four patient's records on maternity ward (ward 11).

- The Trust audits the in-patient and delivery areas. The February 2015 audit results for central delivery suite and ward 11 showed that staff had accurately recorded medicines administered.
- One senior midwife told us they had responded to patient feedback about delayed pain relief. Evidence on the ward 11 notice board showed that midwifery staff had implemented changes following this feedback.
- On the day we visited the gynaecology ward there were five gynaecology patients; we spoke to three of them and pain relief was not raised as a problem.

Nutrition and hydration

- We spoke to specialist infant feeding staff who told us they also worked with a group of volunteers who encouraged and supported new mums to breastfeed their new babies. They told us that they provided monthly breast feeding workshops for patients between 30-32 weeks pregnant. The Trust followed NICE guidelines on encouraging and supporting new mothers to breastfeed.
- The Trust monitored how many new mothers chose to breastfeed their babies on the maternity dashboard. The numbers of mothers who had chosen to breast feed was slightly less than the target of 75% at 71.4%.
- Staff told us they were aiming to be a Level 3 United International Children's Emergency Fund (UNICEF) baby friendly maternity service. This is good because UNICEF baby friendly is an internationally recognised quality mark for infant nutrition support.
- Two of the six post natal patients we spoke to told us they had received good support with breast feeding. We spoke to domestic staff on maternity ward (ward 11) who told us they offered drinks seven times daily to breastfeeding mothers.

Patient outcomes

- Patient outcomes are good at James Paget maternity services. Comparative data showed that the Trust performs well against a range of benchmarks. For example the Trust rates for emergency caesarean section are favourable (8.%) for multiple births and (15.5%) for single births. Caesarean section increases the risk of maternal complications such as haemorrhage, infection and thrombosis. The Trust has a target of below 20% of all caesarean sections for both multiple and single emergency caesarean sections.

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- Readmission rates for babies less than 28 days old were low at 12 at year end March 2015.
- Booking rates at 12 weeks was 92.7% versus a target of 90%. This was good because it showed patients were given maternity care at the earliest opportunity.
- Monitoring of VTE (blood clots) was at 97.5%.
- At James Paget Hospital 13.% of babies were delivered by the midwifery led birthing unit in the twelve months to April 2015. The home birth rate was 1.9%. Community midwifery staff told us they were working hard to improve the choice of home birth, out of hours and at weekends. The Maternity services development plan (05/06/2015) included reference to improving home birth services.
- The Royal College of Obstetrics and Gynaecology (RCOG) compare maternity services nationally against 11 quality indicators for example perineal tears during delivery are low at 1.6% at James Paget hospital by year end April 2014. The last RCOG report of on Patterns of Maternity Care in English NHS Hospitals was completed for 2012 and showed third and fourth degree perineal tears at between 1.1% and 3.7% James Paget hospital figures are below national average figures of 2.5% and 6.9%.
- The Trust had identified audit activity around NICE guidelines and senior midwives or consultants had been allocated to complete these. A planned audit of NICE guidelines for ectopic pregnancy and return to theatre for gynaecology patients had not been done.
- Practice development midwives also told us that they included students and domestic staff in training to recognise signs of patient deterioration. We saw on-line evidence of UNICEF training for all midwifery staff and we saw other evidence that training attendance is monitored.
- The practice development midwives provided evidence that since Collaborative Learning Action Workshops (CLAW) training commenced in January 2015. Practice development midwives described CLAW training as scenario based multi-disciplinary training in emergency skills and drills. We saw that 65% of midwifery staff had participated in this multidisciplinary training.
- There was a template midwifery support worker orientation, training and competency assessment manual. This was good because it promoted staff insight into their knowledge and required development opportunities. The practice development midwives had also developed a similar manual for bank midwifery support staff. This was good because it showed bank staff could expect an appropriate induction to the service.
- We saw evidence that gynaecology nursing staff on ward 4 had received specialist training in family planning and sonography.
- We had received an anonymous whistleblowing letter directly and forwarded from other agencies shortly before the planned inspection. The letter alleged amongst other issues inappropriate recruitment of senior medical and clinical staff. The Trust provided evidence that appropriate recruitment and pre-employment checks had been undertaken.

Competent staff

- Staff to whom we spoke to told us about an increase in support following appointment of the new head of midwifery. They told us they felt they had been invested in and empowered by the head of midwifery to innovate. Practice development midwives (PDM) provided evidence of completed specialist midwife training including emergency skills and drills training, multi-disciplinary root cause analysis training and Anti D on-line learning in response to a patient incident.
- Anti-D is a blood borne condition affecting mothers who have rhesus negative (RhD negative) blood type and that can cause complications for them and their unborn babies. Treatment is available and routinely provided during pregnancy for pregnant mothers and their babies who are assessed as at risk of developing rhesus negative (RhD negative) disease.

Multidisciplinary working

- Communication with the community maternity team was good. Staff told us on central delivery suite that community midwives had provided cover for the wards when they were short staffed.
- Community midwifery staff told us that they had allocated named midwives to GP services in the area.
- A copy of the discharge information sent to GP's was seen for one patient and included important and relevant information.
- Staff told us that the head of midwifery had an 'open session' every Friday and all staff including cleaners to consultants were invited to air their views. This was good because it showed the head of midwifery engages with all colleagues.

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Seven-day services

- Junior medical staff and midwifery staff confirmed the availability of consultant advice out of hours. They told us consultants have responded by attending when required. There is an on-call rota for consultant of the week (COW).
- We were told that diagnostic imaging is a seven day service, but MRI is limited at the weekend. This was good because patients did not have to wait until a weekday before diagnostic imaging was available to support clinicians identifying and starting a course of treatment.

Access to information

- We found notes to be cumbersome, owing to the amount of risk assessments they contained but notes were available. There were three recorded incidents of patients' notes being mixed up; there were no incidents relating to missing notes.
- We were told that records are scanned six weeks after a baby has been born.
- Staff told us there was currently no dedicated maternity IT system.
- Some staff told us this had limited the opportunity for effective audit. We spoke to the head of midwifery about this. She told us that sourcing a suitable electronic program for recording notes was being jointly undertaken with senior midwives involvement and that a business case had been drafted for purchase.
- We asked ante-natal and delivery staff how they dealt with pregnant women from out of the area who presented without their hand held notes. We were told that they would contact the patient's booked hospital of choice for information including about any potential social or medical issues requiring escalation to colleagues or other agencies.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Evidence of consent being checked and recorded was seen in four sets of patient notes on maternity ward (ward 11). Staff told us that maternity services did not have a dedicated learning difficulties champion, but they accessed the Trust specialist when required. They told us about a multi-disciplinary meeting for a

maternity patient who lacked capacity. The meeting had been facilitated by the Trust learning disability specialist to ensure the patient had understood the choices of treatment available.

- Staff including the head of midwifery described the development of a specialist vulnerability midwife team. She told inspectors that this team had recently been formed to respond to the needs of patients with complex health and social needs including mental health needs. The maternity services development plan included review of the perinatal mental health pathway. This was good because it showed the Trust considered all aspects that might impact a patient's experience of giving birth.
- We looked at four sets of patient notes for termination of pregnancy and they complied with the Abortion Act 1967. Six sets of patients notes that we saw on ward 4 included discussion and confirmation of consent to treatment.

Are maternity and gynaecology services caring?

Good



We judged the caring aspect of maternity services as good because feedback about midwifery services was positive, staff were well motivated, dedicated to their roles and patients told us they felt safe and well cared for.

Staff confidently described the efforts they had made to support patients with emotional as well as physical well-being. We observed staff discussing how to meet the needs of a high risk patient taking account of her preferences and balancing this with the risks involved providing her care.

Patients told us staff were caring, accessible and helpful. Patients families and significant others told us they had been involved, that staff respected their privacy and dignity and they go the extra mile to provide care.

Patients were unanimously positive about their experience of maternity services at James Paget Hospital and when asked did not believe improvements were required.

Compassionate care

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- We spoke to ten maternity patients, all of whom told us staff were caring, respectful and friendly. We observed staff caring for patients on wards and in out-patient departments. We saw staff interact with patients in a caring, kind and respectful manner.
- We observed that staff were welcoming, friendly, happy and also showed colleague's compassion and respect. The support provided by supervisors of midwives was exemplary and the feedback about the new Head of Midwifery was unanimously positive.
- This Trust scores slightly above the England average for patients who would recommend James Paget maternity services in the Friends and Family test (FFT) at 96% who would recommend James Paget maternity services.
- The results of FFT were available on the notice board on maternity ward (ward 11) and this showed the Trust scored 96.7% for people who would recommend the service. We observed that staff had sensitively negotiated the assisted delivery date of a high risk patient during the handover.
- The Trust scored better than average for staff during labour in the 2013 care quality commission maternity survey.
- Staff had made sure that termination of pregnancy (ToP) clinic took place at a different time from patients seeking fertility treatment. This protected the privacy and dignity of patients seeking terminations and those seeking fertility treatments.

Understanding and involvement of patients and those close to them

- We spoke to two patients on the ante-natal ward and three patients in ante-natal clinic and in each case they had identified their named midwife and confirmed they had been accessible throughout their pregnancy.
- Three patients and their families in the ante-natal clinic that they had been fully involved and felt included in caring for their pregnant family member told us. This was good because it showed the Trust involves family members in caring for pregnant women.
- We observed staff discussing how to meet the needs of a high risk patient taking account of her preferences and balancing this with the risks involved providing her care.
- We saw evidence in the supervisor of midwives annual report 2015 of how a high risk well-informed patient was supported by midwives in the community and the midwife led birthing unit to have a home birth plan.

- Staff on gynaecology ward (ward4) showed us evidence of training in counselling to support women making difficult choices about their treatment plans.

Emotional support

- We spoke to families who had in the past experienced a poor outcome and had more recently had good treatment.
- Ante-natal patients told us they felt well cared for and when asked stated they thought the service did not need to improve.
- Staff on the post-natal ward described how patients whose babies had to be looked after in the neonatal intensive care unit (NNIU) were looked after in side rooms to reduce further distress from other crying babies and protect their privacy and dignity.
- We saw the newly created Rosemary suite on central delivery suite and staff sensitively described how bereaved patients were looked after in this area.
- Gynaecology clinic treated a variety of conditions including those seeking a termination of pregnancy (ToP) and patients seeking fertility treatment.
- Staff described how they ensure Termination of pregnancy patients and are not mixed and leaflets only made available for Termination of pregnancy on the two days the clinic provided this treatment. We observed staff treat patients sensitively and non-judgementally in the gynaecology clinic.

Are maternity and gynaecology services responsive?

Good



We judged that maternity services were good for responsiveness because patients' were consistently cared for by named and accessible midwives and antenatal clinics were provided at a mixture of times to ensure working mothers could attend. Staff provided a variety of information informing patients about pre and post natal care including what to expect from ante-natal care, pain relief during birth and breast feeding.

Midwives were making service improvements some in response to patient feedback or incidents but much more in response to staff being empowered by managers.

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The environment of the central delivery suite had recently been upgraded and part of this area had been allocated to provide a service for pregnant women with concerns or requiring ante-natal checks that couldn't be done in the community. We found that patients had a choice of midwife led care in the Dolphin suite, consultant led care for high risk pregnancies or a limited home birth service.

Service planning and delivery to meet the needs of local people

- Central delivery suite (CDS) staff told our inspectors that the Rosemary suite was used to preserve the privacy and dignity of patients and family members where the birth had been traumatic and the outcome might have been poor. This delivery room had a rest area where family or birthing partners could make refreshments and drink them in comfort.
- We visited the early pregnancy assessment unit (EPAU). We found that the examination and ultrasound scanning rooms were cramped. This meant that birth partners had to sit at the bottom of the scanning couch whilst their partner's abdomen was being scanned.
- Staff told us about ongoing joint working to streamline pathways with the neighbouring hospital with which James Paget works closely, but we did not see this joint working reflected in the obstetrics and gynaecology services forward plan. We saw in the maternity service development plan a commitment to establish standardised pathways of care to ensure that women receive evidence based care.
- The Maternity Services Liaison Committee had faltered earlier in the year but restarted in June 2015. Maternity services liaison committee is a multidisciplinary meeting forum that includes patient representation that works to develop the service to meet the needs of patients in a locality and is good practice.

Access and flow

- Patients who presented through A&E out of hours were referred to the early pregnancy assessment unit (EPAU) and looked after in the triage bay on central delivery suite. The ante-natal clinic manager told us that during the day the route was through ante-natal clinic for assessment before being sent to the triage area on central delivery suite if required.

- GP Surgeries have a named community midwife. All patients we spoke to knew who their named midwife was and confirmed they had been able to contact their midwife for advice during their pregnancy.
- We asked about patients who present from out of the area and were told the delivery suite would contact the patients 'booked' hospital. This ensured staff liaised with other agencies who may be involved in a patient's care.
- We visited the ante-natal clinic which shared facilities with phlebotomy, ultrasound services and the outpatient clinic for children and young people (CYP).
- On the day of our visit the service for children and young people expected to treat 47 children. Both clinics were very busy. Some of the children waiting for their appointments had very obvious life limiting disabilities. Some of the expectant women were waiting for scans for suspected but as yet undiagnosed foetal abnormalities.
- Bed occupancy rates for this Trust are lower than the England average. The maternity dashboard information does not currently include the percentage of patients seen by a midwife or consultant within 30 and 60 minutes of arrival.
- In 2014 the percentage of pregnant women accessing antenatal care seen within 12 weeks was 94.45% compared with 92.7% in 2015. The Trust performs better than the target figure of 90%.
- The Trust gave us information from the maternity dashboard that showed the maternity service was closed once due to capacity on 21 February 2014.
- The practice development midwives told us of the work they are doing using social media to increase the use of the midwife led birth unit and make this the birthplace of choice in the locality.
- Termination of pregnancy services for pregnancy less than nine weeks are available on Fridays and Mondays. There's no termination of pregnancy service available at other times and this limited patient choice. Gynaecology clinics for other procedures were spaced sensitively and to protect patient privacy.

Meeting people's individual needs

- Patients had a choice of midwife led care in the Dolphin suite, consultant led care for high risk pregnancies or a home birth service. The head of midwifery told us the home birth service was limited because there was a shortage of community midwives to cover shifts in the

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evenings and at weekends. The ante-natal clinic manager told inspectors that choice of birth place was discussed at initial booking but could be changed to reflect increased or decreased risks throughout a pregnancy.

- Midwives were actively reaching out to pregnant women to promote the midwife led unit (Dolphin suite) through use of on-line information and social media. This was through the Born at the Paget Twitter page. Staff told us they wanted to encourage more women to make James Paget hospital their booked hospital of choice.
- The environment of central delivery suite had been upgraded and included a facility for patients and family members where the birth had been traumatic and the outcome might have been poor (Rosemary suite). The other new delivery rooms were en-suite and were spacious and airy.
- The care pathway is decided at the first booking appointment, but could be changed to reflect decreased or increased risks throughout a pregnancy. Patients were given an A4 sized booklet at the first booking appointment and that provided useful and helpful information about pregnancy including risks and delivery options.
- Staff told us about the creation of a specialist midwifery team to work with women with particular vulnerabilities including mental health needs. The head of midwifery identified as one of her challenges implementation of a transitional baby care unit. We saw evidence of these plans in a time bound maternity service development plan.
- We found that patients were given a named midwife, had access to telephone information from them and were consistently cared for by their named midwife throughout their pregnancy.
- There was evidence of mental health risk assessments in the in the hand held note template.
- We looked at 19 sets of gynaecology and six sets of maternity notes and in each case people's individual circumstances had been taken into account of and actioned. Staff told us confidently how to access additional support for patients or themselves in treating patients with complex health or social needs. Patients' told us they had been well cared for and had felt supported.
- Staff knew how to access interpretative services when required but we saw limited amounts of information in other languages during ward observations or in patient information leaflets.
- Staff told us there's no dedicated learning disabilities lead role in maternity services. However, the Trust employed a qualified learning disability nurse who works across all directorates. Staff told us of an occasion when this person worked with maternity staff to provide an appropriate care pathway for a person who lacked capacity.
- The walls in the clinic rooms were thin. There was a television set on in the waiting room. Staff had told us this was to minimise waiting patients overhearing consultations. Staff had also told us that they had previously had a complaint about this.
- The gynaecology in-patient ward (ward 4) had taken some steps to become Dementia friendly and had an easy method for patients identified as at risk of falls through use of a blue sticker.
- The recently been upgraded environment of central delivery suite (CDS) included an area referred to as Rosemary suite. The Rosemary suite contained a small lounge and kitchen area. The other delivery rooms were clean, tidy, airy and all of them had en-suite facilities. This was good because it showed that the Trust provided appropriate areas for privacy whilst being conducive to the new family unit.
- On central delivery suite a four-bed bay area was used as a triage area for women who may have concerns that can't be checked out in the community. Staff told us in a focus group that they had made this change having been invited to identify improvements and been empowered by the head of midwifery to make these changes. They had made this adaptation to the service to improve the experience of patients. A patient using this area told our inspectors her care had been very good.
- None of the maternity patients we spoke to commented about the food. One post-natal and one gynaecology patient told us there was a lack of choice and that portions were small.
- We saw evidence that three nurses on ward 4 had been trained in providing procedures in the gynaecology clinic for example in family planning and administering termination of pregnancy medication. One nurse had also been trained in counselling.

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- Staff had been trained in counselling techniques to help women in making decisions about fertility treatment and or terminations of pregnancy.

Learning from complaints and concerns

- Complaints about gynaecology, maternity and early pregnancy assessment unit were investigated and whether these had been partially upheld, upheld or unsubstantiated recorded.
- The majority of the complaints were individualised and many related to poor communications between teams or patients. None of the complaints required disclosure under the Duty of Candour (the Duty of Candour is a regulation requiring NHS providers to be open and honest with service users and other 'relevant persons' (people acting lawfully on behalf of service users) when things go wrong with care and treatment, giving them reasonable support, truthful information and a written apology.
- We looked at the records of complaints and we saw that there were 13 complaints relating to maternity services; four of these related to diagnosis of foetal abnormalities.
- There were 10 complaints about gynaecology services; four of these were about access to fertility services.
- We found that management staff were aware of the complaints that had been received and how these had been managed and or resolved.
- We spoke to the head of midwifery about complaints and concerns. The head of midwifery had identified governance reform as a priority early in her employment with the Trust. Some surgical activity had been moved to enable staff including consultants the opportunity to participate in combined education and audit meetings. We saw evidence of discussion and shared learning from incidents and complex cases discussed in perinatal mortality minutes and the maternity governance board minutes. This was good because it showed that learning from incidents and complaints is shared across professional disciplines in maternity and gynaecology services.

Are maternity and gynaecology services well-led?

Good



We rated maternity and gynaecology services good for well-led. The head of midwifery had reviewed and reinvigorated the governance structure. The head of midwifery had implemented a new reporting structure within maternity services, had empowered staff to innovate and had a five year development plan for the service.

Staff we spoke to in focus groups told us that a shift in culture occurred since the appointment of the head of Midwifery and we saw that some elements of maternity services leadership were outstanding. All professional disciplines saw the head of midwifery as a strong, dedicated and supportive leader. Midwifery staff told us in a focus group that other senior management had been more visible and appeared more willing to engage since changes had been made by the head of midwifery. We heard that the combination of senior nurses and the Head of Midwifery were empowering staff to develop the service. Midwives told us that supervisors of midwives and practice development midwives were dedicated, professional and supportive.

Vision and strategy for this service

- The Trust had incorporated the five care Quality Commission (CQC) domains (Safe, effective, caring, responsive and well-led) into their vision and values. We identified in focus groups that some staff were more or less familiar with the Trust's strategic values and a few told us they had participated in development of these.
- Maternity services had benefited from investment in the in-patient environment and there was a time bound Maternity Services Development Plan.

Governance, risk management and quality measurement

- The maternity governance structure had been revised in such a way as to include all professional disciplines. Risk management practices had been revised, and recently implemented. The reporting structure now included a maternity risk and governance committee that would meet monthly.

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- We saw evidence in the Board Assurance Framework (BAF, May 2015) that the Trust is aware a number of policies and guidelines were out of date. Evidence seen in Safety & Quality Governance Committee meeting minutes showed that the Trust has discussed the BAF and identified lead clinicians to address shortfalls. The Medical Director was responsible for ensuring policies and guidelines were updated. The Trust had a plan in place to ensure these were reviewed and where required updated.
- We saw that some local audit activity had commenced. For example the ward dashboards showed evidence of audit of hand hygiene, Friends and Family Tests (FFT), shoulder dystocia, post-partum haemorrhages and mandatory training attendance.
- The Trust had a forward audit plan for maternity that showed audit history, responsible clinician and proposed start date for all the activity which was September 2015.
- Some national audit activity had yet to be fully completed resulting in a lack of evidence of robust monitoring to support evidence based practice..
- There was a separate obstetrics and gynaecology plan that included planned audit of for example National Institute for Health and Care Excellence (NICE) guidelines for fertility and ectopic pregnancy with a start date of June 2015.
- Maternity and obstetric staff had participated in multi-disciplinary root cause analysis training.

Leadership of service

- Staff told us that lots of work had been started by the head of midwifery following changes in the governance structure. Midwives told us they were pleased to have been empowered to improve maternity services. One supervisor of midwives said, “We were all on springs waiting for opportunities.”
- Staff consistently told us they felt supported, empowered and were happy working at James Paget Hospital. Staff valued their colleagues and managers support during patient care and in particular when traumatic events occurred they told us they had felt supported and valued.
- In the focus group midwives told us that multi-disciplinary working had greatly improved since the new head of midwifery arrived in January 2015. They told us that prior to this time the maternity service had functioned with limited interaction between other

services. They also told us that the director of nursing has started to attend maternity services meetings; gynaecology consultant engagement had improved and they had been able to share maternity service good practice.

- The head of midwifery, appointed in January 2015 rapidly identified key areas of risk and was able to clearly describe the challenges and priorities of her role. For example developing the safety and governance culture and recruiting additional staff through talent spotting and development of current staff.
- The head of midwifery had reviewed the governance structure and changed the list times for some surgical procedures to enable medical and anaesthetic colleagues to attend the education and audit meeting.
- The head of midwifery implemented a daily report so that she could get an overview of how many patients are in the maternity services each day, staffing levels and any risk factors she needed to take account of.
- The practice development midwives (PDM) told us that they had been encouraged by the head of midwifery to develop and provided evidence of improvements in the forms of the emergency skills and drills training manual, the bank midwifery support worker orientation and induction training manual for agency midwives and separately for midwifery support workers. The practice development midwives also provided a copy of the maternity department training report which evidenced multi-disciplinary emergency skills and drills training.
- The midwives responsible for developing the triage bay on central delivery suite explained they had been encouraged by the head of midwifery to implement this change due to increased need for assessment of patients with risks that could not be assessed in the community. For example where foetal heart monitoring might have been required.
- Staff told us that the head of midwifery, the divisional director and director of nursing were highly visible, accessible and respected by staff of all disciplines.
- All staff we spoke to expressed great respect for midwifery colleagues including, the head of midwifery and obstetricians.
- We spoke to medical and nursing staff who had raised concerns about a perceived lack of professionalism of senior medical staff in gynaecology. Staff we spoke to told us that when required medical staff do work together in an emergency but do not reflect the Trust values and behaviours at other times.

Maternity and gynaecology

- Inspectors asked the divisional director about these concerns regarding poor recruitment practices. The divisional director told us that the Trust had commissioned an independent review of the issues and they had an action plan facilitated by the human resources director. The action plan was time bound, with senior staff allocated responsible for implementation and monitoring. The copy dated May 2015 showed some progress had been achieved including review and re-launch of a raising concerns policy, development of a clinical incident reporting trigger list and establishment of a clinical incident review panel.

Culture within the service

- The culture within maternity services was open and promoted co-operative and supportive relationships between staff and patients.
- Staff lacked awareness of the Duty of Candour required of Trusts to inform patients when things go wrong. However, the approach described by maternity staff showed that staff had a genuine desire to provide appropriate care and make amends very quickly when care was sub-optimal.
- We spoke to three junior doctors, three middle grade doctors and three consultants. Junior doctors told us they had been given a thorough induction for obstetrics and gynaecology. They also told us that teaching and learning opportunities happened weekly and were very good.
- We saw evidence in the ward 4 newsletter that the ward manager provides a mixture of encouragement and essential information for other staff working on the gynaecology ward.

Public engagement

- The maternity services use a variety of communication methods including a virtual tour of the Dolphin suite on the Trust website. We saw evidence of use of social

media to encourage patient participation in for example the maternity services liaison committee. Patients told us that they could not think of anything that this service could do better.

- The Trust had plans to expand the use of the midwife led birthing unit and to offer a better access to a head of midwifery birth service; for example through use of a maternity services Twitter account to engage patients.
- The Trust scores well in the FFT and better than the England average in the care quality commission (CQC) survey of women's experiences of maternity services in 2013 for participation of relatives, being spoken to in a way that could be understood and midwife presence during labour.







Staff engagement

- The maternity leadership encouraged a 'bottom-up' approach to innovation and in making changes. Staff told us they had been empowered by the changed approach in leadership. They also told us they felt invested in, valued and supported by the leadership team.
- The 2014 staff survey for James Paget hospital showed that staff at this Trust are consistently more motivated and satisfied with the quality of work and patient care they are able to deliver than for other Trusts nationally.

Innovation, improvement and sustainability

- The environment on central delivery suite (CDS) had recently been upgraded and included a four-bed bay to triage women who might be in labour, or who may have complications that could not be assessed in the community.
- Staff told us in a focus group about reconfiguration of the triage service within the central delivery suite and we saw this worked well.
- The Trust is a UNICEF Level 2 baby friendly organisation and had recently applied for a Level 3 assessment.
- The Trust was part way through a rolling programme of multi-disciplinary root cause analysis training to improve joint investigations when things go wrong.

Services for children and young people

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

Information about the service

James Paget University Hospital NHS Foundation Trust provided children's and young people's services to a population of approximately 230,000 people throughout Great Yarmouth, Lowestoft and Waveney.

Children's services at the trust included a 29 bedded ward called ward 10. Ward 10 provided medical and surgical care and was further broken down into two further areas; 10a and 10b. 10a provided medical care, which included a six bedded bay, four side rooms, two high dependency rooms and a paediatric assessment unit. 10b provided surgical care which consisted of eight beds, along with a six bedded young person's unit. This unit had three single same gender rooms with en-suite facilities for two people aged 13 years or above, as well as a sitting room. As part of the Children's and young people's service, we also visited the Newberry child development centre. The clinic provided healthcare services to children from infancy to adolescence who were vulnerable due to additional needs.

The hospital provided level one care for babies in a nine cot neonatal unit. One cot was designed to provide intensive care up to a period of 24 hours, two cots were high dependency cots and six cots were for babies requiring special care. The neonatal service provided a full range of medical services required by babies born at 30 weeks gestation and above. Babies who were born under 30 weeks gestation or required longer term ventilation were stabilised and transferred to another hospital that could provide on-going ventilation. The Neonatal unit was part of

a network of neonatal services throughout the east of England region and the network had a dedicated transport team for when a sick baby needed transferring to another hospital in the region.

The trust also provided outpatient services for children and young people, from birth to adult care at the hospital and also in the community. The clinic space at the hospital was shared with the antenatal clinic.

During our inspection of children's and young people's services at the James Paget University Hospital NHS Foundation Trust we visited the neonatal unit, the children's outpatient department and ward 10a and 10b. We also visited the surgical theatres and radiology. We spoke with 34 members of staff, including medical staff, nursing staff, housekeeping staff, nursery nurses, play specialists, managers and other members of the multidisciplinary team; five parents and four children.

Services for children and young people

Summary of findings

The children's and young people's service was good overall.

James Paget University NHS Foundation Trust delivered hospital based and community based services to children, young people and their families throughout Great Yarmouth, Lowestoft and Waveney.

The trust did not follow Royal College of Nursing best practice guidance (2013) in relation to nurse staffing levels for children's and young people's services. This was because there were insufficient experienced band six nurses employed over the 24-hour period to provide the necessary support to the nursing team on ward 10. However the trust ensured that an appropriate skill mix of nursing staff was available on the ward.

Although, risks to patients were assessed and managed, staff had not consistently monitored the emergency resuscitation equipment. We found gaps in the records used when checking this equipment and we also found equipment which had passed its expiry date in the resuscitation trolleys on ward 10.

Patients received evidence based care and there good examples of collaborative working in the across the multidisciplinary team. Staff were caring, compassionate and respectful. Staff were positive about working in the service and there was a culture of openness, flexibility and commitment to working as a team. Staff told us they aimed to provide family centred care and empowered parents to take some ownership of care to prepare for discharge. There was a culture of openness, flexibility and commitment. Arrangements were in place to minimise risks to children and young people receiving care, and there was effective monitoring of quality and outcomes.

Are services for children and young people safe?

Requires improvement



The safety of this service required improvement as patients were not always protected from the risk of harm. The trust did not follow Royal College of Nursing (RCN) best practice guidance (2013) in relation to nurse staffing levels for children's and young people's services. This was because there were insufficient experienced band six nurses employed over the 24-hour period to provide the necessary support to the nursing team on ward 10. This had not been identified as a risk of the service's risk register and although staff told us they were only just meeting the guidelines, there were times when the ward was full and staffing levels were not in line with the guidance. Senior staff told us they mitigated the risk by allocating patients to nursery nurses and an additional member of staff over the winter months.

There were shortfalls in children's level 3 safeguarding training with all staff groups except administrative and clerical staff falling significantly below the trusts target of 95%.

We found that medicine refrigerator temperatures were not being monitored at the Newberry child development centre and corrective action was not being taken when the refrigerator temperature was out of its expected range.

There were no emergency call buttons in the toilets at the Newberry child development centre. This meant there could be a delay in summoning help if an emergency situation arose in the toilet area.

Although, risks to patients were assessed and managed, staff had not consistently monitored the emergency resuscitation equipment. We found gaps in the records used when checking this equipment and we also found equipment which had passed its expiry date in the resuscitation trolleys on ward 10.

The service had good systems in place for the prevention and control of infection and there was a good use of tools to detect deterioration of patients on ward 10 and in the neonatal unit.

Incidents

Services for children and young people

- Senior staff were clear about their responsibilities in reporting and reviewing incidents.
- Staff reported incidents and these were discussed at monthly risk management meetings. We saw that incidents were discussed at these meetings; however, an outcome was not given for each incident discussed.
- Staff we spoke with were mostly aware of the themes of incidents being reported throughout children's and young people's services.
- Incidents were reported through the trust's electronic reporting system and there was a tick box for staff to complete if they wished to receive feedback about an incident they had reported. Nursing and medical staff also told us they received feedback about incidents they had reported.
- The Paediatric Secretaries at the Newberry clinic report told us they recorded incident forms which they sent to the clinical co-ordinator. These were investigated and discussed at the monthly Governance Meetings. Incidents were discussed to ensure lessons were learned and staff were able to give examples of where this had happened.
- Information provided by the trust indicated there were 82 reported incidents between January 2015 and April 2015. 38 of these incidents were related to the Newberry clinic. None of these had been classified by the trust as serious incidents requiring investigation. An analysis had been documented for each incident and an outcome was recorded. We saw evidence that appropriate incidents were shared with other staff in order to prevent future reoccurrence.
- Doctors told us that paediatric mortality and morbidity meetings took place and we saw reference to them in the minutes from the risk management meetings. We asked to see the minutes of mortality and morbidity meetings but the trust was unable to provide these. The trust stated they knew this was not good practice and they were putting steps in place to ensure minutes were taken and an action plan was completed and discussed at each meeting.
- The Duty of Candour regulation came into force in November 2014. It is intended to ensure providers are open and transparent with patients and sets out specific requirements that providers must follow when things go wrong with care and treatment. The trust stated the chief executive was responsible for duty of candour, however, this responsibility had been delegated to the director of nursing, and that staff were informed about

duty of candour at induction and were reminded of it at staff meetings. Whilst senior staff were able to tell us that duty of candour referred to being open and honest, staff we spoke with at ward level were unsure about what duty of candour meant for them.

Safety thermometer

- As required, the hospital reported data on patient harm each month to the NHS Health and Social Care Information Centre. This was nationally collected data providing a snapshot of patient harms on one specific day each month. This included data from ward 10. It covered hospital-acquired (new) pressure ulcers; patient falls with harm; urinary tract infections; and venous thromboembolisms (VTE) [A thromboembolism is also known as a deep-vein thrombosis]. From January 2015 to July 2015, ward 10 had reported 100% harm-free care for the snapshot during this period.

Cleanliness, infection control and hygiene

- The Department of Health's Code of Practice on the prevention and control of infections and related guidance was adhered to within the paediatric ward and the neonatal unit.
- All waiting and clinical areas we inspected were visibly clean.
- There were cleaning routines to ensure, for example, the regular cleaning of toys and confirmation that they cleaned equipment each time after use.
- Staff were compliant with the trust's infection control policies and protocols such as hand hygiene and bare below elbows policies.
- Staff demonstrated they had a good understanding of infection prevention and control. There were supplies of personal protective equipment such as gloves and aprons available in clinical areas and we observed staff using them appropriately. Staff wore visibly clean uniforms.
- All wards had antibacterial foam dispensers at the entrances, by sinks and by patient's bedside areas. Appropriate signage regarding hand washing for staff and visitors was on display.
- We observed that the management of sharps complied with Health and Safety (Sharp Instruments in Healthcare) Regulations 2013.
- There were adequate side rooms which were used for babies, children and young people who needed to be kept in isolation due to infection, or to avoid infection.

Services for children and young people

- There had been no recent incidents of hospital acquired *Clostridium difficile* (C-Diff) or methicillin resistant staphylococcus aureus (MRSA) in the children's and young people's services.
- Hand hygiene audits were undertaken to monitor compliance with hand hygiene, with the result included in the ward dashboard for ward 10 and the neonatal unit. We noted that compliance was at 100%.
- There had been no recent incidents of hospital-acquired *Clostridium difficile* (C-diff) or MRSA in the children's and young people's services.
- There were cleaning rotas for toys, nursery and clinical areas at the Newberry child development centre.
- We noticed a large clinical waste disposal unit on wheels in one corner of the nursery at the Newberry child development clinic. This could be accessed by children and posed an infection control hazard. The clinical co-ordinator told us there were plans in place to partition the unit so it could not be accessed.

Environment and equipment

- The buildings, although dated in part, looked well maintained.
- In order to maintain the security of babies, children and young people, visitors were required to use the intercom system outside the paediatric ward and the neonatal unit to identify themselves on arrival before they were able to access the ward areas. Staff had swipe cards to access and exit these doors.
- We saw equipment suitable for babies, children and young people in all clinical areas.
- We reviewed a sample of equipment items on ward 10 and the neonatal ward and found that equipment had been serviced and Portable Appliance Test (PAT) tested in line with requirements. We saw evidence that PAT testing took place at the Newberry child development centre. However, a blood glucose machine in the dental room did not have a PAT test label and we were not able to identify when it was last tested. We escalated this to the nurse in charge.
- The checking of oxygen and suction on ward 10 was undertaken by the house keeper on the ward. This person had received informal training by the nurses on the ward to undertake this task. We checked to see if this task was included in the job description of the house keeper and found that for this trust it was. We noted gaps in the checking of oxygen and suction equipment. The gaps corresponded with the house

keeper not being on duty. This meant that registered nurses were not taking responsibility for the checking of this equipment as stated in the trust's resuscitation policy and essential lifesaving equipment was not always checked on a daily basis as it should have been.

- There were three resuscitation trolleys on ward 10. Two were located on ward 10a, one in each of the high dependency side rooms; the other was located on ward 10b, the surgical area of the ward. We examined the resuscitation trolleys on ward 10a and 10b, to ensure daily checks were taking place and the equipment was safe to use and fit for purpose. We found there were gaps in entries for the checking of the resuscitation trolleys, which meant the equipment on the trolleys was not always checked appropriately. We scrutinised the checking records from January 2015 to June 2015 and found there were long periods of time when the resuscitation trolleys in the high dependency side rooms had not been checked. Between January 2015 and June 2015 the resuscitation trolley in side room one had not been checked between six and 16 times on a monthly basis. The resuscitation trolley in side room two had not been checked between six and 20 times for the same period of time. The resuscitation trolley located in 10b was checked on a daily basis. We spoke with a senior nurse about the gaps in checking the equipment in the high dependency rooms. The nurse told us that staff did not check the trolleys because they did not want to disturb patients at night. In addition, the tamper proof tabs were removed from the trolleys when the high dependency rooms were in use so that staff could quickly access the equipment in an emergency. We checked the equipment on all three resuscitation trolleys and found equipment that had passed its expiry date on all three trolleys. The equipment consisted of endotracheal tubes [endotracheal tubes are tubes that go into the trachea to aid a patients breathing in an emergency situation] syringes and intravenous giving sets which could have been used to administer medication into a vein and dressings. We also found some equipment for which the packaging had been opened. The equipment was no longer sterile and the expiry date was no longer valid. This meant that patients were not always protected from the risk of avoidable harm. We escalated our concerns immediately to a senior member of nursing staff. The next day we saw

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that action had been taken to remove all out of date equipment and an action plan was drawn up to ensure appropriate checking of emergency resuscitation equipment took place.

- The shortfalls in monitoring the resuscitation equipment meant that staff were in breach of the trust resuscitation policy which identified that 'staff perform and record daily resuscitation equipment checks.
- Resuscitation equipment on the neonatal unit and the recovery area of the surgical theatre was recorded as checked appropriately.
- There was no resuscitation equipment in the paediatric outpatient area. Nursing staff told us that in the event of an emergency, patients would be taken to ward 11 and an emergency call would be put out to the resuscitation team. The nearest resuscitation trolley and defibrillator (equipment used to treat life-threatening heart conditions) was on ward 11. A senior nurse told us this had been approved by the resuscitation department and a risk assessment had been drawn up. We asked the trust for their risk assessment in relation to this. The risk assessment was received following our inspection and had a date of 25 August 2015. We could therefore not be assured that a risk assessment had previously been undertaken.

Medicines

- The trust policy for safe management of medicines was in line with National Institute for Health and Care Excellence (NICE) guidance. We saw that staff used local trust protocols when administering medication for babies, children and young people.
- Medications were prescribed on medication administration charts throughout the children's and young people's services.
- We looked at the prescription and medicine records of five patients on the paediatric ward. We saw that appropriate arrangements were in place for recording the administration of medicines. These records were clear and fully completed. Medication administration charts included allergies and the weight of each patient.
- Medicines requiring cool storage were stored appropriately on ward 10 and in the neonatal unit. Records showed that medicines were stored at the correct temperature and so would be fit for use.. However, we found that medicines requiring cool storage were not always stored as they should have been at the Newberry child development centre. We

found a medicines refrigerator in the dental clinic had a reading of 9.3°C. There was no record to indicate the refrigerator temperature had been monitored and appropriate action had not been taken. Patients were therefore at risk of receiving medication that was not fit for purpose. We escalated this immediately to the sister in charge of the clinic.

- Controlled drugs (medicines that are required to be stored and recorded separately) were stored and recorded appropriately.
- There was a pharmacy top-up service for ward stock and other medicines were ordered on an individual basis. This meant that medication was available for patients when it was needed.
- A pharmacist technician visited the paediatric ward each weekday. Pharmacy staff checked that the medicines patients were taking when they were admitted were correct and that records were up to date.
- The pharmacist for the paediatric ward was not a specialist in paediatric medicine and there was no pharmacist allocated to the neonatal unit. However, staff on the neonatal unit told us they could obtain advice from a pharmacist if this was required.
- Liquid medications on ward 10 were not dated and signed on opening. 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.
- There was a quarterly audit of controlled medicines across the division.

Records

- Information Governance training was included in the trust's mandatory training programme.
- Babies, children's and young people's records were kept securely.
- We reviewed the medical and nursing records for five patients who were receiving care throughout the children's and young people's service. These records were mostly complete, accurate, legible and up-to-date. However, within two sets of the records we noticed that the fluid balance charts had not always been totalled up at the end. This meant the fluid balance for each patient was not always available to inform the treatment of patients.
- The trust had developed a paediatric assessment booklet which was age specific. There was one for

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patients aged 0 to 11 months, one to four years, five to 12 years and 13 to 18 years. This was a multidisciplinary record which allowed members of the team to document relevant information relating to the patient's admission. We saw good evidence of multidisciplinary input within the records.

- Risk assessments had been completed for children where required, for example, a venous thromboembolism (VTE) risk assessment was undertaken for young people aged between 13 and 18 years.
- A records audit had been undertaken on ward 10. However, it was difficult to determine when the audit had been completed and how frequently the audits were performed. The audit information looked at various aspects of documentation including patient identification, nutrition and fluids, care planning, pain, medication charts and the recording of physiological observations. The compliance rate varied from 100% for pain scores to 75% for patient identification. There was no action plan attached to the audit or any indication of whether scores had improved or got worse.

Safeguarding

- Safeguarding governance reporting arrangements were in place to ensure that safeguarding processes were monitored trust wide.
- The trust had an up-to-date local safeguarding children policy in place. This had been written in line with national policy and guidance. We noted that the policy did not include a section on the process to follow in deciding whether or not a safeguarding referral was required when a patient or their parent self-discharged before the patient was deemed medically fit.
- The trust had developed guidelines for the management of children under the age of 16 who absconded from children inpatient areas. This gave guidance on the risk factors that indicated a child would be at risk from absconding and the actions to take to minimise the risk. The guidance also detailed the actions that should be taken in the event of a child absconding or being abducted.
- The trust had a three year children's safeguarding strategy which set out the trusts priorities for safeguarding children. The roles and responsibilities of the named leads for safeguarding children were clearly set out within the strategy.
- The trust had named safeguarding leads who worked alongside the director of nursing. The director of nursing was the executive lead for safeguarding children within the trust. The trust also had a named non-executive director for the safeguarding of children and young people.
- The named nursing lead for safeguarding had only been in post since May 2015 and was working hard to develop the service. There was no paediatric liaison nurse or health visitor within the trust and we were told that historically this role had been undertaken by the nursing lead for safeguarding. This was impacting on their workload and the development of the service.
- An annual trust children's and young people's safeguarding report was presented at trust board.
- The trust met the statutory requirements in relation to 'Disclosure and Barring Service (DBS)' checks. All staff working with children underwent an enhanced level of DBS assessment.
- The trust had responded to a national safeguarding concern which had led to the publication of a report with recommendations from the trusts that had an association with the perpetrator. In 2014 the trust set up a multidisciplinary team to review the recommendations within the report and the group developed an action plan for implementing the recommendations of the report within the trust.
- The trust had a safeguarding training strategy which outlined the commitment of the trust to provide safeguarding training for all staff working within the trust.
- We spoke with members of staff of all grades on ward 10 and the neonatal unit, and they all confirmed they were up-to-date with their level 3 safeguarding of children training. The trust's most recent training figures for the elective division confirmed that 100% of administrative and clerical staff had completed this training, however all other staff groups were below the trust's target of 95% for completion of this training with 87% of staff completing level 3 training in children's services.
- Nursing staff who were working in the recovery area of theatres told us they had not undertaken level 3 training in the safeguarding of children. They worked solely within the recovery area.
- All nursing and medical staff we spoke with knew who the trust's safeguarding leads were and how to seek guidance.

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- We reviewed the nursing and medical records of a patient who had been identified as having a safeguard in place. The patient had been discharged the evening before and the discharging doctor had overlooked the safeguarding concerns prior to discharging the patient. We looked at the trust's database and found the patient was not on the trust's safeguarding database. The lead for safeguarding acknowledged the patient should have been on the database and this was an oversight due to a combination of factors. Following escalation of our concerns appropriate referrals were made for the patient who had been discharged.
- We found the electronic database for children of concern had only recently been implemented. It was well populated with appropriate information. We saw good evidence of communication across all agencies concerned with the safeguarding of children.
- At the time of our inspection the trust had no regular child protection supervision in place for staff. However, the safeguarding lead told us this was a gap in the service but there was a plan to develop child protection supervision in the future. The trust had just developed a safeguarding supervision policy to ensure appropriate staff received supervision and to ensure safeguarding practice was in line with national policy.
- Ward 10 was funded to provide two high dependency beds for children.
- The level one neonatal unit had nine cots, one of which was an intensive care cot, which could be used for up to 24 hours, two were high dependency cots and six were for babies requiring special care.
- The neonatal unit was part of a network of neonatal services throughout the east of England region and the network had a dedicated team from the acute neonatal transfer service (ANTS) for when a sick baby needed transferring to another hospital in the region.
- The service also had access to the children's acute transport service (CATS) for the transfer of children requiring paediatric intensive care support at another hospital within the region.
- Children and young people who deteriorated whilst visiting the outpatient clinic were initially taken to ward 11 where their condition could be monitored.
- Data provided by the trust indicated that ward 10 admitted young people with mental health concerns up to the age of 19 years. Staff were aware of the potential risks of admitting these patients to the paediatric ward, however there was no risk assessment to determine the level of risk or to determine the actions that should be undertaken to reduce the level of risk.
- The children's and young people's service had introduced paediatric sepsis six and recognised sepsis as a clinical emergency. Staff used a paediatric sepsis six tool to detect whether a child was experiencing sepsis. The tool outlined the steps that should be followed in the event of a child developing sepsis. Information from the trust indicated the standard of performance for 2015 was at 100%.

Mandatory training

- Mandatory training was completed in a variety of ways, including face to face and eLearning.
- We spoke with members of staff of all grades, and they all confirmed they had received a range of mandatory training and training specific to their roles, for example health and safety, infection control, information governance and medicine management.
- Divisional mandatory training data submitted by the trust showed that between 63% to 100% of staff were up to date with mandatory training. This did not meet the trust's target of 95%.

Assessing and responding to patient risk

- A paediatric early warning (PEWS) tool was used to monitor and manage deteriorating patients on ward 10 and a neonatal early warning score (Neonatal EWS) was used to monitor and manage deteriorating babies within the neonatal unit and transitioning care patients on ward 11. The PEWS was adapted according to the child's age and we saw examples of these having been completed with scores accurately calculated.

Nursing staffing

- At the time of our inspection, the trust was not using an acuity tool to identify the required nursing staffing levels for ward 10. The lead nurse for children's and young people's services told us they had tried to use an adapted tool to triangulate staffing acuity, however had experienced difficulties because of the complexities of the services provided on ward 10. The service was looking at the Paediatric Acuity and Nurse Dependency Assessment (PANDA) tool to see if they could use it within the service.
- Best practice staffing guidance had not been fully applied within the children's and young people's service as senior nurse cover at band six was not always present

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on every shift on ward 10. We reviewed two nursing off duty rotas from ward 10 which showed that band six cover was not available on the night shift. This meant that experienced, competent band six nursing provision was not available to support staff 24 hours a day seven days a week as recommended by the Royal College of Nursing guidance which defines staffing levels for children and young people's services. This had not been identified as a risk of the service's risk register and although staff told us they were only just meeting the guidelines, there were times when the ward was full and staffing levels were not in line with the guidance. Senior staff told us they mitigated the risk by allocating patients to nursery nurses and an additional member of staff over the winter months.

- On the neonatal unit there were three members of staff on each shift. One of which was qualified in the speciality of neonatal nursing, one was a registered nurse and one a nursery nurse. In addition, there was a band seven senior sister who had no clinical workload. This allowed the unit to achieve one to one nursing care for babies requiring intensive care, one to two nursing care for babies requiring high dependency care and one nurse to four babies who were receiving special care.
- The trust did not use agency nurses within the children's and young people's service. Nursing staff explained that the hospital's own staff were used to provide 'bank' cover. Because nurses rotated between the neonatal unit, ward 10, theatres and the emergency department, their skills were transferrable between all of these areas.
- We observed a nurse handover where an overview and update was given to the incoming team by the nurse in charge. The handover was clear and efficient and was backed up by an electronically updated multidisciplinary handover sheet.
- A review of incidents showed no reporting for staffing shortages on ward 10 with one reported incident for the neonatal unit. There were no shortages reported as incidents for the children's outpatient clinic.

Medical staffing

- The children's and young people's service had a higher percentage of consultants and middle grade doctors than the England average.
- The trust met the 2015 standards for acute general paediatric services as recommended by the Royal College of Paediatrics and Child Health (RCPCH). The children's and young people's service employed six full

time paediatric consultants and two consultants who filled registrar shifts as and when needed. This meant the trust used their own medical staff rather than filling shifts with locum doctors.

- Consultant cover for ward 10 and the neonatal unit was available 24 hours a day, seven days a week. The consultant rotas provided details of which paediatricians to contact that week. Medical and nursing staff said they could access consultants out of hours and described the consultant team, registrars and middle grade doctors as supportive. There was a separate rota for ward 10 and the neonatal unit. A senior doctor and a junior doctor covered the neonatal unit 24 hours a day, seven days a week. The same arrangements were in place for ward 10.
- There were sufficient doctors on duty to ensure safe and effective care. We found all rotas fully covered, with consultants attending at night and weekends when needed.
- There were shortfalls in medical staffing at the Newberry child development centre. There had been a full time consultant vacancy since February 2013. The position had been advertised on three occasions but there had been no expression of interest. This post had been filled with a long term locum doctor. The trust reported another consultant was due to retire in April 2016 which would result in further challenges to recruitment and viability of the service.

Major incident awareness and training

- Staff confirmed they had received fire training. Information provided by the trust indicated that most staff throughout the elective division had received this training but only 85% of midwives and nurses and 86% of medical and dental staff had completed this training.
- Information received by the trust did not indicate that major incident awareness was covered as a part of mandatory or statutory training.

Are services for children and young people effective?

Good



The effectiveness of this service was good.

Services for children and young people

Overall the service provided effective services to the local population and multidisciplinary team working had resulted in positive outcomes for children. The provision of service was evidence based and clinical guidelines we reviewed were all within their review date.

Auditing systems were in place, which had informed practice, introduced changes and lessons learnt to improve outcomes for children and young people. The neonatal service had been accredited with stage two United Nations International Children's Emergency Fund (UNICEF) Baby Friendly accreditation.

Evidence-based care and treatment

- Guidance from authorities such as the Royal College of Paediatricians and Child Health (RCPCH) and the National Institute for Health and Care Excellence (NICE) were used to inform care.
- Medical staff confirmed the use of evidence based guidelines. We saw the guidelines used in the neonatal unit were effectively East of England adapted guidelines.
- We reviewed a selection of guidelines and observed them all to be in date.
- The children's and young people's service had implemented paediatric sepsis six with the recognition that sepsis was a clinical emergency. There were clear guidelines for staff to follow.
- The trust had taken part in the 2014/15 healthcare quality improvement partnership audits for paediatric diabetes, childhood epilepsy and neonatal intensive and special care. and were included for the asthma audit for 2016.
- The trust used evidence based guidelines for recognising conditions such as bronchiolitis and gastroenteritis.
- There was a comprehensive audit plan in place for children's services with an identified clinician to lead each.

Pain relief

- Distraction techniques were used to distract children from painful procedures and anaesthetic cream was used when taking blood from children.
- An audit of patient records on ward 10 showed a 100% compliance rate with monitoring patient's pain scores.

- Staff told us they would initially ask patients about their pain, but would also consult with parents and carers as they were in a better position to know whether their child was in pain.
- Children's pain scores were incorporated into the patient's early warning sign charts. We saw evidence of these being recorded through the documentation reviews we undertook.

Nutrition and hydration

- Drinks, snacks and an appropriate choice of food were available for children and young people.
- There was a multidisciplinary approach to provide support for children with their long-term nutritional needs.
- We observed a meal time and found that choice was supported and that children and young people got their preferred meal when they wanted it.
- The nutrition provided for babies and children on ward 10 was age appropriate. Parents were involved in the planning of their child's nutrition.
- The neonatal unit actively encouraged breast feeding and were stage two accredited for the United Nations International Children's Emergency Fund (UNICEF) baby friendly initiative.
- The patients and parents we spoke with told us they were satisfied with the food and hydration provided.

Patient outcomes

- A dashboard was used by the department to monitor performance. The dashboard reported on data relating to staffing levels, patient safety, infection control, patient experience and workforce management.
- Readmission rates for paediatric patients were higher than the England average for patients who were undergoing non-elective general surgery up until 17 years of age.
- Readmission rates for children aged between one and 17 years was worse than the England average for patients who had asthma and diabetes. Proportion of children with HbA1c [HbA1c is a measure used for diagnosing diabetes] level in target is much less than the England average in Paediatric Diabetes Audit 13/14. Doctors at the trust told us this was because there was a higher incidence of childhood obesity in the area.

Services for children and young people

- Multiple admission rates for children attending the James Paget were lower and therefore better than the England average for diabetes and epilepsy but slightly worse than the average for asthma.
- The trust had introduced the sepsis 6 bundle throughout children's and young people's services in June 2015. At the time of our inspection this had not yet been audited. There were plans to complete an audit in September 2015.
- For 2015/16 the paediatric clinical audit plan included a list of audits the trust was due to take part in. We saw there were regular paediatric acute and community audit meetings and these were led by a consultant paediatrician.

Competent staff

- Staff confirmed attendance and satisfaction with corporate and local induction processes.
- All staff within children's and young people's services rotated between ward 10, the neonatal unit, emergency department and the recovery area. This ensured staff maintained skills in all of these areas and allowed for flexibility of skilled staff as required throughout the service.
- Information received by the trust indicated that staff undertook simulation training. These were run once a month by a paediatrician and two paediatric nurses. A simulation baby was used and scenarios were given, for example for acute bronchiolitis. A debrief session took place following the scenario. Simulation sessions covered anatomy and physiology refreshers, training on the use of the paediatric early warning score (PEWS) tool and recognition of the deteriorating child with appropriate actions.
- Future sessions had been set using a simulation man so that adolescent scenarios can be undertaken.
- All staff we spoke with told us they had received an annual appraisal. The trust provided details of staff appraisal rates within the elective division from April 2014 to April 2015. The proportion of staff who had received an appraisal within this timeframe was between 83 to 100%.
- Staff working on ward 10 were responsible for caring for young people who had mental health concerns but had received very little training to prepare them for this role.

- Junior doctors confirmed that they had appropriate supervision and appraisals, and doctors confirmed they were up to date with their revalidation.

Multidisciplinary working

- A full multidisciplinary team meeting took place on a monthly basis.
- Daily ward rounds took place with attendance from the nursing lead for safeguarding and physiotherapist attending each Friday.
- We saw good evidence of multidisciplinary team working and staff told us that access to members of the multidisciplinary team such as physiotherapy and dietetics was good. However staff reported there was not adequate access to speech and language therapies throughout the children's and young people's service.
- Multidisciplinary team involvement was evident in children's and young people's medical and nursing records.
- Play therapists were available on the ward. They helped medical and nursing staff by supporting patients and developing plans to deal with managing pain or devising distraction techniques when children were having investigations undertaken.
- There were clear procedures in place to transfer children between the emergency department (ED) and the ward. Staff reported good working relationships between the two services.
- Whilst transition pathways were in place for patients with diabetes, there were no transition pathways for children with complex neurological conditions or for children with cystic fibrosis. The trust however stated they were in the process of rolling this out trust wide and developed an action plan. The action plan had been drawn up in August 2015, with an agenda to formally cascade transitional care planned in September 2015.
- The children's and young people's service had access to mental health support services.
- Information provided by the trust indicated there was no clinical psychology service accessible to the community outpatient team.
- The child development clinic at Newberry provided a diagnostic service for children with autism. Multiagency team meetings took place and families were referred to specialist services as required.

Services for children and young people

- Multiagency meetings at the Newberry child development centre took place in school term time. This enabled schools and the education system to be involved.

Seven-day services

- Twenty-four hour paediatric and neonatal consultant cover was in place. The consultant rotas provided details of which paediatricians to contact that week. Medical and nursing staff said they could access consultants out of hours and described the consultant team as supportive.
- Staff could access out-of-hours investigations, for example, imaging and urgent laboratory tests.
- Child and adolescent mental health services (CAMHS) were available from nine to five, Monday to Friday and for four hours on a Saturday morning. There was a crisis resolution team that could be contacted out of hours.

Access to information

- The children's nurses and doctors discussed information relating to the care of babies, children and young people at handovers to ensure essential information was communicated and help with continuity of care.
- The children's nurses and doctors spoke with parents about their loved ones to ensure they were kept up-to-date with plans and were involved wherever they could be.
- We observed as part of one post-operative child's journey that their parents received discharge letter and discharge information including who to contact if they were worried.
- Children's and young people's services did not have a discharge liaison officer, but discharge planning was multidisciplinary. On discharge a letter was sent to the patient's GP and health visitor and a nurse discharge letter was given to parents.
- Following discharge, staff on the neonatal unit undertook follow up phone calls to parents after discharge to discuss with parents how the baby is doing now, and to obtain feedback about their stay on the Neonatal Unit.
- One of the paediatric secretaries told us it was becoming more difficult to ensure people's records were available for their clinic appointments. This was because of the number of sites being used for

appointments. An incident of a set of records not being available was reported that morning. Staff told us that information was scanned into the electronic record system.

Consent

- The trust had an up-to-date local consent to examination or treatment policy to ensure staff were seeking consent in line with national guidance and legislation.
- Staff were required to undertake training in gaining consent as part of the trust's mandatory training programme. The trust had a target of 95% for the uptake of this training. 95% of nursing and midwifery staff, 93% of medical and dental staff and 100% of allied health professionals had completed this training throughout the elective division.
- Staff were required to undertake Mental Capacity Act (MCA) and Deprivation of Liberty Safeguard (DoLS) training as part of the trust's mandatory training programme. We looked at the uptake of this training and saw that medical staff were not included in the data. The uptake of this training by other staff was above the trust's target of 95%.
- Staff obtained consent from patients and or their parents / carers appropriately in relation to care and treatment. Staff were able to explain how consent was sought and how they involved both the child and the person with parental responsibility in obtaining consent where appropriate.
- The staff we spoke with had a good understanding of Fraser guidelines and Gillick competencies for assessing a child's ability to provide consent. [Gillick competence is a term used to decide whether a child (16 years or younger) is able to consent to their own medical treatment, without the need for parental permission or knowledge]. We saw a good example of this in the imaging department.
- We noted that verbal and / or written consent was obtained for both medical and surgical interventions. Consent forms for surgical procedures included an explanation of any risks to the child from receiving treatment.

Are services for children and young people caring?

Services for children and young people

Good



The care provided to children and young people using this service was good.

Children, young people and their parents said they had received compassionate care with good emotional support. Parents and young people said they were fully informed and had been involved in decisions relating to their treatment and care.

Facilities for both parents and children were satisfactory and support had been provided by the multi-disciplinary team during the child's admission, stay and in preparation for their discharge home.

Compassionate care

- Throughout our inspection we observed that all medical and nursing staff provided compassionate and sensitive family centred care that met the needs of babies, children, and young people and their parents or carers.
- At the Newberry child development clinic we observed an apprentice secretary interacting with a young person and were seen to be kind, cheerful and helpful.
- Staff had a positive and friendly approach and explained what they were doing, for example when administering medication or completing their clinical observations.
- We spoke with 5 parents of children and young people using the service who told us they were happy with the care and support they and their children had received.
- We spoke with one young person who told us that staff treated them with respect and made them feel involved in their care.
- Parents were able to accompany their children to theatres and recovery areas.
- The 2014 inpatient and day case surgery survey showed that children's and young people's services at the trust were found to be performing in line with or better than the national average in all aspects of care delivery.

Understanding and involvement of patients and those close to them

- We spoke with five parents about their experiences. Without exception, they told us they had been involved in and were happy with the care and treatment their children had received.

- Staff on ward 10 had designed a banana tree, on which children could provide feedback on their experiences of their care. There were numerous comments on the banana tree which indicated children had received a positive experience of their care. Negative comments were called fallen bananas and were placed at the foot of the tree. We saw one fallen banana at the foot of the tree which indicated a child did not like the needle they had in their hand.
- A wide selection of information was available for young people to access and parents told us they had received enough information to enable them to care for their child's needs.
- Families at the Newberry child development centre were involved in multiagency meetings concerning the care of their child.

Emotional support

- Nursing and medical staff provided emotional support to parents, children and young people on ward 10 and the neonatal unit.
- Patients and their families could access support as required from the chaplaincy service which provided a service across the hospital.
- The play specialist liaised with schools to ensure school work could be accessed whilst children were in hospital.
- Families of young people newly diagnosed with autism were visited at home six weeks following diagnosis. This allowed appropriate support to be given and to ensure families were aware of other support mechanisms for children with autism.

Are services for children and young people responsive?

Good



The responsiveness of this service was good.

The acute children's service was responsive and generally met children's needs. Where targets had not been achieved efforts had been made by the consultant staff to meet them. The trust however had been slow to respond to concerns relating to the children's outpatient clinic area which was shared with the antenatal clinic.

Although there was no clear plan in place to meet the needs of local people, access to the service and flow

Services for children and young people

through it, worked well. This was because there were short lengths of stay within the department and a low level of demand. The service had good support from a specialist centre in Cambridge.

There was evidence of transition pathway development although the only established transition pathway in place for young people with diabetes.

The parents and staff we spoke with told us that the care delivered within the neonatal unit, children's ward and paediatric clinics had met their needs.

There were shortfalls in medical staffing at the Newberry child development centre. This was impacting on referral to treatment times and had led to a backlog of patients who were waiting for appointments to be seen.

Service planning and delivery to meet the needs of local people

- The trust had a service level agreement with a mental health trust for the provision of a child and adolescent mental health service (CAMHS).
- Staff told us of their concerns relating to the children's outpatient clinic which was not meeting the needs of local people. The clinic waiting area was shared with women who were attending antenatal clinic. This was not an ideal situation for either group of patients.
- There was no dedicated recovery area for children. We found the paediatric recovery area in theatres was used to support both adults and children in the same area but separated by curtains around the bed space. This meant the dignity and privacy of patients in the recovery area could be compromised. We asked the trust for their risk assessment around this area of practice. We saw the risk assessment had been undertaken towards the end of August. This meant the risk had not been formally assessed previously. The risk assessment identified the recovery area would be improved during phase three of the upgrade project to provide an area which was more appropriate to the needs of paediatric patients.
- The children's and young people's service had a separate treatment room. This was a jungle themed room and was located off the ward. Invasive procedures such as taking blood were undertaken in this room. This was to prevent the children from associating their bed space with unpleasant experiences such as having their blood taken.

- Children who were booked in for operations were asked to come to the hospital on a Friday and were pre-clerked. The procedure was discussed and information was provided to parents and where applicable patients. Parents were given time to digest the information and consent was then taken when the child or young person was admitted to the ward for their procedure.
- A texting service was available for the parents of children who had gone to theatre for an operation. This was to ensure parents could be with their children at the earliest opportunity.
- The neonatal unit had a dedicated room for rooming in or as a place for fathers to stay if their baby was sick.
- The facilities at the Newberry child development centre were difficult to access for people using wheelchairs as some areas of the building were narrow.
- The learning disability liaison nurse also covered children's services supporting children and their parents.

Access and flow

- Neonatal and children's services provided good access to its services. Children with long-term conditions and those who had previously been admitted to the ward had open access to ward 10. The ward kept details of children and young people requiring open access and could easily access their records.
- The paediatric ward received referrals directly from the emergency department, GPs or midwives. The ward had an assessment unit, from which, depending on the condition of the child, they were either admitted or discharged home.
- Between February 2014 and January 2015, 93% of children under the age of one year had an average length of stay of less than one day.
- Neonates were admitted via maternity as a planned or emergency admission.
- The clinical lead for children's and young people's service told us there was a backlog for appointments in the community. Waiting times for new patients remained at six months and over twelve months for follow up appointments. However staff at the clinic told us that times for new patients had improved for children from one year to six years of age. This remained on the service's risk register.

Meeting people's individual needs

Services for children and young people

- There was a play area for young children who contained toys and books and a separate area for adolescents with a television, DVDs and books. A computer gaming system was available and the ward had free Wi-Fi which patients and their families could access.
- Parents had the option to stay overnight with their child. The ward could provide a foldaway bed or reclining chair if required.
- Translation services were available if required through a service called INTRAN. We were told there was limited demand for translation services.
- Patients with learning disabilities had an additional care plan which clearly set out their specific care needs. There was a learning disabilities liaison nurse at the trust.
- The learning disability and autism liaison nurse had received an employee of the year award in 2014 because they had made a significant impact on ensuring people with specific needs were recognised and were given equal access to care and treatment.
- Children with long term conditions had open access to the paediatric ward.
- Relatives of patients on the neonatal unit and ward 10 were provided with free car parking and were able to get a discount on meals purchased at the hospital.
- The neonatal unit had developed a breastfeeding pack to encourage new mums whose babies were on the neonatal unit to hand express their breast milk. The pack contained information and tips on hand expressing along with a personal expressing log in which mothers could detail the amount of milk they had expressed and the time they had spent doing positive touch or skin to skin holding as appropriate. The pack also contained a sterile galley pot, oral syringes and labels. There were knitted triangles that new mothers could place next to their breast to develop their individual smell. These were then placed in the cot with the baby so the baby could become familiar with their smell of their mother.
- To enhance family Centred Care on the neonatal unit, all babies admitted to the unit were given a memory bag on admission; a photo of the baby was taken so that parents had a first photo of their baby.
- Babies who were admitted to the neonatal unit, but who came from further afield, for example holiday makers, were given a bucket and spade upon their discharge. Staff told us this was given as a memento to remind them of their time spent in Great Yarmouth.
- The trust scored about the same as other trusts in the 2014 children's survey for having appropriate equipment or adaptation for children. Inpatient wards and outpatient clinics areas were accessible for people with disabilities, in line with the Equality Act 2010.
- Patients who were admitted to the ward with mental health needs were assessed by a member of staff from the child and adolescent mental health service (CAMHS) wherever possible. This service was available from 8.30am to 3pm Monday to Friday and Saturday morning. There was a clear pathway for emergency CAMH out of hours service. However, nursing staff told us if a child or young person was admitted to the ward on a Saturday evening, they would have to wait until Monday morning to be assessed.

Learning from complaints and concerns

- A small number of complaints had been received about the children's and young people's service. A total of 12 complaints had been received for the period January 2015 to August 2015. Five of these related to ward 10 whilst seven related to the outpatients department.
- Parents and visitors could raise concerns and complaints locally at ward level, or through the Patient Advice and Liaison Service (PALS). Leaflets were available to inform patients and the public about the procedure to follow should they wish to make a complaint.
- A paediatric secretary at the Newberry told us where complaints had been made; these had been or were being investigated.

Are services for children and young people well-led?

Good



The leadership of this service was good.

The leadership, governance and culture of the service promoted the delivery of high quality family-centred care.

A clear leadership structure was in place within the service. Individual management of the different areas providing acute children's services were well led.

Governance processes and some of the known clinical risks had been monitored. However staff throughout the

Services for children and young people

children's and young person's service told us they felt the admission of some young people who were in receipt of services from the child and adolescent mental health services (CAMHS) posed a risk to the service, especially as the service was admitting these patients up to the age of 19 years. However, this did not feature on the service's risk register.

Evidence of on-going innovation and improvement had taken place within the service which meant that service provision had been focused towards the needs of the child's and surrounding community's needs. There was a comprehensive audit plan in place for the coming years.

Vision and strategy for this service

- The lead nurse for children's and young people's services told us that staff had been given the chance to contribute to the trust's vision and values through the speciality forum. However when we spoke with nursing staff about the vision and values for the trust they were unsure about what the vision and values were. Not one member of staff told us they had been involved in the development of these vision and values.
- We saw the vision for children's and young people's services was displayed in the staff room. They were to deliver excellence in healthcare, high quality education and research.

Governance, risk management and quality measurement

- The service had a risk register which contained three current risks to the service. These included a brief record of the actions taken to mitigate risks, and we saw that there was appropriate assignment to an executive team member, with a review date to identify any outstanding actions or changes in risk levels. One of the risks identified was failure to meet NICE guidance in relation to ulcerative colitis. There was a clear and timely plan to address this risk.
- Staff throughout the children's and young person's service told us they felt the admission of some young people who were in receipt of services from the child and adolescent mental health services (CAMHS) posed a risk to the service, especially as the service was admitting patients up to the age of 19 years. However, this did not feature on the risk register.

- The leads for the children's and young people's service told us that governance was fed up to the board but they felt that nothing was ever fed back down from the board.
- A records audit had been undertaken on ward 10 though it was difficult to determine when the audit had been completed and how frequently the audits were performed. The compliance rate varied from 100% for pain scores to 75% for patient identification. There was no action plan attached to the audit or any indication of whether scores had improved or got worse.
- A comprehensive audit plan was in place for the children's services including sepsis (that was underway at the time of our inspection), pneumonia and others based on NICE guidance and treatment. All audits had been assigned to a clinician to lead.

Leadership of service

- The children's and young people's service was part of the elective care division.
- The children's and young people's service was led by a senior nurse and a lead clinician who had dedicated leadership time. They provided clear direction and were well liked and respected by staff. The leads for the service were aware of the risks within the service but were unable to tell us who represented the children's and young people's service at executive level, but did tell us they received good support from the director of nursing and from the director of finance.
- Ward staff on the paediatric ward and the neonatal unit felt well supported by their ward leaders and told us they felt able to raise any concerns with them.
- We observed good leadership skills during medical and nursing handovers.
- Best practice staffing guidance had not been fully implemented within the children's services. This was because senior nurse cover at band six had not been present at all times during the 24-hour period to provide the necessary support to the nursing team on ward 10.

Culture within the service

- There was a culture of openness, flexibility and willingness among all of the teams and staff we spoke with. Without exception all staff spoke positively about the service they provided and we saw that morale was good.

Services for children and young people







- Staff worked well together and there were positive working relationships between all staff involved in the delivery of children's and young people's services.
- Teamwork was cited as strength throughout the team and some staff told us they joined the children's and young people's service because of the reputation the team had gained for working as a team.
- Nursing and medical staff spoke positively about the quality of care they provided for patients and were proud to work at the hospital. Staff at all levels told us the trust was a good place to work and they enjoyed working there.
- The trust encouraged staff to raise concerns and provided staff with a confidential email address if they did not feel comfortable to raise concerns in person. All of the staff we spoke with told us that should they need to raise a concern they felt confident and supported to do so.
- During our inspection we noticed a clear family centred culture throughout the children and young people's service. Staff we spoke with at all levels were focussed on ensuring the best outcomes for the patients and families in their care.
- Patients were encouraged to give feedback about the care they had received.
- Patients and their families were engaged through the feedback from the NHS Friends and Family test and complaints and concerns raised through PALS.
- Members of the public were invited to the trust's Annual General Meeting to hear about the work the trust had been doing and their plans for the future.
- We were told that staff were able to raise issues as part of the daily handover or as part of their annual appraisal.
- The staff we spoke with told us that they felt confident in raising concerns with managers.

Innovation, improvement and sustainability

- The children's and young people's service had received a remarkable service award in 2014.
- The trust stated they were currently working on their business continuity management plans across the entire trust. They had a draft business continuity management plan which aimed to ensure that children's and young people's services could be delivered in exceptional circumstances. When we looked at the plan we found it to be incomplete. This meant the service did not have an up-to-date business continuity plan.

Public and staff engagement

End of life care

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

Information about the service

James Paget Hospital provides end of life care to patients with progressive life limiting illness. Conditions include cancer, advanced organ failure, such as heart and renal failure and neurological conditions. The palliative care team provides support to patients and staff at all wards within the hospital and in the community. This team also provides training to staff on the wards in various aspects of palliative care. In 2014 the hospital reported 1038 patients' deaths which took place in the hospital. There was 1225 patients referred to the team in 2014/2015, this included estimated 25% of referrals received from general practitioners and district nurses and 2% of self-referrals and those made by relatives of a patient. Majority of all patients referred to the team in 2014/2015 suffered from cancer (52%).

The specialist palliative care team was led by the lead palliative care consultant and a lead nurse. There was another palliative care consultant working part time and nine palliative care nurses supported by an occupational therapist and a team of administrators. In addition, the bereavement officer provided bereavement support after death and the chaplaincy team.

During our inspection we spoke with six patients and three of their relatives, We also spoke with 47 members of staff which included; the palliative care team, bereavement officer and mortuary staff, chaplaincy, nursing, medical staff, allied health professionals, and porters.

Summary of findings

The safety of end of life services provided at James Paget University Hospital required improvement. The end of life services also required improvement across the effective and well led domains. We found that staff providing end of life services were caring and responsive to the needs of patients. Patients 'do not attempt cardio-pulmonary resuscitation' (DNACPR) forms were sometimes incomplete. Patients did not have a clear care plan which specified their wishes regarding end of life care. Introduction of the end of life care pathway in replacement of the Liverpool Care Pathway was slow and lacked oversight at the board level. Staff knew how to report concerns but these reports were not analysed and used to improve the service. The trust had scored much worse than the national average in the national care of the dying audit.

The trust did not monitor the quality of the service effectively, for example no audits were carried out to check if there were any obstacles to patient's discharge and to ensure patients died in their preferred location. We also noted that the trust was proactive in developing links with local providers of end of life care and tried to influence how the services were delivered to the local population. Patients' complaints had been responded to by local team members and appropriate actions were taken in response. There was no routine audit of the palliative care team's response times and we were unable to fully assess the service to ensure the team was always responsive. The specialist palliative care team

End of life care

was poorly represented within the elective division and there was no non-executive director to who could provide representation of end of life care at board level. There was limited capacity to develop the service and undertake research due to recruitment issues.

Staff across the hospital were respectful and maintained patients' dignity, there was a person centred culture. Specialist palliative care team members felt supported in their work and they worked well as a team. Staff were clear about their roles and their involvement in decision making. Patients said staff were caring and compassionate. They had appropriate access to pain relief and told us they were happy with the food and drink offered. Palliative care and end of life team members were competent and knowledgeable. There were examples of good multidisciplinary team working. The palliative care team was visible on all wards and nursing staff knew how to contact them.

Are end of life care services safe?

Requires improvement



Safe required improvement because patients Do Not Attempt Cardiopulmonary Resuscitation (DNA CPR) forms were not always completed accurately. The trust did not meet the requirement set by the Association for Palliative Medicine of Great Britain and Ireland, and the National Council for Palliative Care related to number of palliative care consultant working at the hospital.

The results of the national care of the dying audit indicated that not all patients had been recognised as dying at the end of their lives by the multidisciplinary team. We found that staff knew how to report concerns. The majority of patients in their last days were suitably assessed. There were no serious incidents relating to end of life care in the hospital. Staff on wards where end of life care was provided had received end of life training.

Incidents

- The trust had not completed an analysis of incidents related to end of life care to inform service improvement plans. Staff told us that there had been no serious incidents reported relating to end of life care in the hospital within the past 12 months.
- Staff we spoke to were aware of how to report an incident or raise a concern. All the staff told us they were encouraged to report incidents using the electronic reporting system.
- Hospital deaths were discussed during specialist palliative care multidisciplinary meetings.

Cleanliness, infection control and hygiene

- The mortuary and viewing areas were visibly clean, well maintained and well ventilated. All areas were cleaned by a designated member of staff. Records of the cleaning schedule were available and up to date.
- Mortuary staff did not always follow guidance set by infection control policy or procedures. Staff were wearing uniforms but not all staff adhered to the trust's infection control and hand hygiene policies, we observed some mortuary staff wore rings and jewellery others had long nails.

End of life care

- We observed one freezer was overfilled with specimens. We also saw there were flowers stored in a refrigerator which was not designated for that purpose.

Environment and equipment

- The mortuary had been licenced by the Human Tissue Authority in May 2012 to allow post mortem examination and storage of bodies. Approximately 500 adult post mortem examinations were carried out each year at the hospital, with the majority under the authority of either HM Coroner for Norfolk or HM Coroner for Suffolk. Equipment used in the mortuary was maintained and checked regularly. This included suitably certified and checked trollies and refrigeration system which were maintained by the trust's engineers. Small portable electrical equipment used in the mortuary was checked by a qualified technician. Records of the maintenance schedules were available and up to date.
- The mortuary was suitably equipped to store the bodies of bariatric patients, there were specific trollies and large fridges to accommodate them.
- There were facilities available in the mortuary to store bodies long term. Staff told us these facilities were sufficient to meet the needs of the hospital and local population.
- People reaching the end of their life were nursed on the general wards in the hospital. Staff told us, whenever possible, patients were to be cared for in side rooms on wards in order to offer quiet and private surroundings for the patient and their families. They also said some patients at their end of life were cared for on open wards as use of single rooms was prioritised for patients who required isolation. Ward 17 which was the oncology ward contained single rooms only whilst other wards had two or three single rooms available.
- Equipment such as commodes, bedpans and urinals were readily available. Pressure-relieving equipment, including mattresses, were available for patients requiring them. Equipment was maintained by the estates department.

Medicines

- Staff told us that syringe pumps used to give a continuous dose of painkiller and other medicines were available to help with symptom control in a timely manner. The trust told us that only one type of syringe

pump was used at the hospital and homecare environment since April 2013. Nurses told us they felt confident in using this equipment and that they had received adequate training to be able to do so.

- Controlled drugs were managed appropriately.
- Medicines administration records were accurate. Patients told us they received medicines in timely manner and staff explained the benefits and potential risks involved with medicines administered.
- The hospital used a comprehensive prescription and medication administration record chart for patients which facilitated the safe administration of medicines. Specialised prescription charts supported prescribers to follow the agreed protocols for people who had medicines administered via syringe pumps. Medicines delivered via syringe pumps, were prescribed appropriately and staff were provided with guidance supporting them in making informed decisions.
- There were guidelines setting out the drug management of symptoms for the dying patient and included reducing medication to a minimum, the route of administration, 'as required' medication and the medication necessary to support the management of pain, nausea and vomiting, breathlessness, agitation and respiratory secretions. One patient had a syringe pump for the continuous administration of pain relief medication. We saw a prescription chart for use with the syringe pump which had been designed for continued use once the patient went home. This ensured continuity of care. However, there was no reference to this additional chart on the patient's main prescription chart, so this potentially could be omitted when prescribing or administering medication. Staff told us the chart was new, and that training was planned to make sure that staff knew how to record the use of additional charts.

Records

- We reviewed 26 'do not attempt cardio-pulmonary resuscitation' (DNACPR) forms. Thirteen of these were fully completed in line with the trust's DNACPR policy. Six of those did not contain information related to mental capacity assessments. In four cases there was no records of conversations held with patient's relatives, in six it was not clear if patient was aware there was a

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DNACPR order in place. It was not always clear who had approved the decision as some signatures were illegible and some forms were not countersigned by an appropriate clinician.

- Where patient had a community DNACPR forms these were not routinely reviewed at the time of admission to ensure the decision made was still valid. There were two different DNACPR forms used as a newer form was being piloted.
- The trust carried out an audit of DNACPR forms in May 2015 and July 2015. These audits also indicated that information related to resuscitation decisions were not always documents accurately. For example the audit carried out in July indicated that evidence that decision had not always been communicated to the patient (27%) or with the next of kin (42%).
- Records indicated that the preferred place of care/ preferred place of death or the wishes and preferences of patients and their families were documented in some cases with a use of the 'gold standard framework' advanced care planning booklet in cases where patients were recognised to be at their end of life.
- Risk assessment forms were mostly completed and accessible. It included falls risk assessments and skin integrity assessments.
- Care plans were accessible to all staff.
- The mortuary records, which included body release forms, were accurate.

Safeguarding

- Most staff we asked knew the named leads for adult and children safeguarding. All were aware of actions they would take should there be a need to report a safeguarding incident.
- Records indicated that all members of the specialist palliative care team had completed a safeguarding training for both adults and children which were appropriate to their role within the past twelve months.

Mandatory training

- The palliative care team members said that they had completed mandatory training which included dementia awareness, equality and diversity, manual handling and learning disability and autism awareness. Mandatory training also included medicines

management, safe use of insulin falls prevention and safeguarding adults and children. Training summary records were kept to indicate how many of them had completed this training and when.

- We noted that all of the specialist palliative care team (SPCT) members had up to date information governance training. 88% of the clinical staff working for the SPCT had completed training on infection control and similar percentage attended training related to conflict resolution. 92% of the SPCT members had undertaken basic life support training and 100% fire safety training. In general the team mandatory training uptake was at 96%. However, the trust did not provide us with information related to number of staff that received health and safety training and training related to blood handling; both were listed as mandatory training.
- Porters involved in the transfer of bodies between the ward and mortuary had all been trained in the trust's procedures for transporting bodies to the mortuary and the use of equipment.
- The trust made progress to ensure all staff caring for dying patients received training in end of life which included communication skills training, and skills for supporting families and those close to dying patients. The trust had carried out teaching needs analysis to identify which staff will require end of life training and which level of training as a minimum. It focused on clinical staff, but also included communications training for non-clinical staff. The trust established that 60 whole training days were required in order to train all staff over 2015/2016 and was well underway of providing this training to staff across the hospital. Many of the staff we spoke to on wards where end of life care was provided, including end of life link nurses, had received a three days long end of life training. They told us this helped them to improve their subject awareness, how to provide effective support to people at their end of life and develop communication skills in order to be able to talk about death with patients and their relatives.
- Syringe driver training was provided during the corporate induction program. Competencies were also assessed by a member of a specialist palliative care team who were available to provide additional training when required. Staff confirmed that there was always a member of staff on duty who was assessed as competent in this care.

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Assessing and responding to patient risk

- The trust had system for flagging those patients who were receiving end of life care. Doctors and nurses were aware of how to refer patients to the specialist palliative care team and felt that referrals were made in timely manner.
- The results of the national care of the dying audit published in May 2014 demonstrated that identification of patients who were dying was below the national average at 23% as opposed to the England average of 61%. This means that sometimes there was lack of documented evidence within the last episode of care that the patient was expected to die in the coming hours or days. However, the trust scored better than the national average for those patients who had been assessed within their last 24 hours, with 85% compared to the England average of 82%, being assessed.
- The trust used the early warning score (EWS) system for monitoring acutely-ill patients, to alert staff of deterioration in their condition. The tool allowed staff to monitor patient observations, such as their heart rate, blood pressure, temperature and oxygen levels at the bedside and staff calculated an early warning score for each patient. It was used appropriately to alert appropriate clinician to patients who may be deteriorating.
- Staff had received training in basic life support. There was standard emergency equipment available to support patients in an emergency throughout the hospital.
- We observed patients had easy access to call bells and we observed their calls were responded to promptly.

Nursing staffing

- The hospital specialist palliative care team consisted of a lead nurse for end of life and nine palliative care clinical nurse specialists. The team was an integrated service providing care within the hospital and across the community. They also provided a telephone advice and support line which is accessible to patients, families, carers and professionals and operated 7 days a week 9am to 5pm.
- Specialist palliative care team members did not feel staffing levels were sufficient to allow seven days face to face service. We were told that the trust was not

commissioned to provide this service. There was only one member of the team available to provide telephone advice during weekends and bank holidays (day time only).

- There were palliative care 'link' nurses, on most of the wards we visited, that had attended an additional three day long end of life training.
- The sickness rate among the palliative care team members at 5.4% (August 2014 to July 2015) was worse than the trust's average sickness rate of 3.2% (May 2014 to April 2014).

Medical staffing

- There was one palliative care consultant working full time and another one who was working part time (1.5 whole time equivalent). This was not in line with the Association for Palliative Medicine of Great Britain and Ireland, and the National Council for Palliative Care which states there should be a minimum of one consultant per 250 beds. The hospital had approximately 470 beds and palliative care doctors were also responsible for providing care within the hospital and across the community. The trust had advertised a consultant position but was unable to fill the vacancy.
- Palliative care consultants provided Monday to Friday, face-to-face reviews. However, there was lack of out of hours on-call support provided by a consultant at night during the week and weekends.

Security

- Access to the mortuary was controlled by the mortuary staff, security team and porters office. There was closed circuit television in operation in corridors outside of the mortuary entrance to ensure only authorised people accessed the hospital mortuary. Record of visitors and staff visiting the mortuary was kept and we saw staff were using it accurately.

Major incident awareness

- We looked at the mortuary's storage contingency plans. The mortuary had the capacity to store 100 deceased patients. There were approximately 80 spaces used at the time of the inspection and staff told us that was a usual number. There was additional foldable racking system available on site which could be used to increase storage facilities. A manager told us that temporary cold rooms could be arranged at short notice should there be a need

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Are end of life care services effective?

Requires improvement



End of life care required improvement. The trust had scored much worse than the national average in the national care of the dying audit. Patients mental capacity was not always appropriately assessed when decisions related to end of life care were made. Care and treatment was delivered in line with current evidence-based standards, however, introduction of the end of life care pathway in replacement of the Liverpool Care Pathway (LCP) was slow.

Patients had appropriate access to pain relief. Palliative care and end of life team members were competent and knowledgeable and there were good examples of the multidisciplinary team working. The trust provided quality training to ensure staff were competent and able to meet patients' needs adequately.

Evidence-based care and treatment

- There was lack of unified approach to end of life care across at the hospital and the trust was not proactive in order to response to changing national guidance related to end of life care. The Liverpool care pathway was phased out by the trust in July 2014, as required by the national guidance. However, the trust did not replace it with another end of life care plan or toolkit which would support staff to focus their care to specific needs of people at their end of life.
- The trust had developed an action plan in response to the "More Care Less Pathway" and staff were aware of the five priorities for care set out by "One Chance to Get it Right" report recommending the approach to caring for dying people. The implementation of a new care plan was being rolled out on a short stay medical unit at the time of the inspection. The action plan indicated it commenced in May 2015, however, at the time of inspection not all of the staff working on the ward were trained in using it and they told us that the "uptake was slow". They also said they had potentially fewer patients at their end of life than anticipated due to the nature of the support provided (short stay medical unit). On-call medical staff, working on the ward during weekends,

were unfamiliar with the framework. Senior members of staff were unclear how the effectiveness of the care plan introduction would be assessed before it would be introduced to other wards.

- The trust's DNACPR policy was updated in September 2014. It had been developed in line with the Resuscitation Council Framework and The Association of Anaesthetists and General Medical Council's guidance.
- The trust did not use the self-assessment tool which had been developed by the National End of Life Care Intelligence Network in partnership with Public Health England, to help monitor the quality of services. They had established a "task and finish group" to monitor and maintain the standards of end of life care. The group, chaired by the director of nursing and patients' experience, met monthly.
- Doctors and nurses had access to end of life resource file located on each of the wards which contained information and leaflets related to available support and general guidelines such as The National Gold Standard Framework Centre's guidance for clinicians to support earlier recognition of patients nearing the end of life and information on safe use of strong opioids and anticipatory drugs.

Pain relief

- Patients told us they had access to pain controlling medication whenever required.
- The trust's results from the national care of the dying audit for hospitals, showed slightly worse results for "Medication prescribed prn for the 5 key symptoms that may develop during the dying phase" with 46% of cases achieving 5/5 compared to 51% for England.
- There was an operational guide on how to manage key symptoms of dying patients. It provided advice on managing pain, restlessness and agitation, breathing difficulties or nausea and vomiting. The staff we spoke to were aware of this guidance and used it.
- Nurses we spoke with had knowledge of the treatments and symptom management to address pain appropriately.
- Three of the palliative care team nurses were 'prescribers' able to prescribe pain control medication in situation where one of the doctors was not available or in the community settings.

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- There was a pain team which provided services five days a week. Services of this team were available to patients who were not meeting the referral criteria set for the specialist palliative care team.
- One of the questions of the national survey of bereaved people was checking whether pain support was adequate and how well pain was relieved during the last three months of life. The trust did not participate in this survey therefore we were unable to assess it adequately and compare with other hospitals.

Nutrition and hydration

- Most patients we spoke with were happy with the food and drink provided by the hospital.
- We observed that all patients had access to drinks that were within their reach.
- The national care of the dying audit found that only 31% of patients was scored as having the sufficient level of assessment of their nutritional requirements, this was worse than the England average of 41%.
- In the national care of the dying audit, the trust scored the same as the England average (50%) on the proportion of patients that had a sufficient assessment of the patient's hydration requirements
- We observed nutritional assessments were completed and that nursing records such as nutrition and fluid charts were thorough and summarised accurately. We saw that menus catered for cultural preferences.
- The 'malnutrition universal screening tool' ('MUST') was used across the hospital. This tool was developed by the Malnutrition Advisory Group, a standing committee of British Association for Parenteral and Enteral Nutrition. Nurses told us that it was used as part of the admission or initial assessment of a person to assess people's nutritional status. Staff were aware of the referral process and criteria for patients who required speech and language therapist or dietician's input. However, they told us it can take up to two days for the low risk referrals to be responded to.

Patient outcomes

- The trust scored worse than the England's average in three out of seven organizational key performance indicators and eight out of ten clinical key performance indicators related to patients' outcomes. The hospital formed the task and finish group to improve the service in response to this audit. This group had met monthly and an action plan in response to the national care of

the dying audit. However, we noted that the trust was slow to respond to findings of this audit results of which were published in May 2014. The action plan in response to the results of this audit was developed only in 2015. It was very brief and generic focusing on three key points; identifying patients at their end of life; rolling out individual care plans and education programme to support staff with meeting needs of patients and family members. At the time of the inspection all actions were indicated as "in progress".

Competent staff

- The specialist palliative care team had developed "what on earth do I say" training in partnership with a local university. It is a one day course aimed to build confidence and staff skills needed in implementing the five key priorities as set out in the national guidance. It focused on sensitive, open and honest communication with patients and their families. This course was piloted on the short stay medical unit and ward 1. This training was offered to all teams including therapy, nursing and medical staff and healthcare assistants. Many of the nurses we met on wards told us they had completed this training and thought this was very useful and it had increased their ability to speak about end of life.
- All registered nurses working at the hospital were offered opportunity to shadow a palliative care nurses in the community and hospital.
- Palliative care and end of life team members were competent and knowledgeable. They were aware of the most recent developments within their specialities including changes in national guidance.
- 89% of the palliative care team members have been appraised within the past twelve months. This was slightly below the trust's target of 90% but higher than the average of 77%.

Multidisciplinary working

- Multidisciplinary team meetings were organised weekly. We noted that these were attended by social services, occupational therapist, physiotherapist, discharge coordinator, community liaison nurse, and members of the specialist palliative care team. These meetings were open hospital clinicians who could just 'drop in' in order to discuss specific patients' needs. These meetings were also attended by local providers of end of life care in the community.

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- The palliative care team was supported by occupational therapists who provided community support.
- The team had established close links with other providers of end of life care including local hospice, charitable organisations, primary care providers and community nurses. These were used to establish educational initiative network with an aim to improve patients experience while they move across care settings.
- There was an allocated member of the specialist palliative care team who led on rapid discharge. They worked in conjunction with the East Coast Community Health Care liaison nurse. They were also supported by the pharmacy service which developed pre packed medicine bags which were ready to be dispatched at the time of patients discharge. This included standard medicines used to manage symptoms, including pain, for patients at their end of life.
- There was a multidisciplinary approach to care for patients at the end of their life within the intensive care unit (ICU). This involved any staff who had a view of the patient or was involved with their care. The discussion could extend to the opinion of a consultant who, although may not have been directly involved with the patient care, could offer an independent opinion. The family and the patient, where this was possible, would be involved in any discussions. The staff would check on admission to the unit if the patient had made an Advanced Directive to limit or refuse certain aspects of care, or expressed a wish not to be resuscitated in the event of a cardiac or respiratory arrest.

Seven-day services

- The palliative care team was available to provide face to face support Monday to Friday from 9am to 5pm. Not all nurses were clear on what out of hours support was available to patients. Palliative care consultant told us it was provided by the local 111 NHS non-emergency service as the seven-day service was not contracted by the local clinical commissioning group. Patients in the community could also call a hospice located in Ipswich which offered on-call support 5pm -9am.
- The specialist palliative care team also provided telephone support to patients in the community and those in the hospital. It was available Monday to Sunday from 9am to 5pm.
- The pharmacy department provided a dispensing and supply service and clinical pharmacy service to most

wards from 9am to 5pm Monday to Thursday and 9.30am to 5pm on Friday. During weekends and bank holidays they were available 10.15am to 2pm. On-call pharmacists was available at other times. The pharmacy department was aware of the need to provide a prompt service for take home medicines.

- There was an identified bereavement officer, working part time Monday to Friday.
- The pastoral care team provided daily support to patients and relatives to ensure that the spiritual needs of dying patients and their relatives were met
- Mortuary staff were available Monday to Friday between 8am to 4.30pm. There were arrangements and out of hours procedure to allow bodies to be released out of hours and during the weekend and provision of a 24hours on call service to facilitate viewings, admission of deceased persons from external sources and release of deceased persons from the mortuary.

Access to information

- All DNACPR forms were filed in patient notes and were easily available to staff.
- Nurses and doctors told us they felt they had sufficient access to information in order to support clinical decision making.
- Specialist palliative care team used centralised system designed to provide clinicians and health professionals with a single shared electronic health record available in real time at the point of care. This system could be accessed by some of the GPs working in the area (8 out of 24) and patient data could be shared securely across services promoting efficiency and standardisation. It could also be accessed by team members working in the community and other community nurses.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients' capacity to consent was not always recorded on the DNACPR forms. CPR status documentation internal audit completed in May 2015 also indicated that capacity assessment section of the form was not always completed. Eight patients without capacity had a DNACPR order in place but only in five cases (62%) this had been discussed with the patient's family. The audit recommended that a repeat audit should be carried out to check if completion of the 'capacity assessment box' and documentation of discussion with family had improved but did not set timescale for this action.

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- Staff on wards were not clear on guidance they would use, or actions they should take, if they were unclear whether a patient had the capacity to consent. Records indicated that all palliative care nurses and doctors had completed training related to Mental Capacity Act and Deprivation of Liberty Safeguards. Training on obtaining patients' consent was also provided by the trust and was mandatory for clinical staff working for the team, records indicated that 93% of them had received it.
- Not in all cases patients' views related to resuscitation were clearly recorded in their notes and on the form. For example in one case, as indicated on the form, the discussion did not take place as patient did not have their hearing aid with them.

Are end of life care services caring?

Good



End of life services were good for caring because patients said staff were caring and compassionate. Most patients said they were involved in planning their own care and making decisions. The palliative care team members performed patient reviews in a sensitive, caring and professional manner, engaging well with the patient. We observed staff being respectful and maintaining patients' dignity, there was strong person centred culture. Patients had access to range of complimentary services provided by organisations working in partnership with the trust. New staff did not always introduce themselves when they spoke with patients and relatives.

Compassionate care

- Most of the patients and relatives we spoke to told us staff were very caring and that they had no complaints or concerns.
- We observed that staff demonstrated a positive and proactive attitude towards caring for dying people. They described how important end of life care was and how their work impacted on the overall service. Staff were compassionate and caring to patients and their relatives. All the staff we spoke to were very clear about their role in ensuring people received appropriate support.
- One of the questions of the national survey of bereaved people was checking whether family members were

satisfied with the service provided and if they felt involved in the care planning process. The trust did not participate in this survey therefore we were unable to assess it adequately and compare with other hospitals.

- The trust carried internal audit to assess quality of the service provided by the specialist palliative care team. 61 patients referred to the specialist palliative care service were sent a questionnaire between October 2014 and December 2014, three months from the date of the initial referral if the service met their expectations. Most of the feedback provided by the 24 patients who had returned the questionnaire was positive. We noted that this audit was not indicative as it represented views of a small number (2%) of 1225 patients referred to the team in 2014/2015.
- The trust had not participated in the last national survey of bereaved families (VOICES). Therefore were unable to assess outcomes, compare the care provided with other hospitals, and use it to improve the service.
- We observed that staff handled bodies in a professional and respectful way. The mortuary staff told us that patients that arrived at the mortuary were cared for appropriately by the nursing staff shortly after death. Nursing staff were provided with training how to perform procedures respectfully. An audit was undertaken to monitor the quality of the service provided and staff were provided with immediate feedback if any concerns were highlighted by the mortuary staff.
- Porters told us they had no concerns regarding staff handling bodies on wards and thought they were respectful and maintained patients' dignity.
- Patients' records and nursing care plans demonstrated that regular comfort ward rounds took place to ensure patients were kept comfortably.

Patient understanding and involvement

- Staff provided patients with information on how to contact the palliative care team and where able to obtain additional support and information if required.
- Nurses were professional, explaining to patients about their medicines and encouraging them to take them.
- We observed that staff made efforts to contact family members after their relative had died and in many cases had involved them in the decision making process.
- Palliative care doctor told us that patients referred to the specialist palliative care service were sent a questionnaire after three months from the referral

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asking them if they found the service helpful, if the service met their expectations and if they were happy with the allocated nurse. Records indicated that 61 questionnaires were sent out between October 2014 and December 2014 and 24 were returned. Although the responses received were mostly positive some of the patients made comments related inadequate pain control or hospital staff not introducing themselves when approaching patient. There was an action plan prepared in response to this survey, however it was generic and it was unclear who was responsible for implementing it and did not set any deadlines. The improvement plan was designed around the document One Chance to Get it Right, published by the Leadership Alliance for the Care of dying people

- Not all patients had care plans which specified their wishes regarding end of life care.
- Most patients' notes indicated they were kept actively involved in their own care and relatives were kept involved in the management of the patient with the patient's consent. However, not in all cases there was a record of conversations held with patient in relation of the DNCPR order in place.
- The national care of the dying audit showed that the trust performed poorly health professional's discussions with both the patient and their relatives/friends regarding their recognition that the patient is dying and communication regarding the patient's plan of care for the dying phase.

Emotional support

- Specialist palliative care nurses received training to provide emotional support and told us they felt confident discussing issues related to end of life care with patients and their families.
- Families were not routinely invited back to the ward to speak with the doctor who provided care to their relative at the end of their life. Bad news were delivered by the senior nurse in charge of the ward.
- There was a bereavement officer who worked part time. They were supported by the mortuary staff and worked alongside general register office officer who were able to issue death certificates on site on designated days. Staff working there were compassionate and proud of the support they delivered, comforting relatives and making sure people left knowledgeable about what to do following a death.

- The chaplaincy held a regular ecumenical memorial services for both adults and children who died in the hospital. They were available daily to provide spiritual and emotional support when appropriate. A group of volunteers working with the chaplaincy team offered spiritual support to patients of all or no faiths. Volunteers also supported patients who had no or very few relatives or friends providing company

Are end of life care services responsive?

Good



The trust had been active in developing links with local providers of end of life care and tried to influence how the services were delivered to the local population by linking with the other NHS trusts, local GPs and nursing homes. The palliative care team was visible on all wards and nursing staff knew how to contact them. There were palliative care link nurses on some of the individual wards who acted as links between palliative care team, the staff and patients of the clinical areas where they work Patients' complaints had been responded to by local team members and appropriate actions were taken in response.

However the trust did not monitor effectively if there were any obstacles to patient's discharge to ensure prompt response and that patients died in their preferred location. Staff were not always aware of patient's wishes in regards to their preferred place of death. Not all patients had a care plan which specified their wishes regarding end of life care. The trust collected data related to preferred place of care but they did not routinely analyse it to benchmark against other services and inform service planning. There was no routine audit of the palliative care team's response times and we were unable to fully assess the service to ensure the team was always responsive.

Service planning and delivery

- The trust put itself forward to take on the role of lead provider for palliative care in the geographical area and had been granted this role by the clinical commissioning group. The trust aimed to "enhance the services by putting all elements together and making it as easy as possible for patients to access what they need". The director of nursing who was the end of life lead at the trust had also been involved with the local

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end of life group run by the commissioning group and Norfolk's end of life care providers' group. Specialist palliative care team (SPCT) also tried to influence how the services were delivered to the local population by linking with the East Coast Community Healthcare NHS Trust, local GPs and nursing homes among other organisations. Lead consultant told us these initiatives helped to understand and influence development and improve provision of the integrated end of life care. However, they felt there was lack of local leadership to drive improvements and ensure consistency in relation to end of life care across the region. This was linked to the incorporation of the Anglia Cancer Network into the East of England Strategic Clinical Network in March 2013.

- We were told the trust had good working relations with the local clinical commissioning groups and felt engaged in planning services in order to meet the needs of the local population. However, the specialist palliative care team operated in a difficult economic environment. They were required to present an argument in order to maintain the current service levels and protect the money allocated to the team. At the time of the inspection there was no formal agreement in place for providing end of life services in 2015/2016 by the trust.
- The trust used an electronic patients record system that was used to store patient information, including palliative care records. The palliative care team told us they were encouraging the use of the system across various care settings by working closely with GPs, other teams across the hospital and external providers. We were told that eight out of 24 GP surgeries could access the system and further efforts were made to incorporate it into the 'clinical portal' that will allow clinicians to view information about individual patients in a 'virtual' electronic patient record drawn from information held in different clinical systems.
- There was 1225 patients referred to the team in 2014/2015, this included estimated 25% of referrals received from general practitioners and district nurses and 2% of self-referrals and those made by relatives of a patient. Majority of all patients referred to the team in 2014/2015 suffered from cancer (52%). Although the trust gathered information on which team had referred the patient to the specialist palliative care team this was not routinely

analysed to establish which specialities and wards accessed the palliative care more than others. Therefore it was not possible for the team to raise awareness of their service with specific clinical teams.

- There were palliative care link nurses on some of the individual wards who acted as links between palliative care team, the staff and patients of the clinical areas where they work. It included link nurses wards 1, 2, 4,12,16,17, A&E, intensive care unit, renal unit and on the short stay medical unit.
- There were no specific designated palliative care beds in the hospital. Some of the patients at the end of their life were cared for in the main ward areas.

Access and flow

- Palliative care team members were visible on all wards and nursing staff knew how to contact them.
- The trust told us there were 50 referrals to the SPCT in July 2015 all referrals had a first contact within 24 hours either by a phone call to the ward (50), review of notes (14) or face to face with the patient (28). This response time was in line with the operational procedure which required the team to respond to urgent referral within 24 hours. There was no routine audit of the palliative care team's response times and time taken to complete the assessment and we were unable to fully assess it to ensure this was in line with the trust's policy.
- The porters told us that they were able to respond to calls made requesting body transfer promptly (usually within 10 minutes) and they were able to prioritise accordingly. However depending on patient's relatives' wishes patients could be kept on wards for longer periods of time.
- The complex discharge team aimed to facilitate a fast track discharge to a patients preferred location "as quickly as possible and preferably within 48 hours of the fast track paperwork's completion". The trust reported that the main cause for delays was lack of vacant accommodation within the residential or nursing home settings.
- Nurses we spoke to were aware of patient's wishes related to preferred place of care and the place where patient wished to die. 45% (119 out of 266 where preference was clearly indicated) said they would prefer to die at home. We noted that in 21% (80) of all cases there was no record of the preferred place of care listed.

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The reasons for lack of information included; patients being unable to discuss as they were unconscious or too drowsy, patient not being “psychologically ready” or too anxious.

- From the records provided by the trust we have established that 57% (217 out of 378) of those who were cared for at the hospital, and died between January 2015 and July 2015, had died in their preferred place of care. For illustrative purpose we benchmarked this information against the last national survey of bereaved people (VOICES 2014) which indicates that in 2014 more than 70% have died in the “right place”.

Meeting people’s individual needs

- Staff told us that occasionally they were unable to provide single room to patients in the final days and hours of their life due to there being a limited numbers of side rooms. There were limited facilities for relatives in order to allow them to spend time with the patient.
- There was various printed information available to patients and their relatives including leaflets on what needed to be done when someone was dying or on services provided by the bereavement office and the specialist palliative care team.
- Staff told us that translation services were available through INTRAN and there was general no delays in accessing them when required.
- The national care of the dying audit for hospitals in England found that 24% of patients had documentation of a spiritual needs assessment at the trust this was much lower than the England average (37%).
- Chaplaincy, team members told us they visited wards every Friday and they were informed of those patients who were at the end of their life so they could provide appropriate support. However, they also said staff did not always routinely highlighted whether they had discussed the patient’s spiritual requirements with them or indicate patients preference at the time of admission.
- Mortuary viewing facilities were appropriate and allowed relatives privacy.
- There was a procedure for the management of deceased patients’ belongings. Record of deceased patient’s belongings was kept and possessions were adequately secured and accounted for.

Learning from complaints and concerns

- The trust had not completed an analysis of complaints related to end of life care to inform service improvement plans.
- Staff told us that complaints were handled in line with the trust policy.

Are end of life care services well-led?

Requires improvement



The specialist palliative care team was poorly represented within the elective division. The trust was required to appoint a non-executive director to take lead and provide representation of end of life care at board level but this requirement was not fulfilled. The trust had long term strategy in place for palliative care team and end of life care to ensure service sustainability, however this was unclear how goals set in the strategy would be achieved and who how progress would be monitored. There was limited capacity to undertake research and national trials due to recruitment issues.

We also noted that specialist palliative care team members felt supported in their work and they worked well as a team. Staff were clear about their roles and their involvement in decision making. All staff we spoke with demonstrated a positive and proactive attitude towards caring for dying people.

Vision and strategy for this service

- There was an end of life service development plan developed in August 2014 guided by the national guidance for provision of the end of life care set by The National Institute for Health and Care Excellence. The document listed speciality direction and key developments over the next five years, such as development of a specialist palliative care unit and introduction of the palliative care support worker post.
- The specialist palliative care team were very committed to across the hospital training provision, analysed training needs across the trust and devised training to meet variety of staff needs. This was seen as a key point in delivering quality in end of life care.

End of life care

- There was good end of life care awareness across the hospital and “sense of ownership” with staff on individual wards taking responsibility in leading in the field and specialist palliative care team providing support and expertise.
- We reviewed an action plan in response to the national care of dying audit. This briefly set out the key areas the trust would improve around the delivery of end of life care. The action was brief and did not fully cover the areas where the organisational and clinical KPIs were not met or below the expected standard. A work programme to achieve compliance was in place and focused on training provision and development of a comprehensive end of life care plan in replacement of the Liverpool Care Pathway.

Governance, risk management and quality measurement

- The specialist palliative care team was managed within a large combined elective division which included children services, maternity and gynaecology, and surgery among other services. We have analysed minutes from the divisional board meetings (February to May 2015) which indicated that specialist palliative care team was not represented during those meetings and there were no discussions related to end of life care or specialist palliative care.
- There was limited evidence that the trust had adequate systems for monitoring the quality of the service. For example to identify patients who were not offered palliative care in their last days and hours of life, relatives views, or specialist palliative care team response times.
- Specialist palliative care operational policy for 2015/2016 was developed in partnership with the strategic clinical network. It clearly highlighted what the key performance indicators for the team are in terms of response times and levels of intervention. However, there was lack of routine monitoring to ensure these were fully met. The trust had audited a small sample of referrals in July 2015 to check if response was provided within 24 hours. This audit indicated that in all 50 cases this indicator was met and that the trust would re-audit in 12 months. We noted that this audit covered only a small portion of all referrals made throughout the year (2%). It also was not specific to indicate various levels of intervention (4 levels listed by the policy) or illustrate if staff prioritised appropriately taking into account various urgency levels.
- The director of nursing had been appointed as the nominated trust lead for the development of end of life care. Although they were involved and participated in the local end of life group run by the commissioning group and Norfolk’s end of life care providers’ group there was no accountability at board level for the quality of end of life care. As recommended by the “More Care Less Pathway” report and the national care of the dying audit the trust was required to appoint a non-executive director to take lead and provide representation of end of life care at board level. They were also required to present an annual report on end of life care to the board. This requirement was put in place in 2013 in order to ensure non-executive directors engagement in end of life discussions.
- As recommended by the “More Care Less Pathway” report (2013) and the national care of the dying audit for hospitals, all trusts should also have a designated lay member with specific responsibility for care of the dying. To ensure public and patient representation was established and maintained within the trust and to champion end of life care. The trust did not address this requirement.
- Staff were clear about the role of the senior responsible clinician in end of life care and their involvement in decision making.
- Risks related to end of life care were logged on the local risk register. It included lack of commissioned specialist palliative care beds available locally and limited provision for end of life in-patient care. One vacant consultant post and limited availability of a specialist physiotherapy and social worker support were also listed on the register, as well as poor outcomes of the national care of the dying audit which highlighted difficulties in providing end of life care. These risks were monitored through end of life steering group which reported to carer and patient experience committee.

Leadership of service

- There was good leadership within the specialist palliative care team, led by the palliative care consultants and the nursing lead. We observed that the team were visible, responsive and very active in promoting good quality care. Outside the trust, the

End of life care

team were involved in regional end of life groups and developing links with external providers. However, the team was constrained by lack of staff with one vacant consultant post. This affected ability of the team to respond promptly to local and national development, such as changes in end of life care planning, and limited participation in national audits (VOICES) and research.

- The clinical lead and end of life lead were aware of issues relating to their specialities and had developed action plans to ensure service improvement. The hospital formed the task and finish group, which met monthly, to improve the service and monitor implementation of action plans. We noted that the trust was slow to respond to findings of external audit results. For example the action plan, in response to the results of the national care of dying audit published in May 2014, was developed only in 2015 and at the time of the inspection all actions were indicated as “in progress”.
- The trust failed to appoint a non-executive director with responsibility for leading and providing representation of end of life care.

Culture within the service

- Staff on the wards and members of the palliative care team we spoke to were focused on providing a good experience for patients. They were patient-focused and aimed to provide the best possible care. The team were passionate about supporting patients, families and staff in end of life care. All staff we spoke with demonstrated a positive and proactive attitude towards caring for dying people. They described how important end of life care was and how their work impacted on the overall service.
- Specialist palliative care team members felt supported in their work. They told us they were encouraged by their immediate line managers to report any concerns they had and could discuss any issues with their manager.
- We observed that the palliative care team worked well as a team. They spoke about supporting each other and helping out whenever required. They felt involved in all decisions made and changes implemented and were able to help with service improvement.





Public and staff engagement

- To ensure public and patient representation was established and maintained within the trust, they were required to appoint a layperson as part of the board to champion end of life care. This requirement was not fulfilled.
- The trust did not participate in the bereaved families' survey in order to gather relatives views related to end of life care received by the patients who died at the hospital. However, the trust carried out a patient satisfaction survey between October 2014 and December 2014. The responses received were mostly positive.
- We were told that staff engagement with end of life care had improved in the months leading up to our inspection. Nurses we spoke to were aware of the end of life task and finish group and that the trust had developed end of life training and was working towards implementing a new individualised end of life care plan.
- The chaplaincy organised regular remembrance service for adults, children and staff. A book of remembrance was available in the chapel where the name of the deceased could be placed.

Innovation, improvement and sustainability

- The trust had long term strategy in place for palliative care team and end of life care to ensure service sustainability, however this was unclear how goals set in the strategy would be achieved and who how progress would be monitored.
- Relatives of a deceased patient were able to receive death certificates in the bereavement suite as there was a general register office officer, able to issue certificates on site on designated days. This meant that the relative were able to view the body, meet the bereavement officer and receive a death certificate at the same location and at the same time which minimised inconvenience to them.

Outpatients and diagnostic imaging

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

Information about the service

Outpatients and radiology department services at the James Paget University Hospitals NHS Foundation Trust are provided at the James Paget Hospital, Beccles War and District Community Hospital, Kirkley Children's Centre and the Newberry Child Development Clinic. Between April 2014 and March 2015 there were 218,628 appointments.

The radiology department provides core services across four sections: routine x-ray; computerised tomography (CT); magnetic resonance imaging (MRI) cross sectional imaging; breast imaging and ultrasound. The outpatients department covered a wide range of specialities including general surgery; urology; trauma and orthopaedics; ear, nose and throat (ENT); ophthalmology; oral surgery; plastic surgery; general medicine; cardiology; dermatology; neurology; rheumatology; and gynaecology.

As part of our inspection we visited 13 outpatients departments inclusive of the audiology clinic; diabetes clinic; anti-coagulant clinic; and ophthalmology clinic. We also visited main x-ray; ultrasound, and CT and MRI services in the radiology department. We spoke with 38 patients in the locations listed above. We looked at 14 sets of medical records and spoke with 42 members of staff including medical staff, nursing staff (registered and non-registered), managerial and administrative staff.

Summary of findings

Overall we rated the outpatients and diagnostic imaging services as good. Medicines storage and management was safe and robust in outpatients and diagnostic imaging services, clinical environments were visibly clean with regular auditing of cleanliness. Nursing staffing levels were well maintained to provide the level of care required. The reporting, managing and learning from incidents was well embedded and supported by an electronic system that was easily accessible for all relevant staff.

The auditing of equipment and clinical practice was well embedded across outpatients and diagnostic imaging services with sharing of learning happening at both local and senior level. Patients felt well cared for and respected in the outpatients and diagnostic imaging services, with patient's privacy and dignity being maintained by staff.

Referral to treatment times (RTT) were better than the England average for outpatients and diagnostic imaging services and the waiting time for patients with suspected cancers was exceptionally good and there was dedicated provision for people with dementia in outpatients and diagnostic imaging services.

Local leadership was good within the outpatients and diagnostic imaging services. Staff were aware of the trust's values and there was good clinical governance

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monitoring and escalation, and there were service-level strategies for forward planning over the next three to five years. Outpatients and diagnostic imaging staff felt proud to work at this trust.

The use of both paper and electronic medical records introduced a risk of information being misplaced or not available within outpatients and diagnostic imaging services. The use of several different electronic systems for items such as medical records, investigations, reporting, patient note tracking, and cancer pathways was confusing and not robust. Systems were not joined up with each other which meant that all information regarding a patient may not be on one system or always accessible.

Staff compliance levels for mandatory training were on track to reach the trusts target level by March 2016. Auditing of clinical guidelines was not robust across all departments, meaning that good practice was not always being shared.

Some clinical areas were cramped due to the increased demand on services, which impacted on maintaining patient's privacy and dignity. However this was due to be addressed as outlined in a new estates strategy. Although some departments with outpatients and diagnostic imaging services had service development plans in place, this was not consistent across all departments.

The monitoring of complaints was done at local level and senior level, however the reporting of complaints was confusing and contradictory at times meaning that departments may not always be able to improve practice when complaints data is not robust. The senior executive team were visible to local leaders who knew how and when to contact them. However, senior executive visibility was not always present for front line staff.

Are outpatient and diagnostic imaging services safe?

Good



Safety was good within the outpatients and radiology departments. Clinical environments were visibly clean and well monitored using an infection prevention society tool. Medicines management, security and storage was good in both services with robust recording of access. Training was proactive within the fracture clinic to explore issues around safeguarding. Management of incidents and learning was proactive in the radiology department. Radiology and the different outpatient departments were either at full staffing levels or were almost at full staffing levels, and plans were in place to address any shortfalls. The ophthalmology clinic was proactive in the development of competencies of new staff to ensure safe practice regarding ophthalmic care.

There were concerns around infection control processes and monitoring within the diabetes clinic. The Trust is three years into a project to convert from paper to electronic records. As a result there was a mix of paper based and electronic records in use which could impact on patient safety due to an increased risk of information being missed, not recorded, or not available when required.

Incidents

- Incidents and near misses were reported by staff using an electronic incident reporting system. This system also provided an overview of how many incidents each department had open at any given time, including any with outstanding actions. This was monitored by the service lead for each clinic or department and provided the opportunity to assess incidents for any trends. Staff from all departments inspected confirmed that the person entering the incident onto the system would receive individual feedback once the incident was closed, informing them of the outcome and any learning.
- Support was available from the trust's risk and governance manager for incident reporting guidance.
- Feedback from incidents was shared at team meetings within fracture clinic, audiology, medical outpatients, computerised tomography (CT) /magnetic resonance imaging (MRI), main x-ray and ultrasound to ensure that

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whole-team learning took place. Main x-ray also displayed learning from incidents on staff notice boards although this was not common practice across all departments

- Staff within the radiology department service provided the example of an incident involving storage of images in an incorrect record on the electronic system. To reduce the risk of this reoccurring, actions were implemented which included marking each examination performed as 'ended' and a double check introduced for every new appointment to ensure that the correct patient was selected.
- The divisional lead nurses submitted bi-monthly patient safety reports to the patient safety and executive committees which included action plans and learning points from incidents. Not all incidents were included due to the high volume, but examples of incidents promoting learning were chosen by the lead nurse for inclusion in the report. This report included data for incidents of duty of candour such as the number of moderate harm and above incidents, the number of patients informed of the incident verbally and the number of letters produced regarding the incident. However the report did not give sufficient detail, for example, the June 2015 elective division patient safety report stated that there had been six incidents of moderate harm or above with two patients being informed verbally and one letter being produced. No information is given regarding the notification of the remaining incidents to the patients.
- There had been no serious incidents (SI's) reported in the year prior to our inspection for outpatients services, and three serious incidents in radiology between November 2014 and August 2015. The oldest incident related to incorrect reporting of an image. The action plan status for this SI was set to green on a traffic light score indicating that an action plan had been completed. The next two incidents related to overexposure and the delay of an urgent referral. There were no action plan statuses for these SI's in the trust's emergency division patient safety report for July 2015, indicating that these SI's were still being investigated.
- An email distribution list to department staff had been generated in medical outpatients where learning from incidents was disseminated. Example given of an incident where a sample had been incorrectly labelled, process was changed so that double checks of samples and patient identification were signed against.

- There was inconsistency in the categorisation of incidents being reported on to the electronic system. For example there were 56 incidents recorded incidents related to medical records at the time of inspection. However when three were sampled, two were incorrectly assigned to medical records. The medical records manager would review each incident report to determine which incidents required attention from medical records and which needed to be re-assigned to the correct department. This was not efficient and potentially caused a delay in incidents being investigated.

Cleanliness, infection control and hygiene

- The outpatient clinics and imaging department were visibly clean and uncluttered. Hand gel dispensers were available along the clinic corridors for both staff and patients and carers, and hand washing information posters were on display.
- Cleaning regimes were in place across all departments, and regular audits were undertaken to assess the effectiveness of the cleaning. Although daily room cleaning audits were seen in the radiology department and we were told that the cleaning of radiology equipment is done within set guidelines with internal scan probes being cleaned in the sterile services department, we saw no evidence in team or departmental meeting minutes of discussion or feedback on infection prevention and control (IPAC) audit performance.
- Outpatient department clinical staff undertook IPAC audits such as hand washing and environmental audits, and submit the results to the IPAC committee via an electronic dashboard. Domestic staff performed cleanliness audits on a monthly basis and report these back to the relevant department lead nurse. Infection prevention and control audits are undertaken by each department's IPAC link nurse. 'Glow and Tell' audits were undertaken to determine the effectiveness of staff's hand washing techniques. We sampled results from the ears, nose and throat clinic, the ophthalmology clinic and the fracture clinic and plaster room, the average score was 97% compliance meaning that staff hand washing techniques were helping to prevent the spread of infection.
- Clinics were organised to minimise the risk of cross infection, for example in the ear wax removal clinic patients known to have infections were put at the end of

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clinic lists and attending clinicians wore full personal protective equipment (PPE) such as disposable aprons and gloves. The clinic furniture and equipment would be cleaned with disinfectant and the IPAC team would be informed.

- Where known, infectious patients were flagged on the patient information system.
- In the diabetic clinic where a patient had an open infection, neither medical nor administrative staff were seen to apply hand gel when entering or leaving the clinic room. This was despite the trust promoting, with posters, its policy on the use of hand gel upon entering and leaving clinical areas.

Environment and equipment

- Clinical environments were cramped in some areas such as the clinical measurements clinic and the fracture clinic due to increasing demand on services. This meant that limited seating and space made it difficult for patients to access the clinical areas during busy times, particularly if they were on a stretcher or bed or in a wheelchair. In the clinical measurements clinic it was impossible for patients in beds to gain access to the clinic and in fracture clinic all furniture had to be removed and left in the corridor temporarily for patients in beds, stretchers or wheelchairs. A new estates strategy for 2015-16 included a resolution for this.
- The trust had a contract in place with a regional radiation protection service for the monitoring and auditing of radiology equipment. This service sent a representative to the radiation protection meetings to advise on any new practice and kept the trust up to date with processes. The trust's procedures for checking of equipment against ionising radiation (medical exposure) regulations (IRMER), such as beam alignment checks, was audited by the service. This ensured both the service and the trust remain well informed of any issues regarding radiation protection both regionally and within the trust.
- The trust had reported four radiology errors in the past year. This number of reported errors was lower than other trusts in the region, however the number was consistent with the size of the trust and amount of radiological examinations performed. The types of errors reported were consistent with the national

picture of radiological errors. We were told that manufacturer engineer support for radiology equipment was usually provided within 24 hours of a request being made.

- The radiology department had raised the profile of radiation regulations (IRMER) with staff by ensuring that the information was on display in every room in radiology.
- Safety of both patients and equipment was supported by the use of closed circuit television (CCTV) equipment to monitor the radiology department's use out of hours.
- There was a monthly rota for daily checks amongst the outpatients departments that would access any of three resuscitation trolleys. All daily checks were complete and recording was signed, dated and timed. Fridge temperature checks were also complete and showed no history of the fridge providing an out of range temperature within the last six months checked.
- There was a blood glucose monitoring machine and a dedicated box for anyone enduring a hypoglycaemic episode, kept in the ophthalmology clinic which was in a central location to the surrounding outpatient clinical areas such as ENT and urology, this was kept in the same room as one of the three resuscitation trolleys. All daily checks of the resuscitation trolleys were complete and recording was signed, dated and timed.
- There were trained radiation protection supervisors (RPS) in the radiology department. They had regular weekly contact with the radiation protection advisor (RPA) based at another provider to share best practice and ensure that protocols were in line with current guidance and recognised practice. The service provided by the RPA included the monitoring of radiation, attendance at protection meetings with the RPS, and the auditing of equipment annually or as required to ensure safety. Audits were seen that demonstrate this

Medicines

- Prescription pads were securely stored in all departments and in the fracture clinic there was an added security measure where any prescriptions issued were also recorded in a separate diary for the pharmacy department to check, reducing the risk of prescription pads being used by anyone other than the appropriate doctor or surgeon and ensuring that the correct patient received the correct prescription.
- Emergency drugs were stored securely on all resuscitation trolleys; this reduced the accessibility of

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these drugs to anyone who was not authorised to use them. Some medication needed to be stored at certain temperatures in order to maintain its effectiveness. There was a system in place to ensure daily monitoring and recording of areas where medications were stored. Fridge temperature checks were all complete, signed and dated in all departments

- Contrast medium, used in some radiological examinations to improve the visibility of inside the body, was kept locked in secure cupboards for x-ray and CT procedures.
- Patients receiving injections in the rheumatology clinic had their medication charts signed and dated and medications for administering were double checked with another clinician including checks of the patient's name, allergies and consent.

Records

- The trust began its programme of transferring paper records to electronic records in 2012 and now has approximately 5,000 paper records outstanding from approximately 250,000. Both a paper and electronic file system is used throughout the trust which increases the risk of information being missed, duplicated or misfiled.
- An electronic system is used to track paper medical records throughout the trust and for the generating of clinic lists. Patient details entered onto this system trigger the start of the 18 week wait for the start of treatment from referral.
- A third party scanning company provided the majority of the scanning of paper records to electronic records for the trust.
- Paper medical records were scanned on to an electronic health record system with the exception of paediatric growth charts and care pathways that were complex. These records remained in paper format and were securely stored in the medical records department, leaving the department when the patient attended as an outpatient or inpatient.
- Paper front sheets were used for appointments which made up a temporary patient file, this would be scanned to the electronic patient record after clinic by the medical records department. Dictated and transcribed notes from outpatient clinic appointments or inpatient admissions would also be scanned into the electronic patient record. 10% of these files were kept for 30 days for quality assurance checks where scan quality, orientation, correct electronic file, file section

and optical character recognition were checked. The temporary paper files were then stored in the medical records department. Systems were in place to ensure secure handling of paper records. All paper records were delivered around the trust in lockable cages with secure locks, which were accessible only to designated staff via access codes. Notes being delivered to clinics at other sites were also transported in locked boxes. An electronic system was in use which allowed staff to track every location the notes had been sent to and received by.

- An email account had been set up which was checked daily, for staff to email when they found sections of medical records misfiled electronically. Medical records staff would be able to amend these misfiles although this was not monitored so data could not be fed back to the third party company providing the scanning of the paper notes.
- Requests for clinical investigations were paper based and were scanned onto the electronic patient record.
- Some radiology reporting was outsourced to other providers when internal capacity was not able to meet demand. The trust monitored turnaround times with these providers to reduce the risk of reporting delays.
- There was an effective electronic system in place for the tracking of paper medical records. For example in one outpatient clinic we saw that five sets of medical records were not in the department at the time of the clinic, the electronic system allowed all five sets of records to be traced and ultimately provided in time (three were in other departments where patients were having other examinations before clinic, one was with the patient on the ward as an inpatient and one was at another site and was being transported to the clinic).
- In the clinical measurements department there was an excellent reporting and review system adapted by one of the hospital electronic systems and the IT department in association with the equipment manufacturers for echocardiography, meaning that results could be reviewed anywhere onsite or remotely where access was provided.

Mandatory training

- Mandatory training and e-learning were consistently provided during work time for staff with the exception of training on the trust's values and vision.

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- The majority of staff in departments were up to date with their mandatory training, and those that were not had dates booked in for outstanding training sessions.
- Overall mandatory training compliance for outpatients and radiology department was 86%. Staff in the radiology department had an overall compliance rate of 79%, the anticoagulation nursing staff were 88% compliant, audiology staff were 79% compliant, computerised tomography and magnetic resonance imaging staff were 96% compliant, clinical measurement staff were 83% compliant, department of medicine clinic staff were 84% compliant, dermatology staff were 65% compliant, diabetes clinic staff were 97% compliant, diagnostic imaging nurses were 97% compliant, ears, nose and throat clinic staff were 97% compliant, gynaecology clinic staff were 74% compliant, ophthalmology clinic staff were 95% compliant, orthoptic clinic staff were 93% compliant, pain clinic staff were 92% compliant, plaster room staff were 58% compliant, rheumatology clinic staff were 93% compliant, surgical clinic staff were 79% compliant, orthopaedic clinic staff were 92% compliant, ultrasound clinic staff were 97% compliant,

Assessing and responding to patient risk

- The 2014-2015 outpatients and radiology departments training figures for safeguarding were approximately 87% safeguarding adults and approximately 76% across safeguarding children levels one and two.
- In the radiology department not all women of child bearing age had their pregnancy status checked. A rolling two week audit was completed which showed that the most common radiological examination occurring where women did not have their last menstrual period (LMP) date checked was the pelvis, with 14 out of 33 examinations where LMP was not checked. Half of women over the age of 50 did not have their LMP checked. An audit action plan had been created to address this lack and focused on the appropriate scanning of referral and waiver forms on to the electronic system. This was being rolled out and was due to be re-audited in a year's time. In the outpatients and radiology departments, staff were aware of the emergency call system for cardiac arrests.

Nursing staffing

- Nursing staffing in the outpatients department was almost at full establishment. The requirement in the

outpatients department was 1.0 full time equivalent (FTE) outpatient services manager, 0.85 FTE senior sister or charge nurse, 0.53 FTE sister or charge nurse, 2.5 FTE staff nurses, and 15.7 FTE outpatient assistants. The actual establishment consisted of 1.0 FTE outpatient services manager, 0.96 FTE senior sister or charge nurse, 0.53 FTE sister or charge nurse, 2.1 FTE staff nurses, and 15.2 FTE outpatient assistants. This meant that overall, the outpatients department were 0.4 FTE short for staff nurses and 0.5 FTE short for outpatient assistants.

- Establishment in the radiology department was slightly below requirement. The requirement was 0.8 FTE band seven, 0.27 FTE band six, 4.76 FTE band five, and 1.0 FTE band two. Actual establishment consisted of 0.8 FTE band seven, 0.00 FTE band six, 4.55 FTE band five, and 1.0 FTE band two. This meant that the radiology department were 0.27 FTE short of band six nurses and 0.21 FTE short of band five nurses.
- Bank staff had been used to fill vacancies in the outpatients and radiology departments, with 140 registered nurse hours requested and filled, and 177 healthcare assistant hours requested and filled in the three months prior to our inspection.
- There was at least one trained nurse per clinic session with health care assistants working alongside each medical staff member in outpatient clinics. Vacancies were proactively managed, for example in the fracture clinic there was recruitment underway for a senior trained nurse to replace a member of staff who was due to retire. The timing of this allowed for a period of handover to take place so that the standard of care provision was not affected and service was not disrupted.

Medical staffing

- The limited clinical specialities at the trust affected the range of imaging and interventional procedures which had a negative impact on the recruitment of radiologists. Locums are relied upon to support the service. At the time of our inspection radiology had seven substantive radiologists in post, three locums and one vacancy.
- Radiologists provide ad hoc second opinions on reports to the ultrasound service.
- Low medical staffing levels and high locum support in dermatology was on the risk register. However the trust

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were ensuring cover of the speciality by enlisting an overseas consultant for a week at a time, having retained specialists in clinic and developing specialist nurses.

- Between May 2015 and August 2015 there had been five locums supporting the outpatient departments, specifically the neurology, dermatology and gastro-intestinal clinics. Between November 2014 and August 2015 there had been eight locums supporting the radiology department.

Major incident awareness and training

- There was training available for staff so that they would know how to respond to a range of incidents and emergencies that could affect patient care, such as extreme weather conditions, outbreaks of infectious diseases or major transport accidents.
- Major incident training exercises occurred twice yearly where designated staff would receive telephone calls from the switchboard informing them of their roles and requirements for the incident.
- Nurses in medical outpatients were aware of the business continuity strategy and that they could be drafted in as required, they had experienced test calls when training exercises had occurred.
- There was a contingency plan in place for the electronic systems used in the radiology department so that in the event of an outage, a degree of workflow could still be maintained.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

We did not rate the effectiveness of the service. Care and treatment were evidence based and followed recognised national guidance.

Auditing was well embedded, with centralised coordination of audit planning, activity, review, learning and implementation of change. Students in radiology were encouraged to audit as part of their dissertations. The imaging service was in the process of applying to enrol in the Imaging Services Accreditation Scheme (ISAS). Medical outpatients allocate each speciality one day a week to video conference multi-disciplinary partners at other sites,

ensuring quick, effective care. The ophthalmology service had set up satellite clinics across Great Yarmouth and Waveney to meet the needs of patients requiring monthly follow up appointments.

Whilst nursing, radiology and medical staff in departments such as ultrasound and ophthalmology were involved in the auditing of compliance to relevant clinical guidelines, the auditing of compliance with clinical guidelines was not consistent across other departments such as ears nose and throat (ENT).

There were several different electronic systems in use for patient records, patient note tracking, pathology reports, radiology reports, incident reporting, and particular cancer pathways. These systems were not inter-linked which increased the risk of important information not being received by the right clinician at the right time.

Evidence-based care and treatment

- One to two monthly divisional audit meetings took place with a large clinical attendance from across the trust. These meetings allowed for the presentation of varying clinical audits that had taken place and for the dissemination of any learning that had arisen from these audits. Case studies of actual clinical scenarios that had occurred were also discussed to elicit any improvements that could potentially be made in the future.
- There were robust clinical audit forward plans in place for both the elective and emergency divisions covering the radiology department and the departments that held outpatients clinics. These included both national and local audits. A total of 66 elective and 18 emergency division national and local clinical audits were planned for the years 2015-2016.
- Clinical guidelines from the National Institute for Health and Care Excellence (NICE) were followed, such as those for first, second and third trimester pregnancy scans and reports, all of which were available to staff on the intranet, and a paediatric otitis media care pathway based on NICE guidelines in the audiology clinic.
- There were arrangements in place within specialities for the on-going monitoring and updating of staff of clinical audit activity. For example in the radiology department, audits and clinical checks such as the checking of the resuscitation trolleys are divided up for monitoring by different radiographers. One consultant radiologist was the audit lead with responsibilities for national audits,

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local surveys and local reviews. Guidelines were in place for pregnancy and deep vein thrombosis (DVT)/pulmonary embolism (PE), ureteric colic and the use of contrast nephropathy. These were being updated across the region with other nephrology colleagues to ensure best practice. In dermatology, National Institute of Clinical Excellence (NICE) and British Association of Dermatology (BAD) guidelines were reviewed by consultants and senior nurses and included on the dermatology section of the trust's intranet so that the whole team could access them with ease. This meant that there were processes in place and accountability taken within departments for their own auditing.

- The radiology department has a comprehensive programme of clinical audit. Samples of individual audits were reviewed which demonstrated a process of feedback to the department of audit findings in team meetings. Radiation dose monthly checks were performed for x-ray. Computed tomography (CT) dose audits were also completed which were informative of how radiation levels used in different types of CT scans measured against national standards, with guidance on any actions to be taken.
- The ophthalmology clinic had a robust audit plan which was disseminated to the whole department. An audit meeting was held throughout the year which presented audits in order of sub-speciality. One audit sampled was the fluorescein angiogram audit performed in March 2015, which showed some non-compliance to the set benchmark. Recommendations had been made within the audit report with an annual re-audit planned, meaning that learning was taking place and being tested. The department maintained a file with all relevant policies and guidelines for care, inclusive of patient group directives, standard operating procedures, clinical guidelines, clinic protocols and policies. This was maintained and updated regularly to ensure staff had access to information.
- The dermatology department participated in the British Association of Dermatologists (BAD) programme of audits, although these audits did not appear in the elective or emergency clinical audit forward plans. There was a system in place for review of the guidelines by consultants and senior nurses and these were accessible to staff via the trust intranet. Recent audits included the audit of routine checks on patients on methotrexate, and the World Health Organisation (WHO) checklist audit which was viewed during our inspection.

- Clinical guidelines for ENT were not well shared between medical and nursing staff, meaning that nursing staff were less likely to be aware of expected standards of care provision. The ENT clinical audit plan for 2015-2016 consisted of one audit based on national recommendations.

Patient outcomes

- Both real and hypothetical patient journeys were discussed at the fracture clinic team meetings to discuss and explore the effectiveness of the service provided.
- Cancer patients going through complex care pathways and receiving clinical interventions across more than one location had their pathway coordinated by a patient pathway coordinator. The patient's care and all of their clinical interventions would be tracked and discussed at weekly multidisciplinary meetings, utilising an electronic system that tracks all chemotherapy interventions in the local area.
- Trust-wide audits such as infection control and health and safety audits were undertaken in the fracture clinic, with one orthopaedic audit listed on the elective clinical audit forward plan.
- The radiology department was in the early stages of making an application to join the Imaging Services Accreditation Scheme (ISAS) which is designed to help radiology department services ensure that their patients consistently receive high quality care, delivered by competent staff in safe environments.

Competent staff

- Training of staff for service development was encouraged within departments, for example, staff training was occurring to further develop and support the provision of the highly specialised musculo-skeletal ultrasound service.
- Training was encouraged and supported by a staff study leave budget for the payment of study costs, access to which was discussed at staff appraisals. Training requested and approved from appraisal was often anticipated to be disseminated by the staff member to the rest of the team, encouraging whole-team learning.
- In the ophthalmology clinic, staff members were given a competency booklet to work through that ensured they became skilled in providing ophthalmic care. The booklet was amended for technicians according to their

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role. New staff to the department attended an awareness day provided by a local association for the blind. This meant that staff were competent in the specific care required by patients attending that clinic.

- Staff across outpatients and radiology departments had up to date appraisals or had one planned. We saw that appraisals were out of date for nursing staff in ENT, however the cause of this was due to the charge nurse only recently coming into post and completing appraisal training. A plan was in place to commence staff appraisals upon the verification of the course completion by the charge nurse's manager.
- There was no consistency regarding regular one to one sessions for nurses. Fracture clinic held these monthly and recorded them, the ultrasound department were introducing them at the time of the inspection, the audiology clinic held them on an ad hoc basis and the ear wax removal clinic held them informally throughout the year and did not record them. This meant that not all clinicians had their learning needs monitored and met in between appraisals.
- There was a pilot review of administrative function in the elective division where work volumes were being reviewed with the aim of informing the innovation of IT systems, staffing levels and adequate work streams. Weekly analysis by a senior administrator showed themes by speciality of clinical correspondence falling outside of the set key performance indicator (KPI). The KPI determined the timeframes in which the trust must send out clinical correspondence.
- In radiology, staff were audited against their health and care professions council (HCPC) re-registration. This meant that the department actively ensured their staff met the working standards set out by the HCPC.
- In medical outpatients staff had been encouraged to train in other specialities such as phlebotomy or dermatology so that assistance can be provided across departments when required.
- In phlebotomy, staff received annual observation of care provision. This meant that staff skills in the procedures they were employed to carry out were assessed and checked annually.

Multidisciplinary working

- There was computerised tomography (CT) and magnetic resonance imaging (MRI) service representation on the

committees for both stroke and trauma patients, ensuring that all departments involved in the care of stroke and trauma patients were involved in service planning and updates.

- Audiology worked closely with the ears, nose and throat (ENT) department where approximately 30% of their paediatric cases were referred onto. Adult cases were offered hearing tests in audiology at the same time as the ENT clinic supporting ease of access for the patients.
- Audiology clinic had a working arrangement for the provision of the new-born hearing screening programme, with health visitors from two local community healthcare providers reviewing babies and referring them to the audiology clinic as appropriate, with initial appointments taking place in the home of the child.
- Specialisms within medical outpatients used video calls to link in with multidisciplinary (MDT) partners in other sites, with each specialism allocated one day a week to discuss the care of patients. This meant that care provided was robust and well supported by an MDT.
- There was a system of direct referral in radiology for example – patients who had been referred from primary care for plan film or chest x-rays whose films showed an abnormality would be directly referred as appropriate from radiology rather than referring back to requesting GP for them to do it.

Seven-day services

- Services provided over seven days were being introduced gradually as need was being acknowledged, for example the fracture clinic ran five days per week but feasibility was being considered for rolling out weekend clinics. Similarly the medical outpatients ran seven-day services temporarily according to service demand.
- The trust was proactive in accommodating the need for seven day surgery within the radiology department, for example a bid had been submitted to the senior leadership to increase staffing for the provision of seven day working for the computerised tomography (CT) and magnetic resonance imaging (MRI) services.

Access to information

- Patients and/or their legal representatives could request access to their medical records with approximately

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2,100 requests made in 2014-2015. Approximately one to two requests were face to face visits to the medical records department and the remaining requests were for photocopies or encrypted electronic information.

- Information leaflets were available for patients for different procedures and after care instructions in surgical outpatients departments.
- There were trouble-shooting radiologists available for any urgent requests or reviews of reports or films.
- The electronic system for pathology results was not linked with any of the trust's other electronic data systems which increased the risk that important information may not be available or easily accessible when required. Anti-coagulation clinic results could be accessed electronically by patient's general practitioners in primary care, although results on different electronic systems used by the trust did not all have the same availability to primary care.
- There was effective monitoring of time taken from attendance in CT scanning department to having a verified report. The timeliness of head scans requested via the emergency department was also monitored inclusive of reasons for excessive delays.

Consent, Mental Capacity Act and Deprivation of Liberty Incident reporting systems

- There were processes in place to obtain informed consent. This included full explanation of procedure beforehand with associated benefits and risks. The consent form was then signed and dated. This meant that patients had the opportunity to ask questions and clarify points prior to any procedure taking place. Consent was gained for all aspects of care, for example consent was also gained from patients for the door to the examination room to be locked for intimate exams in radiology.
- Two sets of medical records were selected at random for review, both contained consent forms completed appropriately, with signatures from the consultant and patient on the appointment date and countersignatures taken on the date of surgery in dermatology clinic, information sheets were given to patients prior to consent being gained. Implied consent was taken for patch testing and cryotherapy, written consent was taken for photodynamic therapy, surgeries, and ultraviolet A (UVA) and ultraviolet B (UVB) treatments.
- A set of medical records in fracture clinic had a consent form signed and dated by a consultant but signed and

not dated by a patient in clinic, and not countersigned on the day of the procedure. This meant that consent may not always be confirmed with patients on the day of their procedures.

Are outpatient and diagnostic imaging services caring?

Good



Caring was good in the outpatients and radiology department. 21 Patients told us that that they felt well cared for; respected and involved by those caring for them. Medical, nursing and administrative staff addressed patients in a respectful manner. Care was provided in a way that maintained the privacy and dignity of patients and care was provided that met patient's needs and preferences. There were some areas, such as fracture clinic and clinical measurements, where the environment was not ideal leading to potential issues with maintaining a patient's privacy and dignity.

Compassionate care

- Patient's privacy was respected when booking into clinics, for example only the first line of patient's addresses and the last three digits of their telephone numbers were requested when confirming patient's identities.
- In radiology nine patients told us that they were happy with their care, they were seen in a timely manner by friendly staff.
- In medical outpatients we were informed of a patient receiving support with personal hygiene after soiling themselves in the clinic, with clean clothing being provided. A box of clean clothing and toiletries was placed in the clinic for possible future occurrence's which had been utilised on one occasion since up to the time of our inspection.
- Four urology consultations were observed with patient consent; the care provided at each consultation was caring, compassionate and provided clear information on treatment options.
- An observed consultation in the diabetes clinic showed a consultant take the time to arrange an urgent admission for a patient. The consultant explained the reason for the admission and eased the patient's concerns about his medications.

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Understanding and involvement of patients and those close to them

- The support of relatives and carers was facilitated in both outpatients department and radiology department. For example in radiology relatives could attend the x-ray appointment and stand behind the screen if the patient required them to be there. In medical outpatients patients could bring another person into their appointment with them if they wished.
- In medical outpatients a card had been developed that was given to patients when their observations were being taken that included details of any delays in the clinic, how to request a chaperone if required one and how to provide feedback regarding their experience, although we did not see evidence of this rolled out in other clinics.
- One patient and their carer stated that staff had requested the patient's permission to speak to the carer as the patient was deaf in both ears, a solution that the patient communicated they were happy with.
- Sensitive issues around the management of conditions were handled in a compassionate way, for example in the diabetic clinic a consultant approached the issues of family planning and pregnancy with a woman in relation to her condition, enabling her involvement in her future care.
- Individual patient needs were met in clinic in a caring manner, for example in medical outpatients we were told of staff working into their lunch break to provide a quiet environment for one patient with learning disabilities who did not like being in a crowd of people.
- Patient survey data for the outpatients department showed that the average percentage of patients who would recommend the department was 96.5% between April 2015 and July 2015. Patient survey data for provided for computerised tomography (CT) and magnetic resonance (MR) scanning departments in May 2015 showed that 93% of patients would recommend the service. We did not receive any data for other radiological services.

Emotional support

- Patient's anxieties about their treatment are resolved in a caring manner. For example patients feeling anxious about their first treatment in the ear wax removal clinic are supported by the exploration of any previous negative experiences and informing them of the

procedure in advance of any treatment commencing. One patient and their relative told us that a doctor treating them at an emergency appointment took the time to settle their anxieties by discussing their condition and putting them at ease with the treatment in advance of it happening.

- Supportive care was provided in by both medical and nursing staff. For example one patient told us that their consultant had transported them to other departments in their wheelchair so they did not have to wait for a porter, making the patient feel cared for. The nurses in the clinic had also provided care to the patient in their wheelchair as they struggled when attempting to mobilise out of it. The patient told us that they had been assured that care would be provided around their needs.

Are outpatient and diagnostic imaging services responsive?

Good



Responsiveness was good within outpatients and radiology department. There was a dedicated dementia care liaison nurse who monitored clinic lists for dementia patients attending and would attend appointments with patients to ensure their needs were met. To assist with access and flow there were clinic coordinators who tracked complex care pathways and acted as a liaison with the patient, as well as managing the 18 week wait for each speciality, where patients have the right to start their treatment within a maximum of 18 weeks from referral; the booking of new outpatient clinic appointments; and appointment slot issues.

Announcements for late running clinics were seen in some departments but this was not consistent across all departments. Patient advice and liaison service (PALS) posters were not consistently displayed in all areas so some patients may not have been aware of how to raise a concern or complaint.

Service planning and delivery to meet the needs of local people

- In ophthalmology patients with age-related macular degeneration (AMD) who required monthly follow up

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appointments for life could attend a satellite clinic nearer their home if they wished to do so. Satellite clinics were set up in different towns within Great Yarmouth and Waveney.

- There was a lack of forward planning regarding staffing in the nurse led ear wax removal clinic. There was one nurse specialist due to retire, who could prescribe antibiotic ear drops. The service plan was to recruit more band five nurses however none of them would be nurse prescribers (the existing nurse in post had been refused funding to do a nurse prescriber course), so the clinic would have to rely on the availability of doctors in the future to prescribe.
- Referral to treatment time (RTT) in the hearing aid clinic was seven weeks in December 2013, however due to hearing tests being available in some high street opticians and pharmacies since the spring of 2015 leading to increased referrals, this had increased to 10 weeks. The trust planned to recruit another part time staff member with the aim of reducing the RTT back to seven weeks by the end of 2015. This person was not in post at the time of our inspection.
- The overall new to follow up ratio for the period covering January 2015 to March 2015 for the outpatients department was 2.14. This meant that for every new appointment taking place, there were 2.14 follow up appointments taking place also. This reflected the trust to be ranked 50th nationally in comparison with other trusts, and 4th regionally against 10 other trusts across Norfolk, Suffolk, Peterborough and Cambridge.
- There was a one stop children's allergy clinic in place to decrease the number of hospital appointments children needed to make.
- Ad hoc clinics were set up on Saturdays as required to meet service demand in the ultrasound, neurology and dermatology clinics, with extended clinic sessions running until 7:30 p.m. three days a week in the ultrasound department including a Sunday morning ultrasound service offered for gynaecology inpatients. Additional clinic space had been created to expand the number of patients that could be seen. At the time of our inspection the RTT for general medical ultrasound appointments was four to six weeks.
- The SOS clinic which provided rapid access care within 24 hours did not operate out of hours. Out of hours care for ophthalmology patients was provided at another trust. To ensure that ophthalmic patients received prompt and appropriate care in times of emergency,

existing patients were advised to call accident and emergency or their general practitioner before arriving at the hospital, preventing a potential unnecessary trip to the wrong trust.

Access and flow

- The referral to treatment time (RTT) for patients whose treatment did not require them being admitted to hospital was consistently better than the England average. Between December 2014 and May 2015, overall non-admitted RTT within 18 weeks was achieved in 99% of cases.
- The speciality with the lowest average waiting time was ophthalmology with an average of 2.4 weeks wait. The speciality with the highest average waiting time was neurology with 11.8 weeks wait.
- The trust held patient tracking list meetings weekly with a membership of the Interim director of operations, deputy director of operations (elective), deputy director of operations (emergency), head of informatics, pathway process manager, outpatient managers elective and emergency, and service managers for all specialities. The aim of the meetings was to review the trust position against access targets and take action accordingly to ensure the trust delivers these waiting times. A rolling action point document was produced detailing any actions needing to be taken and this was disseminated to the relevant clinical specialities.
- Did not attend (DNA) rates at the trust were slightly better than the England average
- The percentage of appointments cancelled by the trust was slightly worse than the England average. There were 218,628 outpatient appointments occurring between April 2014 and March 2015, with 28,686 appointments cancelled between January 2015 and July 2015.
- The percentage of people with a suspected cancer diagnosis waiting less than 2 weeks to see a specialist was better than the England average, being achieved in 97% of cases and 100% of cases for breast cancer. The percentage of cancer patients waiting less than 31 days from their diagnosis to receiving their first treatment was better than the England average too.
- The percentage of patients waiting 6 weeks or more for a radiology appointment has been consistently better than the England average.
- In fracture clinic a senior nurse would verbally announce any delay in appointment times to patients in the waiting area. Updates to waiting times were written on

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the white board in the waiting area. However the plaster room, based within the fracture clinic, did not have any system or process in place to keep patients informed of how long they would be waiting for their appointment. We spoke with one patient who had been waiting for 40 minutes and was given no information regarding their wait.

- In ophthalmology and ENT clinics, electronic display boards informed patients of if and how long the clinic was running behind.
- There was a backlog of approximately 2,000 ophthalmology follow up patients in previous 12 months to our inspection. Saturday clinics had been implemented to reduce this number, which were still running, and the backlog was reduced to approximately 300 at the time of the inspection. Risk assessments had been performed in collaboration with ophthalmology clinicians in August 2014 and April 2015 to assess the risk of serious incidents occurring due to this backlog. The risk assessment provided a rolling set of mitigating actions to reduce the follow up waiting list, reduce the risk of harm occurring to the patients waiting and to ensure that measures undertaken were clinically appropriate.
- There was an access policy in place for managing patients that did not attend (DNA) their appointments. Clinical review of DNA's was undertaken by the consultant and a decision would be made to reschedule or discharge the patient with communication being sent out to both the referrer and the patient.

Meeting people's individual needs

- Staff knew how to access protocols and guidelines for learning disability and patients on the intranet.
- A dementia care liaison nurse was available throughout the trust who sent lists to outpatient's clinics of dementia patients they were expecting each week. This allowed the clinic staff to prioritise clinic lists in such a way that dementia patients experienced reduced stress whilst in clinic. The liaison nurse was also available to attend appointments with dementia patients if required.
- The ultrasound service had allocated one of their own staff as a dementia champion who could attend appointments with dementia patients. Diabetics, dementia patients, learning disability patients and

patients with additional needs were booked at the beginning of each list. Depending on the degree of need, patients with mobility issues received a double slot for their appointment.

- There were good examples of clinics being responsive to dementia patient's needs. For example in the fracture clinic a red dot sticker was placed on the notes of dementia patients which informed staff of the patient's condition, so that priority appointment slots could be allocated to them. In medical outpatients reminiscent boxes had been introduced for dementia patients whilst in the clinic, as well as dementia clocks which display date and time in a way that helps to ease dementia-related anxiety.
- There were hearing loop systems installed in some clinical areas such as the fracture clinic, ear wax clinic and ENT clinic for hard of hearing patients, but not all clinics had hearing loops meaning that some hard of hearing patients may have struggled to hear depending on which clinic they were attending.
- Unique letter templates in larger and bolder text were produced in the ophthalmology clinic for patients with visual problems. The clinic signage was in contrasting black and yellow for ease of sight.
- Translation posters were displayed in waiting areas and clinics offering telephone or face to face interpretation services if required. Staff would gain the permission of divisional management to use the INTRAN services.
- Staff knew how to access a storeroom of bariatric equipment such as hoists, walking frames, commodes and wheelchairs for obese patients. There were various types of seating seen in outpatient clinics for bariatric patients or patients with different mobility needs.
- The ophthalmology clinic was centrally located near several other clinics and had a disability bathroom located within it. However this was not well sign posted in the neighbouring clinics so patients may not have been aware of this facility.
- Cold water drinking fountains were not consistently available in all clinical areas.
- All rooms in the ultrasound service had signage indicating when an examination was in progress and informing people to knock and wait. A radio had been put in the waiting area to minimise the risk of any conversations being heard through the examination room doors. There were also changing facilities for patients ensuring that the privacy and dignity of patients was maintained.

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- Patients needing to get undressed in the radiology department were offered changing rooms that were located next to the x-ray room, helping to maintain their privacy and dignity.

Learning from complaints and concerns

- Staff knew how to access the patient advice and liaison service (PALS). There was a consistent approach of resolving informal complaints within departments rather than escalating them to PALS. However we saw inconsistent monitoring of this process across departments. For example, the radiology department produced a report for their team meetings that demonstrated all compliments and complaints received and details of responses sent to complainants, actions required and completion dates. Other departments did not record their informal complaints.
- PALS posters were displayed in many departments but this was not consistent for all departments that patients attended. This meant that not all patients may be aware of how to raise an issue or concern with the trust.
- There was inconsistency across departments of staff receiving feedback from PALS patient feedback forms. For example, in the ENT clinic feedback forms were collected every three days and fed back to staff at team meetings, however we saw no evidence that these were reported to the PALS department for recording and monitoring. Team meeting minutes in the radiology department showed that staff were fed back to regarding any PALS feedback, however this was not the case in other departments.
- There was a bi-monthly report to the Carer and Patient Experience Committee which detailed complaints by department. There was a bi-monthly report to the carer and patient experience committee which detailed complaints by department. The report was not clear regarding the number of complaints made and the number of issues involved in each complaint. For example, the March 2015 report stated there were six complaints received that related to the trauma and orthopaedic outpatients department. However the breakdown of complaints from the same report stated there were three complaints in the outpatients department, one for gynaecology clinic, one for general surgery and urology clinic and one for the ears nose and throat clinic.

- In the radiology department we reviewed a report demonstrating all compliments and complaints received in the department which included details of responses sent to complainants, actions required and completion dates.
- There was no evidence on display for patients to see what improvements had been made as a result of their feedback in any clinical areas.

Are outpatient and diagnostic imaging services well-led?

Good



Well-led at within outpatients and radiology department was good. There was a leadership briefing meeting every one to two months and included a presentation that was sent to all department leaders. Staff were aware of the trust's vision and values due to training being provided in accordance with staff availability. Staff were supported in their re-validation needs by the provision of workshops facilitated by the trust. An innovative new role had been created in the outpatients department of outpatient assistants who were healthcare assistants trained in administrative functions so that they could book patients upon arrival in clinic, and provide clinical care. Staff felt supported by their department leaders, who informed and involved their teams at team meetings of both departmental and trust wide activities and improvements. Leadership in ophthalmology was maintained on a one to one basis with staff appraisal dates being set and agreed several months in advance so that the department leader could meet with all staff themselves rather than delegating the task.

There was a lack in consistency of awareness of the senior executive team. Whilst the majority of staff knew who the senior leadership were, only some staff could say that the senior leaders were visible around the hospital. Service development planning for future capacity and demand was not consistently undertaken across all departments.

Vision and strategy for this service

- There was consistency across both the outpatients and radiology departments that the values and vision of the

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trust is based on the 6 C's which were care; compassion; competence; communication; courage and commitment. In the radiology department staff had reminder cards reinforcing these values.

- Although service development plans were in place in ophthalmology and radiology, they were not consistently in place across all services, meaning that some services lacked future planning for any increased demand on their capacity.
- Vision and values training had been provided for staff by the trust both within normal working hours and out of hours to ensure that staff would be able to attend around their clinical responsibilities.
- There was a display poster demonstrating the trust's values and behaviours. This showed patients and visitors what they could expect of staff. These posters were not consistently displayed across all clinical areas. This meant that not all patients and visitors were being made aware of what behaviours and attitudes they could expect to be treated with.

Governance, risk management and quality measurement

- There were quarterly multidisciplinary governance meetings where outpatient service leads acted as the link between the staff in their service and the deputy directors of operations.
- The trust divided its services into either an elective or emergency division, and monitored issues such as governance by division. This meant that services providing both elective and emergency care reported into, and received appropriate support and scrutiny from both divisions.
- Risks were consistently reported and discussed but the level of scrutiny was not consistent. For example, the ophthalmology department produced a bi-monthly report for scrutiny at the patient safety committee demonstrating how they managed their risks. However the main x-ray department discussed their risks in their staff meetings.
- A bi-monthly patient safety report was produced and submitted to the patient safety committee for scrutiny which included details of harm prevention; medicines management; risk registers; incidents and serious incidents; clinical audit; mandatory training; and issues for escalation.
- There was a joined up awareness of what each department's main risks were between service level staff

and senior management. For example, senior management told us that an area of risk was the medical staffing of dermatology which was being mitigated in part by the development of specialist nurses. A member of nursing staff in the dermatology clinic also told us that specialist nurses were being developed at present to help address the same risk.

- The ultrasound service had separate sonographers with named responsibility for guidelines, screening, risk management, and quality assurance.
- The ultrasound service held monthly staff meetings where complaints and incidents were discussed. Minutes of these meetings were sent out via an electronic system that required the reader to digitally sign that they had read the information.

Leadership of service

- There was a leadership brief that occurred monthly which was attended by the senior executive team and the communications lead. Minutes from this meeting were disseminated via the departmental leads to ensure staff were informed. This meeting included trust-wide information around innovations and improvements, governance and clinical quality, performance, patient experience, and transformation plans.
- Staff in both outpatients and radiology told us that the executive team were not seen often in clinical areas but that they had met them at meetings.
- There was very clear leadership at divisional level down and a sense of support for service needs. One service lead stated that rather than delegating the task of appraisals they preferred to plan appraisals months in advance so that the staff still got the opportunity to discuss their needs with their lead.
- We were told that the trust provides meetings regarding supporting staff with their revalidation which were encouraged by the nursing and midwifery council and were advertised on the trust's intranet.
- Ultrasound service staff were familiar with the medical director due to the professional speciality of this doctor being relevant to the department. One radiology staff member stated they would be happy to raise concerns with the medical director or chief executive but were less inclined to raise concerns with the director of nursing who they were less familiar with.

Culture within the service

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- Staff across all departments including fracture clinic, radiology, ophthalmology, medical records and administration gave positive feedback about working for the trust, stating “I love working here”; “I love working at this hospital”; “I’m really proud to work here”; “My judgement is trusted and I’m so well supported”; “The Paget feels like family, it’s really inclusive”.

Public and staff engagement

- The trust holds an annual barbecue for all staff to attend if they wish.
- Radiology staff felt they had a strong union representative and would be confident to whistle blow if the need arose.

Innovation, improvement and sustainability

- Consultants from accident and emergency and orthopaedics and an orthopaedic sister were looking at how virtual fracture clinics operate around the country with a view to implementing it at this hospital, which was actively encouraged by the clinical commissioning group. This would cut out unnecessary appointments in fracture clinic for conditions such as sprains presenting in A&E.

- A local charity had funded the post of an eye clinic liaison officer in the age related macular degeneration service. This post raised awareness of the support and assistance available for patients with poor sight.
- A new dual role had been created for outpatient assistants, where health care assistants were also trained in administrative functions and could support the booking into clinic of a patient on arrival as well as providing care. This role was supported by senior management and one service manager informed us that they felt the role worked well in the outpatients department.
- The fracture clinic, in conjunction with orthopaedic surgery, was trialling a ‘patient passport’ which enabled a smoother care pathway and discharge from the service. The patient would complete the passport throughout their care pathway with details of family or carer details, named person for the changing of compression stockings and any meal preparation issues, with the aim of becoming more responsible for their own care.
- There was a new computerised tomography (CT) scanning machine in place with another one due to be installed in September 2015, with a plan submitted in 2015 for new magnetic resonance imaging (MRI) scanning equipment.

Outstanding practice and areas for improvement

Outstanding practice

- Care of patients requiring thrombolysis in the emergency department, with trained consultants and telemedicine access to a consultant neurologist.
- Patient pathways for GP referrals that resulted in 97% of GP referrals not requiring services of the emergency department.
- Spinal injuries nursing and state of the art equipment for patients with spinal cord injury was excellent.
- A charity funded Eye Clinic Liaison Officer raised awareness about support for patients with macular degeneration.
- The trust had been awarded integration status, with other health partners and social care to pioneer seven-day services. This included an Out of Hospital Team chaired by the clinical commissioning group involving social care, the mental health trust and the hospital to identify ways to avoid crises in communities leading to hospital attendance. Data was showing a reduction in admissions.
- The neonatal unit had developed a breastfeeding pack to encourage new mums whose babies were on the neonatal unit to hand express their breast milk. The pack contained information and tips on hand expressing along with a personal expressing log.

Areas for improvement

Action the hospital **MUST** take to improve

- Ensure that all equipment is checked at a frequency as per trust policy including, but not limited to emergency resuscitation equipment.
- Ensure that all patient records are up to date and reflective of patient's needs.
- Ensure a named Non Executive Director for end of life care in line with Department of Health Guidance.
- Ensure that all Do Not Attempt Cardio Pulmonary Resuscitation forms are completed fully and in line with national guidance.
- Accelerate the implementation of the approved replacement for the Liverpool Care Pathway for people receiving end of life care

Action the hospital **SHOULD** take to improve

- Review the application of the assessment under the Mental Capacity Act 2005 in end of life care.
- Review the storage of medicines in theatres to ensure that temperatures are consistent with trust policy.
- Review approach to the care of older people and the provision of senior medical staff in care of the elderly.
- Review audits in end of life care to ensure good practice is followed.
- Review staffing in children's services to ensure it meets national guidance.

- Review the environment within the outpatient area for gynaecology and paediatric patients to ensure that this meets their individual needs.
- The hospital trust should review the level of physiotherapists and pharmacists provided to the intensive care service as staff levels did not meet recommended levels of the Faculty of Intensive Care Medicine Core Standards for allied health professional staffing.
- Mortality and morbidity reviews within intensive care should be recorded in order to demonstrate lessons from any reviews are learned and these can be shared throughout the trust.
- The cover from specialist trainee/registrar doctors in the intensive care unit should be reviewed to ensure this meets recommended safe levels at all times.
- Intensive care should review the use of dementia-specific care plans for patients living with this condition. The trust should also review the provision of mental health support given to patients and their families who are or have been patients in the intensive care unit.
- The hospital trust should review and risk-assess the provision of the intensive care Outreach team service which was not being provided for 24 hours a day in line with national guidance.

Outstanding practice and areas for improvement

- The intensive care team should review the governance within the unit and formalise the structure and meetings.
- Review awareness of the risk register process.

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises Regulation 15 (1)(a)(c)(e) The provider was failing to ensure equipment; including emergency equipment was properly checked. The provider failed to ensure in theatres that all the environment was properly maintained.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services Regulation 17 (1)(2)(c) The provider was failing to ensure that each service user had an accurate, complete and contemporaneous record of their care including Do Not Attempt Cardio Pulmonary Resuscitation and had failed to ensure a consistent approach to end of life care pathway.