Kettering General Hospital NHS Foundation Trust

Quality Report

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This report describes our judgement of the quality of care at this trust. 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 trust	Inadequate
Are services at this trust safe?	Inadequate
Are services at this trust effective?	Requires improvement
Are services at this trust caring?	Good
Are services at this trust responsive?	Requires improvement
Are services at this trust well-led?	Inadequate

Summary of findings

Letter from the Chief Inspector of Hospitals

Kettering General Hospital NHS Foundation Trust provides acute healthcare services to a population of around 320,000 in north Northamptonshire, South Leicestershire and Rutland.

This was the second comprehensive inspection of the trust with the first taking place in September 2014, when it was rated as requires improvement overall. We also carried out an unannounced inspection to the emergency department and some medical care wards in February 2016. As this was a focused inspection, we did not rate the services inspected.

Part of the inspection was announced taking place between 12 and 14 October 2016, with an unannounced inspection taking place 24 October 2016.

Overall, we rated Kettering General Hospital NHS Foundation Trust as inadequate. We rated two key questions, safe and well led, as inadequate. We rated caring as good and effective and responsive as requires improvement.

Three core services were rated as inadequate: urgent and emergency care, children and young people and outpatients and diagnostic imaging. Three services were rated as requires improvement: medical care, surgery and maternity and gynaecology. Two services, which showed improvements since the last inspection, were rated as good: critical care and end of life care.

Our key findings were as follows:

- The board was still relatively new but had seen more stability since the last inspection. There was a lack of capacity to recognise and respond proactively to emerging risks given the focus on urgent priorities
- There was a lack of capacity in the leadership team to consistently embed learning from incidents and audits throughout services to drive improvements. There had not been sufficient improvement in areas of concerns highlighted during our February 2016 inspection. The requirements of the fit and proper person's regulations had not been met.
- Safety was not a sufficient priority. Opportunities to prevent or minimise harm were missed. Risk assessments were not being carried out in line with hospital policy. There was not a holistic approach to the monitoring of safety and performance data, supported and informed by effective, ongoing clinical audits. Action plans had not always been developed to address areas of risk or poor performance and those that were in place were not always effectively monitored.
- Risks identified by the service were not being assessed, monitored and mitigated via effective, comprehensive risk registers. Risk assessments were not being carried out in line with hospital policy.
- Services' risk registers were not comprehensive and many of the risks did not have sufficient assurance that mitigating actions were being monitored. Ward dashboards referred to some local risks but these were not systematically escalated to the service risk register.
- Significant issues that threatened the delivery of safe and effective care were not identified. Risks we identified on inspection were not recognised by the service, including the failure to escalate deteriorating patients, poor junior doctor cover for medical wards, security and access to the children's ward, paediatric nurse competent in the children's ED and the poor completion and storage of patients' records. We were therefore not assured staff at every level in the service had an effective understanding of all the risks to patient safety and were able to assess, mitigate and monitor all known risks.
- The hospital had serious concerns around the accuracy and quality of its referral to treatment (RTT) data and reported position, with the correction of this being a hospital priority. The hospital was working on a plan of data improvement including education, training, changes to systems and process and validation of patient pathways. Some patients also experienced long delays waiting for treatment, specifically for urology, maxillofacial and ear, nose and throat (ENT). In some cases, waits were in excess of 52 weeks. The service did not have the capacity to meet the needs of patients and to run additional clinics to manage waiting lists. There were long waiting lists for the majority of specialities, including medical oncology. The services' own figures from October 2016 showed that 69% of patients were seen within 18 weeks against the national standard of 92% (based on

the trust's unvalidated data). The hospital was not nationally reporting referral to treatment time (RTT) performance at the time of inspection due to historical problems with the validity of data.

- The hospital had taken action to minimise the delays in diagnostics and imaging reporting by outsourcing their radiology reporting. At the time of inspection, there were 11,733 images awaiting a radiology report. These were classified as non-urgent images.
- Generally, staff understood their responsibility to report incidents both internally and externally. Feedback received was variable. Learning from incidents was not always effectively embedded throughout services.
- Complaints were not always handled in a timely manner in almost all services.
- There were not enough registrars and junior doctors to cover the medical wards out of hours and at weekends. Doctors told us there was no electronic handover system and no electronic list of priority patients to alert them to problems out of hours and at weekends in the medical wards. The hospital did not operate a multi-speciality hospital at night team and handover was focused on medical care wards. Working to seven day working in the service was variable.
- There were inadequate numbers of nursing and medical staff to meet the needs of patient's in adults and children's ED. There were not effective processes in place to ensure that all staff were competent to carry out the roles they were tasked within the ED. The coronary care unit had nurse staffing numbers that were below the recommended number stipulated by the British Cardiovascular Society. There was inadequate medical staffing cover in the children and young people's service. The maternity service did not always have sufficient staff, of an appropriate skill mix, to enable the effective delivery of care and treatment. There were times the consultant obstetrician was not present on the labour ward as they would be covering obstetrics and gynaecology and undertaking elective caesarean section lists. The critical care outreach team was not fully established to provide the necessary support and education to the rest of the hospital. The neonatal unit did not always operate in accordance with the required staffing levels. The paediatric outpatient department was not always staffed by registered children's nurses. Nursing staff in both fracture and ophthalmology clinics treated children but did not have level three safeguarding training in line with national recommendations. The trust took action to address this after the inspection.
- The children's waiting area did not provide adequate space for patients waiting to be seen and staff in the children's ED were not able to observe patients waiting at all times in line with guidance. The ED did not have adequate facilities or processes in place to manage patients who presented with mental health illness and were a significant risk to themselves and others.
- The dedicated room for patients who had mental health illness and posed risks to themselves and others was not in line with Royal College of Emergency Medicine (RCEM, 2013) guidelines. The facilities for these patients were not safe. The children's waiting area did not provide adequate space for patients waiting to be seen and staff in the children's ED were not able to observe patients waiting at all times in line with guidance.
- Staff were not always completing safeguarding processes in line with hospital policy and had not received the appropriate level of training. In the ED, staff did not always follow safeguarding processes and safeguarding training levels did not meet the hospital's target or national recommendations. Risks to patients had not been actioned. Only 37% of nursing staff and 29% of medical staff had completed safeguarding level three training at the time of the inspection. Not all staff had completed the required level of children's safeguarding training.
- The hospital did not have a baby abduction policy; it had a flowchart for staff to follow in an event of an abduction. The trust took actions to address this after our inspection. The environment on Skylark ward was not safe, particularly for patients who may be at risk of self-harm or suicide. The trust took actions to address this once we had raised it as an urgent concern.
- The ED was not consistently meeting national targets for service delivery but it had shown improvements in the last three months with performance better that the England average. From July 2016 to October 2016, the average performance against the target was 88%.
- There was a substantial number of delayed ambulance handovers in the ED. This meant that patients were not always receiving an initial clinical assessment in a timely manner and ambulance crews were not made available to respond to 999 calls. From

Summary of findings

April 2016 to September 2016, there were 15,604 ambulance handovers of over 15 minutes. This included 2,202 handovers of over 30 minutes and 323 'black breaches'.

- There was no effective process in place to ensure that patients waiting for up to three hours after streaming were safe to wait and that all patients with 'red flag' symptoms or category two patients were seen by an appropriate clinician for an initial clinical assessment within 15 minutes.
- Nurses on medical care wards had not always followed the escalation process for high-risk patients by informing a doctor when a patient's NEWS score was raised or when the patient's oxygen saturation showed a downward trend. There were NEWS charts which showed dates and times that were not clearly stated and some were not legible.
- Patients were exposed to the risk of receiving inappropriate care and treatment due to poorly written and incomplete care plans. For some patients, there were no individualised care plans; in some cases, the same written care needs were simply copied to a new sheet and changing needs had not been reflected or incorporated.
- Patients' individual care records were not always written and managed in a way that kept patients safe from avoidable harm. Confidential information was not always kept in accordance with the Data Protection Act 1998.
- Medicine storage was not always in line with the national guidance in outpatient areas. For example, fridge temperatures were not checked regularly in some outpatient areas. Expired medication was found in the cardiac unit. Patient's medical notes were not always stored securely in some outpatient areas. Medicine reconciliations had not always been done. Patients had not always been assessed for needing prophylactic medication to combat venous thromboembolisms (VTEs).
- Outcomes for patients were variable in medical care. The hospital had produced poor results in two national audits that the hospital recently participated in the Sentinel Stroke National Audit Programme (SSNAP) audit showed a poor score of D and E in all four quarters of the reporting year. The hospital participated in the 2015 National Diabetes Inpatient Audit: the hospital was worse for 13 out of 15 indicators. There were mixed patient outcomes in surgery and not always an action plan to ensure improvements. Examples included the hip fracture audit and the bowel cancer audit.
- Patient flow and bed capacity to meet demand had been a significant pressure for the hospital for a number of months. Senior managers were in ongoing discussions with commissioners and stakeholders regarding the most appropriate ways of managing the DTOC position as the medical care beds being used were placing a significant pressure on the effective patient flow through the service. Discharges were sometimes delayed due to patients having to wait for ongoing care packages.
- All staff were passionate about providing high quality patient care. Patients we spoke to described staff as caring and professional. Patients told us they were informed of their treatment and care plans.
- Most areas of the hospital were visibly clean and were cleaned regularly. Generally, effective infection control procedures were in place.
- Despite significant staffing pressures, generally patients' needs were met at the time of the inspection in some areas. Actual staffing levels were comparable to the planned levels for most of the wards we visited.
- Pain of individual patients were assessed and managed appropriately. Patients' nutritional and hydration needs were generally appropriately assessed and the food and fluid charts were well maintained.
- Staff understood and respected patients' personal, cultural, social and religious needs, and took these into account and services were generally planned and delivered in a way that took account of the needs of different patients.
- Local leaders within services were generally visible and approachable. Staff told us that the senior leadership team, including both senior management and lead clinicians and nurses, were generally visible and effective.
- Most staff felt involved in the hospital's CARE values which brought staff together to discuss ways to improve services and provide quality care to patients. Staff felt supported and able to speak with the lead nurse if they had concerns.
- There were clear processes and procedures in place regarding the completion of the Five Steps to Safer Surgery checklist. Intensive Care National Audit and

Summary of findings

Research Centre data showed the intensive care unit to be in line with the England average for all areas except delayed discharges. The hospital had received the United Nations Children's Fund (UNICEF) Baby Friendly Initiative full accreditation for its maternity department.

- The hospital had a replacement for the Liverpool Care Pathway (LCP) called the 'Guidance to implement care for the dying patient, and their family and friends'. The document was embedded in practice on the wards we visited. Do not attempt cardio-pulmonary resuscitation (DNACPR) records we reviewed were signed and dated by appropriate senior medical staff. There were clear documented reasons for the decisions recorded.

We saw several areas of outstanding practice including:

- The hospital had direct access to electronic information held by community services, including GPs. This meant that hospital staff could access up-to-date information about patients, for example, details of their current medicine.
- Sixty volunteers supported the chaplaincy service through a programme of daily and weekly visits to wards and clinical departments. Volunteers attended a 10-week training programme, which included awareness sessions on end of life care, dementia, and hearing and visual impairment.
- There was a well-embedded play worker team, funding was sourced through donations from local businesses as well as fund raising activities. This was used to pay for new equipment as well as weekly visits from a music therapist, pet therapist and magician. The unit had modern toys and facilities for the children including a new projector, which projected moving images onto the floor, which entertained children under the supervision of a play worker.
- The hospital had launched a "Joint School" education session for hip and knee replacement patients. The aim was to give patients a clear indication of what to expect from their operation and what was expected form them by the hospital.
- The hospital had launched a new laser operation to support patients who required treatment for benign enlargement of the prostate by using a light laser to reduce the size of the prostate. This process had reduced the surgical time and the length of stay was no more than one day.

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

Importantly, the hospital must take action:

- Ensure that there are sufficient numbers of nursing and medical staff in adults and children's ED to meet the demands of the population and ensure safe care is delivered. To ensure that staff working in children's emergency department (ED) have the correct skills, competence and support to care for children.
- Ensure there is a sufficient number of medical registrars and junior doctors to cover out of hours and weekend shifts at all times across medical care wards. To ensure there is the required level of consultant obstetrician presence on the delivery suite.
- To ensure care and treatment are provided in a safe way for service users by following the British Cardiovascular Society guidance on nurse staffing numbers in the Coronary Care Unit. Ensure there is a sufficient number of nurses working in the Coronary Care Unit at all times.
- To ensure a qualified children's nurse works in the outpatient department in accordance with Royal College of Nursing guidance, 'Defining staffing levels for children and young people's services' which states that, 'a minimum of one registered children's nurse must be available at all times to assist, supervise, support and chaperone children'.
- To ensure that suitably qualified staff in accordance with the agreed numbers set by the hospital and taking into account national policy are employed to cover each shift. In the children's and young people service. There must be suitable numbers of staff trained in Advanced Paediatric Life Support and / or European Paediatric Life Support.
- Ensure that there are effective systems in place to prioritise, assess and treat all patients attending the ED. Ensure that there are effective processes in place to measure time to initial clinical assessment for ambulance handovers and self-presenting patients.
- To review the streaming competency framework and ensure that staff in this position have the necessary skills to identify a deteriorating or seriously ill patient in adult and children's ED. To ensure that all staff in outpatients who have direct contact and assess and treat children have the appropriate level of paediatric competencies to provide safe care and treatment.

Summary of findings

- To ensure the security of the paediatric ward and Rowan ward at all times and review security system on the postnatal ward to minimise the risk of visitors accessing the ward without being challenged.
- Ensure staff in medical care follow the hospital's medication policy in the safe prescribing, cancelling, handling, storage, recording and administration of medicines. Ensure staff follow the hospital's medication procedure for obtaining medicines for patients out of hours. The disposal of controlled drug ampules which have only been partially administered to patients must be recorded in the controlled drug register in the children's and young people service. To ensure that all medications are stored in outpatients areas in line with hospital policy and national guidelines.
- Ensure that the safeguarding children and vulnerable adult policies include all relevant information, specifically, details about female genital mutilation, child sexual exploitation as well as the referrals process for vulnerable adults. Ensure that all staff are trained to the required level of safeguarding children's training and adhere to hospital safeguarding policies.
- To ensure all staff have the required statutory and mandatory training and effective systems are in place to monitor this. To ensure that staff in the radiology department are up-to-date on basic life support training. To ensure that radiation dose awareness in plain film by the radiographers is in line with national standards.
- To ensure staff in ED and medical care have had sufficient training in the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).
- To ensure there are processes and procedures for staff in surgery to adhere to the Food Safety Act 1990 and the Food Hygiene (England) Regulations 2006 (Temperature Control Schedule 4 EU Regulation No.852/2004).
- To ensure that theatre staff comply with the Standards and Recommendations for Safe Perioperative Practice 2011 by the Association of Perioperative Practice or the hospital's operating theatre policy and the theatre standard operating procedure regarding the wearing of cover gowns and footwear when leaving and entering the theatre area.
- To ensure staff are aware of the escalation policy including triggers for escalation in ED and medical care and that these process and reviewed and monitored. Ensure National Early Warning Score (NEWS) charts are filled in clearly, accurately and legibly.
- Ensure that patients' records are completed with appropriate information to understand their care plans. Ensure all patients have person-centred care plans that are well maintained and reflect appropriately patients' changing needs and treatment.
- Ensure all confidential patient information in medical care, surgery and gynaecology and outpatients and diagnostics are stored in accordance with the Data Protection Act 1998.
- To ensure complaints are handled in line with hospital policy and effective systems are in place to monitor this.
- To monitor patients' referral to treatment times, and assess and monitor the risk to patients on the waiting list in surgery, children and young people's service and outpatients and diagnostic services.
- To develop an effective programme of cyclical audits to measure performance with evidence-based protocols and guidance in the ED. To establish a system for continuous monitoring of action plans developed in response to local and national audits. To ensure all clinical guidelines are up to date and reviewed in a timely manner in the maternity and gynaecology service. To ensure the local maternity dashboard meets RCOG good practice No.7 Maternity dashboard, clinical performance and governance scorecard standards.
- To ensure all staff are supported to recognise and escalate potential risks to the safety and quality of care and treatment for all patients and to ensure effective systems are in place to assess, mitigate and monitor these risks. The hospital should ensure that the risk registers are accurate and reflective of risks in series.
- To review the incident reporting processes in children's and young people service to ensure all incidents are reported and investigated and that actions agreed correlate to the concerns identified, are acted on and lessons learned are shared accordingly. Ensure ligature audits are undertaken and acted upon in the children's and young people's service
- Ensure recruitment procedures reflect the fit and proper person's requirements.

In addition the hospital should take action to improve:

Summary of findings

- To review the environment in reception area in ED so that patients' privacy and confidentiality can be respected.
- To monitor the dedicated mental health room so that it meets national recommendations and poses minimum risks to patients and staff.
- Review ways to improve the 'whole system approach' to managing overcrowding in the ED.
- To provide training to staff in dementia awareness, learning disabilities and complex needs in ED.
- Review staff training and awareness of major incident policy and equipment.
- To monitor that equipment in ED is properly maintained and checks for resuscitation equipment are completed in line with trust policy.
- Consider ways to meet the standards in the intercollegiate document 'Standards for children and young people in emergency care settings, 2012'.
- To review the function and use of the emergency decisions unit to ensure that the eligibility criteria are being adhered to.
- To review medical cover for the Discharge Lounge.
- To continue to work to recruit full time staff in an effort to reduce the reliance on agency staff in medical care.
- To monitor that fabric chairs and privacy curtains within the breast pre-assessment clinic have the date of cleaning identified.
- To monitor that the processes and procedures in place to manage the medicines stored in all clinical rooms which exceed the required temperature.
- To support all staff to understand the trust's vision and strategy so that it is embedded within the service.
- To review systems and processes that are in place to ensure the cleanliness of surgical wards.
- To review pharmacy provision to meet the needs of the ICU and be in line with national guidance.
- Review systems for staff in ICU to provide level three safeguarding children's training.
- To review the provision of the outreach service to allow effective utilisation of this service.
- To review processes so that patients are discharged from the ICU within four hours of the decision to discharge to improve the access and flow of patients within the critical care unit.
- To review processes so that the hospital meets the needs of patient requiring admission to ICU at all times.
- To review the data collecting methods to monitor the length of time patients are nursed in recovery whilst either waiting for a bed in ICU or following discharge from ICU.
- To record ambient room temperatures where fluids are stored that requires this, taking action when required.
- Steps should be taken to improve multidisciplinary working within the department between medical staff, nursing staff and allied healthcare professionals.
- To review seven day services in medical are and critical care to ensure patient needs are met.
- To review assessment and screening of delirium for patients cared for in the ICU.
- To review systems for recording essential checks on equipment, including resuscitation equipment in critical care.
- To review facilities so women's privacy and dignity is always protected on the delivery suite.
- To review staffing in maternity so that sufficient staff to ensure midwife-to-birth ratio is at the national average of 1:28.
- To review the current practice where women who were having a termination due to abnormalities were cared for on the delivery suite in rooms next to women delivering healthy babies and Gynaecology and obstetrics patients and women attending for these appointments shared the same waiting room.
- Monitor processes for patients who present with mental health needs are suitably risk assessed when admitted to the children and young people's service to ensure care and support provided meets their needs and that staff are competent to manage difficult behaviours, including restraint.
- Monitor staff training in mental health needs of patients and in the use of tracheostomy in the children and young people's service.
- A comprehensive clinical audit plan should be developed, completed and monitored in the children's and young people service. Policies which are out of date should be reviewed and revised.
- A dashboard should be developed in the children's and young people service to report on and monitor operational performance data each month. Business plans should be developed which consider accurate operational activity data and performance. Objectives should be clearly defined and supported with effective action plans.

Summary of findings

- To review the provision of a face-to-face specialist palliative care service, aiming to achieve as Monday to Sunday service, including bank holidays.
- To review the data collected for patients so that the hospital can assess the number of referrals for patients with or without cancer.
- To review the collection of data in order to assess the percentage of patients at end of life who were discharged within 24 hours to their preferred location.
- To review the processes to in the mortuary so that medicines for coroner's inquests are recorded on receipt and transfer to pharmacy for disposal.
- To consider increasing the education and training provision in the SPCT in line with national guidance.
- To monitor the safety of patients who wait over 40 weeks for non-urgent outpatient appointments.
- To review how clinic waiting times and clinic delays are appropriately displayed and communicated to waiting patients.
- To review facilities so that consultation rooms in all outpatient areas can accommodate wheelchair users when needed.
- To review and monitor all patients on waiting lists to ensure effective prioritisation systems are in place to identify and minimise patient harm.
- Review how the standard operating procedure for managing outpatient clinics cancelled within six weeks is implemented and embedded.

Due to level of concerns found across a number of services and because the quality of health care provided required significant improvement, we served the trust with a warning notice under Section 29A of the Health and Social Care Act 2008.

On the basis of this inspection, I have recommended that the trust be placed into special measures.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Background to Kettering General Hospital NHS Foundation Trust

Kettering General Hospital NHS Foundation Trust provides acute healthcare services to a population of around 320,000 in north Northamptonshire, South Leicestershire and Rutland.

There are approximately 613 inpatient beds and over 3,200 whole time equivalent staff are employed. All acute services are provided at Kettering Hospital with outpatients' services also being provided at Nene Park, Corby Diagnostic Centre and Isebrook Hospital. The findings in this report do not reflect the two sites that we did not inspect: Corby diagnostic centre and Isebrook outpatients.

In 2015/16, the hospital had an income of £218,907,000, and costs of £232,212,000, meaning it had a deficit of £13,304,000 for the year. The hospital predicts that it will have a deficit of £6,355,000 in 2016/17.

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Part of the inspection was announced taking place between 12 and 14 October 2016, with an unannounced inspection taking place 24 October 2016 when we visited Kettering General Hospital and Nene Park.

Our inspection team

Our inspection team was led by:

Chair: Louise Stead, Director of Nursing and Patient Experience, Royal Surrey County Hospital NHS Foundation Trust

Head of Hospital Inspections: Bernadette Hanney, Care Quality Commission

The team included CQC inspectors and a variety of specialists: safeguarding lead, consultants and nurses from paediatrics, medicine, surgical services and critical care, accident and emergency doctor, palliative care nurses, senior managers, an anaesthetist, a consultant midwife and an expert by experience.

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 of people's needs?
- Is it well-led?

Before visiting, we reviewed a range of information we held about Kettering General Hospital NHS Foundation Trust and asked other organisations to share what they knew about the hospital. These included the clinical commissioning group, NHS Improvement, the General Medical Council, the Nursing and Midwifery Council, the royal colleges and the local Health Watch.

We set up a display at the main entrance to encourage and ask people to share their views and experiences of services provided by Kettering General Hospital NHS Foundation Trust. Some people also shared their experience by email, telephone or completing comment cards.

Summary of findings

We carried out this inspection as part of our programme of re-visiting hospitals. We undertook an announced inspection from 12 to 14 October 2016 and unannounced inspection on 24 October 2016.

We talked with patients and staff from all the ward areas and outpatients departments.

What people who use the trust's services say

In the CQC inpatient survey 2015, the trust performed about the same as other trusts for all of the 12 questions.

The trust's overall score in the friends and family test for the percentage of patients who would recommend the trust was about the same as the England average between August 2015 and August 2016. However, the response rate was less than the national average at 16.4% compared to an England average of 24.7%.

In the National Cancer Patient Experience Survey 2015, the trust was in the top 20% of trusts for 10 of the 34 questions, in the middle 60% for 21 questions and in the bottom 20% for three questions.

The trust performed worse than the England average in the patient-led assessments of the care environment (PLACE) 2015 and 2016 for all assessments.

Facts and data about this trust

Kettering General Hospital is part of Kettering General Hospital NHS Foundation Trust.

The hospital serves a population of around 300,000.

In 2015/16 the hospital had:

- 84,000 A&E attendances.(19 July 2015 to 10 July 2016)
- 81,837 inpatient admissions.
- 275,600 outpatient appointments.
- 3,711 births.
- 923 referrals to the specialist palliative care team.
- The hospital reported there had been 1090 in-hospital deaths between April 2015 and March 2016. This represented 51% of the deaths in their catchment area.

Summary of findings

Our judgements about each of our five key questions

	Rating
Are services at this trust safe? **We rated safe as inadequate because:** • The trust lacked a systematic approach to the reporting and analysis of incidents. There were inadequate plans in place to manage risks identified to prevent future incidents and opportunities to prevent or minimize harm were missed and feedback was not always provided on incidents reported. • There had not been sufficient improvement in areas of concern highlighted during our February 2016 inspection in the emergency department (ED). This included risk assessments not being carried out in line with trust policy and paediatric staffing levels. • There were not robust systems in place to assess and respond to patient risks especially within the ED. There were a significant number of delayed ambulance handovers. Patients arriving in the department were not always seen by a clinician in a timely way with untrained receptionists being used to assess patients and escalate any concerns about a patient's condition to the clinical staff. • Planned staffing levels did not always meet national recommendations and to safely meet patients' needs. There were not enough registrars and junior doctors in medicine to cover the medical wards out of hours, especially between 5pm to 9pm (Monday to Friday) and at weekends. The ED and maternity services did not always have sufficient staff to enable the effective delivery of care and treatment. Staffing levels on Skylark ward and in the neonatal intensive care unit levels did not always meet patients' needs. • Staff did not always receive mandatory training in safety systems, processes and practices in line with the trust's training programme. • The design, maintenance and use of facilities and premises did not always meet patients' needs. Not all risks had been identified by the service and actioned. Facilities were not always safe for patients in the ED and the children's ward (Skylark ward). • There were not always reliable systems in place to protect patients and staff from the risks of radiation exposure. Radiographers had poor awareness of radiation dose levels for plain film x-rays.	Inadequate 

Summary of findings

- Care plans in medical care did not always reflect the needs of patients and deteriorating patients were not always managed effectively. Nurses had not always followed the escalation process for high-risk patients by informing a doctor when a patient's NEWS score was raised or when the patient's oxygen saturation showed a downward trend.
- Patients' individual care records were not always managed in a way that kept patients safe. This meant that confidential information was not always kept in accordance with the Data Protection Act 1998.
- The storage and handling of medicines did not always ensure patients' were protected from the risk of harm. Contrast media was not stored securely and could be accessed by unauthorised staff and patients.
- Infection control precautions were not always effective in surgery.
- The environment in the children and young people's service was not safe and secure, particularly for patients who may be at risk of self-harm or suicide.
- Safeguarding children and adult policies and procedures were not effective in ED and the children and young people's service and not all staff in the trust had completed the required level of children's safeguarding training. Not all staff that directly saw and assessed children in some of the main outpatients clinics had had the required level of safeguarding children's' training.
- The trust did not have a baby abduction policy, which would include what measures should be taken to ensure the security and prevention of a baby's abduction whilst on trust premises as defined under the Child Abduction Act 1984.

However:

- Staff were generally aware of their responsibility to be open and honest when things went wrong duty and of the duty of candour regulation.
- Nursing handovers were generally well structured and comprehensive.
- Medicines in ED, critical care, maternity and gynaecology, children and young people, end of life care services were generally stored securely and in line with trust policy and statutory requirements for controlled drugs.
- Staffing in critical care and end of life care was in line with national guidelines, although bank nurses and agency staff were sometimes used to achieve this.

Summary of findings

- Medical staffing in surgery, outpatients and end of life care was appropriate in almost all areas. Consultants worked throughout the week within the surgical services with support by specialist registrars during the weekend.
- There were clear processes and procedures in place regarding the completion of the World Health Organization (WHO) Five Steps to Safer Surgery checklist in surgery and maternity and gynaecology.
- Training levels in surgery, critical care and end of life care services met the recommended target set by the trust. Staff in these services understood their responsibilities regarding safeguarding procedures to protect the safety of vulnerable adults and children.
- There were systems in place in critical care and end of life care to protect patients from harm and a good incident reporting culture. Learning from incident investigations was disseminated to staff in a timely fashion and they were able to tell us about improvements in practice that had occurred as a result.
- The environment and equipment in critical care was clean and supported safe care. It was fit for purpose critical care. The paediatric department had adequate equipment to meet the needs of children and young people, which was maintained and portable appliances had been subject to relevant safety tests. Clinical waste was appropriately stored and disposed of. We saw that all areas of the maternity and gynaecology and children and young people's service we visited were visibly clean and generally well maintained. The mortuary was well maintained. Staff compliance with infection control precautions was appropriate in outpatients.
- In critical care, maternity and gynaecology, and end of life care services, patient records were comprehensive, with all appropriate risk assessments completed.
- The trust used a radiology information system (RIS) and picture archiving and communication system (PACS). This meant patients radiological images and records were stored securely and access was password protected.

Duty of Candour

- From November 2014, NHS providers were required to comply with the Duty of Candour Regulation 20 of the Care Quality Commission (Registration) Regulations 2014. The duty of candour is a regulatory duty that relates to openness and

transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person.

- The trust had a duty of candour policy in place, which had been reviewed in May 2016.
- The trust had undertaken a benchmarking exercise against the key lines of enquiry in a national survey covering the fundamental requirements of duty of candour. From this an action plan was produced which was in the process of being implemented. This included an action to provide a serious incident assurance report at each board meeting to include assurance on the serious incident process and compliance with the duty of candour regulation. This had not commenced at the time of the inspection
- Staff were mostly aware of their responsibility to be open and honest when things went wrong duty and of the duty of candour regulation.
- We reviewed four serious incidents of which for three the duty of candour applied. In each of these, the duty of candour had been considered and the regulation followed although in one it was not clear from the documentation if the patient had reived a copy of the report.
- The records showed the duty of candour had been utilised regarding the two never events in surgery and staff showed awareness and understood their responsibilities of when it would be used.
- There was not always effective application of classification criteria of incidents in the children and young people's service and in outpatients and diagnostic imaging. This meant that as the level of harm had not been correctly established, duty of candour had not always been applied.
- Staff generally in the outpatients and diagnostic service understood their responsibilities and provided examples of when the duty of candour process would be used. We saw guidance within the service, which staff could refer to. For example, we saw in radiology department that where things went wrong, patients would be informed and apologies given to patients. We checked the recent incidents reported and saw that staff had followed the hospital policy and staff we spoke with could clearly articulate when to trigger the duty of candour to patients and their relatives. However, the inconsistency in the management of delayed images and harm reviews meant that we were not fully assured the principles of duty of candour were being consistently applied.

- In September and October 2016, the diagnostic service started undertaking a review of potential harm caused to patients due to a delay in image reporting. In October, the review had identified 56 patients where a pathology was found upon the reporting of images after a significant time period. The data we received gave us limited assurance of the effectiveness of the harm audit process and 29 of the identified patients had not been rated for harm.

Safeguarding

- The director of nursing and quality was the trust lead for safeguarding adults and children. This was further supported by named nurse leads for adults and children and a children's safeguarding paediatrician. The safeguarding leads were not supported by other dedicated staff in their function and reported significant operational pressures to ensure safeguarding concerns were responded to appropriately. Safeguarding leads reported working excessively long hours to maintain effective management of their operational responsibilities.
- Staff did not always follow safeguarding processes and safeguarding training levels did not meet the trust's target or national recommendations in ED. There were not robust systems and processes in place to ensure that patients were safe from abuse. We were not assured that all staff were aware of the processes or had had the required training. The department had a process for identifying and managing patients at risk of abuse; however, we were not assured that all staff were following it.
- During our inspection, we looked at 33 sets of patient records in ED and found that in eight instances the safeguarding process was not always completed in line with the trust policy or national guidelines. This included six instances including children and three of those with potentially suspicious injuries – we highlighted two of the instances to the safeguarding lead for the department. The other instance was highlighted to the senior management team as the patient had been highlighted on the system as having an 'alert' which meant that there should have been a referral made to social services or clearly documented in the patient's notes why this had not been done; however, this information had not been recorded . A referral was made immediately and an internal investigation showed that the clinician treating the patient had considered the information; however, this had not been recorded in line with the trust's policy. We were told that any missed children's

safeguarding referrals were picked up the following day by the registered nurse in children's ED; however, this meant that a vulnerable patient could be discharged to a potentially abusive environment before a referral was made.

- The intercollegiate document 'Safeguarding children – Roles and competencies for healthcare staff' (RCPCH, 2014) provides guidance on levels of safeguarding training for different groups. The document states that 'All clinical staff working with children, young people and/or their parents/carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/child protection concerns' should be trained in safeguarding for children levels one, two and three'.
- We asked the trust for information regarding safeguarding training for nursing and medical staff prior to our inspection and we were not provided with it. During our inspection, we were told that nursing staff compliance with safeguarding level three was 18% and that medical staff compliance was 29% against a hospital target of 85%.
- We highlighted our urgent concerns to the trust regarding the level of safeguarding training and the lack of compliance with the hospital's protocols regarding safeguarding. The trust immediately put in an action plan to address the training needs and we were supplied with updated data on 31 October 2016 that showed that 37% of nursing staff had completed safeguarding level three and there were planned training days throughout November 2016. We also saw that the trust had arranged for bespoke training sessions for staff in ED, which were to be delivered by the clinical lead for safeguarding. The trust told us that they would be conducting regular monthly audits and all safeguarding referrals would continue to be checked on a daily basis by a designated staff member of ED.
- At the time of our inspection, 87% of nursing staff and only 66% of medical staff had completed adult safeguarding (level two) training.
- Arrangements were in place in medical care to safeguard adults and children from abuse that reflected relevant legislation and local requirements. Overall, the service was just below the trust target of 85% for statutory and mandatory training at 83%. From information provided by the trust for June 2016, 94% of staff in the service had had safeguarding adults training level 2 and 93% had had safeguarding children's training level 2, which was better that the trust target of 85
- The training records showed that staff within the surgical team had achieved the hospital target of 85% for both children and

adult safeguarding training with the exception of medical staff who only achieved 64% for their adult safeguarding level 2. For example, the registered nurses had achieved 100% for their level 3 children's safeguarding training and 93% for adult safeguarding level 2 training. Heath care assistants had achieved 90% for level 2 children's safeguarding and 93% for their adult's level 2 training.

- All staff within the ICU were required to complete up to and including level two safeguarding adult and children training. 89% of medical staff and 94% of nursing staff had completed this training which was in line with the hospital target of 85%. However, staff had not had level three safeguarding children's training. Whilst the trust strategy was for all staff to receive level 2 training, this was not in line with the Royal College of Paediatrics and Child Health (RCPCH) intercollegiate document 2014.
- Compliance in maternity and gynaecology with trust statutory safeguarding training, safeguarding level three training, skills and drills training and mandatory training in September 2016 did not meet the trust's target compliance. We saw 100% of midwives in maternity had up to date safeguarding children level two training and 94% had received safeguarding children level three training. Compliance with safeguarding children level two training was at 96% for nurses on Maple ward. However, for safeguarding level three training, compliance was 50%, as out of the two nurses allocated to cover the termination service (who were deemed as requiring level three training), only one was trained.
- Not all medical staff had received training. 76% of medical staff had up to date training in adult safeguarding level 2, 89% had up to date safeguarding children level two training and 82% had received safeguarding children level three training which was below the trust's target of 85%. However, staff we spoke with demonstrated an understanding of the trust's safeguarding procedures and its reporting process. We were showed evidence the service would be at 92% compliance by December 2016 as staff were booked to complete their training in December.
- Whilst the hospital did not have a separate baby abduction policy, baby abduction was discussed within the hospital's internal crisis plan. However, this plan did not include the measures that should be taken to ensure security and to prevent a baby's abduction whilst on hospital premises, as defined under the Child Abduction Act 1984. There was a flowchart on what action to take in the managing major incidents policy. While not all staff were able to direct us to the

abduction flow chart on the intranet, all staff we spoke with were able to tell us how they would respond to an abduction or attempted abduction. They described a lockdown procedure with main doors to the maternity block being closed following the alarm and a member of staff on guard.

- Level 3 safeguarding children training had been completed by 93% of nursing staff, but compliance rates were much lower for medical staff as well as health care assistants and 'other' staff who required level 3 at 78%, 40% and 56% respectively. The hospital's mandatory training target for adult safeguarding level 2 had been met for staff who worked on NICU and the paediatric ward, both achieving over 90%. Paediatric medical staff however had very low attendance at 28%, although they had achieved the level 1 adult safeguarding target of 85%.
- The chaplaincy team, the SPCT and the mortuary/ bereavement team were 100% compliant with child safeguarding level two training and adult safeguarding level one training. Porters, who transferred deceased patients between the wards and the mortuary, undertook safeguarding training as part of staff induction and ongoing mandatory training requirements at the trust.
- Across the main outpatients department, nurses and healthcare assistants who were involved in the assessment and treatment of children did not all have the appropriate level of safeguarding children training. Medical staff and senior nurses were trained to Level three but all other nursing staff were trained to Level two only. This was not in line with the intercollegiate document on safeguarding children and young people (March 2014) which recommends that all nursing and medical staff who have direct contact with children and young people should attain level three safeguarding training. Therefore, we could not be sure that all staff had the sufficient knowledge and skills to safeguard children.
- Safeguarding training was not as well attended by the medical staff in the imaging department. 79% and 86% of radiologists had completed adult level two and child level two training respectively.
- Clinical leads were aware of the guidance for safeguarding level three training for children and told us that safeguarding level three was required for all nursing staff dealing with children. However, we found that not all staff directly dealing with children and young people had level three training in place. For example, adults and children were seen in the maxillofacial clinic and we were told by staff that three staff members had safeguarding level 3 training. Each outpatient setting had a

senior nursing staff who had level three safeguarding competency. The overall compliance rate for Corby outpatients, Nene Park outpatients' clinic, Isebrook, the fracture clinic and ophthalmology was 88%.

- Ophthalmology clinics were conducted for adults and children with full paediatric clinics running on Tuesdays and Wednesdays. We were told that nursing staff had had safeguarding level two training. No nursing staff had attained safeguarding level three training. We raised our concerns to the trust regarding the level of safeguarding training in specific groups, for example, phlebotomy staff. We were told by the hospital that 81% of the hospital phlebotomy staff had undertaken safeguarding level two training. However, we found that 19% of phlebotomists only had level one safeguarding training but had been booked to receive level two training. The trust took actions to address this when we raised it as a concern.

Incidents

- A detailed incident reporting policy was in place, approved in January 2016. It included the process and procedures to follow and referenced the duty of candour and the serious incident policy.
- There had been two strategic executive information systems (STEIS) reportable 'never events' from August 2015 and July 2016 relating to surgery. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. One never event occurred when a swab was inadvertently left inside a patient. The hospital had revised its "swab policy" as a result of learning from this incident . A further checking procedure was in place to ensure the incident did not re-occur. Staff were aware of these new systems. The other never event related to a patient receiving a left knee implant on their right knee. The review identified no adverse effect or harm for the patient. The hospital had instigated actions to prevent a re-occurrence. The service had implemented another "stop and check" process in addition to the one performed as part of the World Health Organisation (WHO) checklist. During our visit to theatre, we observed this procedure in place.
- There were 4,932 incidents reported to NRLS between September 2015 and August 2016, these included eight deaths, 31 with severe harm, 88 moderate harm, 719 low harm and

4,086 no harm. The trust had a lower incident reporting rate per 100 admissions at 6.8 compared to the England average of 8.7. This could be an indicator that not all incidents were being reported.

- A policy for the reporting and management of serious incidents was in place approved in 2015. A weekly serious incident review group met chaired by the director of nursing and quality or the medical director. It was attended by the clinical lead reporting possible serious incidents in their area. We observed one of these meetings and noted it to be an effective process. Additional or emergency meetings of the serious incident review group were held if the incident could not wait for the next one.
- The ED formed a part of the urgent care division and we saw that through a variety of departmental and divisional meetings, daily briefings and departmental newsletters, information regarding incidents was distributed at all levels in the ED. For example, we observed senior nursing staff discuss incidents at a daily shift handover for all staff and the senior ED managers attended trust wide governance meetings where incidents were discussed, which was then disseminated at local departmental meetings. However, we were not assured that learning from incidents was embedded. Staff that we spoke with did not describe any improvements or specific learning from incidents. For example, the May 2016 staff newsletter had a 'learning from incidents' section which described an incident where a child's observations had not been scored appropriately using the paediatric early warning system (PEWS – this is a chart used to identify and escalate deterioration in a child's condition) and the child later deteriorated on the ward and made a full recovery. One of the learning actions was that children should not be waiting in the main waiting room with adults and that PEWS scores must be documented. During our inspection, we saw children waiting in the main waiting area and two out of the 12 children's records we reviewed had no PEWS score documented. Staff that we spoke with were not aware of the incident or associated learning. Staff told us that they had received training on using PEWS.
- In accordance with the NHS England Serious Incident Framework 2015, the medical care service reported 18 serious incidents (SIs) which met the reporting criteria between August 2015 and July 2016. The most common category was suboptimal care of the deteriorating patient, for which there were 10 incidents, comprising 56% of the total serious incidents reported. Eight others were due to other causes. Action plans were in place to embed learning from these incidents.

Summary of findings

- We saw the list of incidents in surgery from August 2015 to July 2016. During this period, there had been 1,061 incidents of which 16 were classed as major, 180 as minor and 37 as moderate. There were no identified themes in relation to the incidents. Incidents were analysed at quality governance meetings to ensure that lessons were learned. Serious incidents were investigated by staff with the appropriate level of seniority, such as clinical leads. All lessons learnt were cascaded to the team during ward and theatre handovers and staff meetings. Staff confirmed this during our inspection.
- There were 216 incidents reported in critical care from August 2015 to July 2016. The majority of the incidents were categorised as low or no harm (97&). The most common themes related to delays in discharge from ICU to other wards due to lack of beds within the trust and out of hours transfers. Actions were being implemented to improve patient flow, including improved communication between ICU staff and the bed management team. There were 43 incidents relating to tissue viability (including pressure ulcers), appropriate actions were taken when these were identified, with involvement from the tissue viability team where necessary.
- The maternity service reported three serious incidents (SIs) to the strategic executive information system (STEIS) between August 2015 and July 2016. These incidents met the reporting criteria set by NHS England. One incident was identified as affecting a baby only. One incident was identified as affecting a mother only and there was one medication incident in accordance with the serious incident framework 2015. We reviewed three root cause analysis investigation reports and saw evidence of learning from these event and actions taken to mitigate future risk. Learning was shared with staff in a variety of methods including team huddles, which were held at the start of each shift and staff noticeboards.
- We saw that 848 maternity (midwifery and obstetrics) incidents and 125 gynaecology incidents were reported between August 2015 and July 2016. For maternity, five incidents were classified as causing major harm, four moderate harm, ten minor harm and 739 no harm. For gynaecology, three incidents were classified as causing major harm, six moderate harm, seven minor harm and 109 no harm. We did not see any specific themes. We observed that all incidents were reviewed daily and where necessary investigations, including root cause analyses, were carried out. Senior staff held regular meetings to identify where trends had occurred and put in place systems to prevent similar occurrences. They also monitored whether the required actions had been addressed.

- The trust had also set a target of seven days for all reported incidents to be reviewed by a manager. In the children and young people's service, the nursing quality indicators for June 2016 demonstrated that the trust was 100% compliant with this target. From our analysis, we saw that 10% of incidents had taken between two and 14 days to be reported and there was no justification for a delay for most of these. For example, one member of staff had turned up and worked a shift with diarrhoea and vomiting, another related to a morbidity case which had already been discussed at the mortality and morbidity group. Both of these examples had taken 14 days to report. These included one patient death, which had taken four days to be reported. From the data provided, it was not possible to determine whether the management team had reviewed all incidents within 72 hours, however, we noted that 5% were still pending management review and had exceeded this timescale by at least two weeks.
- We also saw that of 41 incidents had been classified as minor following the management review, of these only 21% had been subject to a local investigation within the required 10 day timescale specified in the trust policy. For the remainder, 10% had not been subject to a local investigation and were overdue, 36% had taken between 11 and 30 days, 16% between 31and 60 days and 17% between 61 and 151 days.
- We requested the investigation reports for the three serious incidents, which had occurred since December 2015 along with accompanying action plans, meeting minutes where reports were presented, as well as evidence of lessons learned. We were provided with the investigation reports. Two reports were detailed and showed recommendations and evidence of an action plan to ensure learning was applied from the incidents. One report was not dated and was incomplete, there was no action plan. This report lacked detail and failed to identify some of the issues which were apparent, such as not having 1:1 care from an appropriately qualified professional. Although some learning was identified, we saw that further incidents of a similar nature had occurred; therefore demonstrating that learning had not taken place. We raised this with the trust at the time of inspection and action was promptly taken to develop and introduce a new risk assessment form with the support from the Child and Adolescent Mental Health Service (CAMHS) as well as to ensure registered mental health nurses (employed by another provider) are requested to provide 1:1 care as required.
- Concerns from serious incidents were not translated onto the departmental risk register.

- In accordance with the Serious Incident Framework 2015, the outpatients and diagnostic imaging service reported one serious incident (SI) in outpatients, which met the reporting criteria set by NHS England from August 2015 to July 2016. The incident related to delays in treatment meeting the SI criteria. Lessons were learned from this incident.
- Patients who had been on the waiting list for outpatient services for over 40 weeks were reviewed by consultants and prioritised as appropriate. The hospital were conducting clinical harm reviews of these patients. At the time of inspection, 978 patients had been reviewed with 397 outstanding. Of those reviewed, 533 had suffered no harm, 47 had suffered low harm and one patient had suffered moderate harm. This patient was sent for treatment at another local NHS hospital and a serious incident review took place. Whilst the service had a harm review process in place, not all patients waiting over 40 weeks had been reviewed at the time of the inspection.

Cleanliness, infection control and hygiene

- The medical are wards we visited were visibly clean. Standards of cleanliness and hygiene were generally well maintained. Reliable systems were in place to prevent and protect people from a healthcare associated infection.
- Staff generally wore appropriate personal protective equipment (PPE) and followed 'arms bare below the elbows' guidance in clinical areas.
- There were weekly and monthly infection prevention and control (IPC) audits conducted for all areas in ED. These included environmental audits, hand hygiene compliance, cannula management and insertions of vascular devices such as central lines to minimise the risk of health care associated infections (HCAIs). We saw that from January 2016 to August 2016, the compliance to hand hygiene protocols in ED was an average of 98%, which was above the trust target of 95%. All months showed 100% compliance, except for April 2016 which was 80%.
- Infection control precautions were not always effective in surgery. We observed staff on Geddington and Deene B wards not decontaminating their hands after being in direct contact of care with patients. Clinical waste bins were conveyed through the maxillofacial service. These frequently leaked which meant there was a risk of infection control putting both staff and patients at risk. The breast pre-assessment clinic had fabric chairs and privacy curtains. The chairs and curtains had no date when last changed or cleaned which meant there could be a

risk of cross infection due to inappropriate cleaning. Nursing staff did not adhere to the handling of food safely guidance. Theatre staff did not adhere to the trust and national standards by wearing of cover gowns and footwear when leaving and entering the theatre area.

- At the time of our inspection, high standards of cleanliness were maintained in critical care across the department, with reliable systems in place to prevent healthcare-associated infections. The environment and equipment in the unit were visibly clean and all areas were tidy and well organised.
- We saw that all areas of the maternity and gynaecology service we visited were visibly clean and mostly well maintained.
- Standards of cleanliness and hygiene were maintained on the paediatric ward and Neonatal Intensive Care Unit (NICU). We observed the paediatric ward, outpatients' department and NICU to be visibly clean during our inspection. There were cleaning schedules, which outlined the frequency each area required cleaning. Nursing and support staff we spoke with told us that the cleaners did an excellent job and that they had no concerns. All staff were required to compete infection control training. We were provided with data for staff who had completed level one infection control training for the clinical business unit, 'Women and Children's', 88% of staff within this unit had completed infection control training against a trust target of 85%.
- The mortuary and viewing areas were visibly clean and well ventilated. We observed designated staff undertaking cleaning duties. Completed cleaning schedules were available for each area. The mortuary adhered to the trusts standard precautions policy. Cleaning audits for January, April and July 2016 reported 97% compliance, which demonstrated standards of cleanliness and hygiene were maintained to a high standard in the mortuary and viewing areas.
- Standards of cleanliness and hygiene were generally maintained within the outpatients department. For example, we saw cleaning schedules in various departments and observed cleaning of equipment on ophthalmology ward.
- There were no cases of MRSA reported between August 2015 and July 2016. Trusts have a target of preventing all MRSA infections, so the trust met this target within this period. Additionally, the trust reported seven MSSA infections and 21 Clostridium difficile infections over the same period. The trust target for the current financial year was to have less than 24 cases of Clostridium difficile; there had been seven cases from April to August 2016. Other than a small peak in May 2016, this was less than the national average.

Summary of findings

Assessing and responding to risk

- Patients who self-presented to ED were booked in at the reception desk by a member of administrative staff. Patients then moved along the reception desk to a 'streaming' and 'triage' position (streaming is the process of allocating patients to specific groups and/or physical areas of a department). Patients could be streamed to majors, children's ED, minors or GP (GP streaming was between the hours of 10am and 10pm).
- At the streaming position, a dedicated healthcare professional who was either a registered nurse (band 5 and above), advanced clinical practitioner (ACP – an ACP was an independent prescriber who could assess a patient and refer directly to other specialities, order scans and tests, provide front-line treatments such as intravenous antibiotics and analgesia) or pharmacist took details of patients symptoms. An initial rapid triage system (Manchester Triage System) was used to determine the priority of the patient waiting to be seen and identify any conditions that were potentially life/ limb threatening. For example, patients with 'red flag' symptoms as defined by the Royal College of Emergency Medicine (RCEM, 'Triage position statement', 2011) such as crushing chest pains, severe bleeding or severe breathing problems were prioritised to be seen by a clinician. We were not assured that all staff that conducted the streaming were competent and equipped to identify a seriously ill or deteriorating patient; this was also highlighted on the departmental risk register. The hospital had a streaming competency framework book, however, no staff had completed this and the streaming policy document was undated with no author.
- The streaming time was recorded in patient's notes as an 'initial clinical assessment' that was normally recorded on the system within one to two minutes from arrival (booking in). This was not in line with RCEM or NHS England guidelines that state an initial clinical assessment should include a pain assessment, observation and recording of vital signs, brief patient history and immediate care plan. This also meant that patients were recorded as having had this done when this had not yet occurred. The hospital had not identified this as a risk prior to our inspection or recognised that the time recorded as an initial clinical assessment was incorrect.
- After streaming, all patients were then directed to the main waiting area and waited to be called for an actual 'initial clinical assessment' and this included patients with 'red flag' symptoms. The waiting area could not be clearly observed by staff in reception as there was a wall separating the areas. We

asked staff about this and we were told that there was a closed circuit television (CCTV) camera in the waiting area, there were no signs on display telling people that there was a camera, this was not in line with government guidelines (CCTV code of practice, Information Commissioners Office, 2015).

- The ED had information on display that informed patients that they would be seen in order of priority and defined the prioritisation categories, which were one to five and based on Department of Health guidelines. Category one was for immediate life-threatening conditions where patients needed immediate intervention to save their life, category two was for serious conditions but not immediately life-threatening: the information displayed stated that these patients would be seen for an initial clinical assessment within 15 minutes. During our announced and unannounced inspection, we observed four adult patients present with 'red flag' symptoms and waited longer than 15 minutes for an initial clinical assessment. Clear systems were not in place to support this standard, which meant that we were not assured that the sickest patients were being seen first. We raised this as an immediate concern with the trust who took urgent actions to address this, which included a new operational policy that clearly defined which patients should be seen within 15 minutes. The trust immediately put in a process to audit the impact of the changes and provided evidence that an ED consultant had completed an audit at the end of October, which showed an immediate positive impact. The trust planned to continue monitoring and auditing the process until it was fully embedded and present the results to the hospital's quality governance group.
- The intercollegiate document 'Standards for Children and Young People in Emergency Care Settings, RCPCH, 2012' recommends that all children should have an initial clinical assessment (as described above to include pain score) within 15 minutes. The standards states that 'all children attending emergency care settings are visually assessed by a registered practitioner immediately upon arrival, to identify an unresponsive or critically ill/injured child'. Children who presented to the ED were recorded as having their initial clinical assessment at the streaming/triage position; this was not in line with the guidance. We observed two children waiting in excess of 15 minutes to attend the children's ED to have their observations taken.
- During our inspection, we observed some nursing staff using their skills and experience to determine if patients were safe to wait after being streamed. For example, a patient presented with symptoms that were indicative of a stroke and we saw the

nurse at streaming conduct a simple FAST test (this test was used to determine if patients may have suffered a stroke and include observations of the patients Face, Arms, Speech and Time from onset of symptoms). Staff told us this was not a standardised protocol and we were not assured that all staff at the streaming point would have followed the same process.

- There was no effective process in place to ensure that patients waiting for up to three hours after streaming were safe to wait and that all patients with 'red flag' symptoms or category two patients were seen by an appropriate clinician for an initial clinical assessment within 15 minutes. After our inspection, we asked the trust for evidence that showed the initial time to clinical assessment and time to treatment for all patients that walked into the ED. The trust did not provide us with this data and told us that there was no national requirement to report this information for minors' areas. The trust told us that the process in place during our inspection was designed to ensure that majors' patients who self-presented were seen by an appropriate clinician within 15 minutes.
- The nurse in charge conducted two hourly rounding in all areas. This is a safety process whereby the nurse in charge would visit all areas in the department and assess the acuity levels of patients and the capacity in each area. The service provided us with an example of the record sheet for the day of our unannounced visit and we found that the record sheet had not been fully completed in accordance with the hospital policy. For example, the nurse and doctor in charge had not always signed the two hourly entries. Some of the entries gave a detailed description of current waiting times in all areas; however, this was not consistent.
- From April 2016 to September 2016, there were 15,604 ambulance handovers of over 15 minutes. This included 2,202 handovers of over 30 mins and 323 'black breaches'. A 'black breach' occurs when a patient waits over an hour from ambulance arrival at the emergency department until they are handed over to the emergency department staff. The trust had reported 'Nil' black breaches in the 12 months August 2015 to July 2016 as it had not understood the definition of a 'black breach'. Senior managers told us they thought a 'black breach' was defined as a patients waiting over 12 hours on a trolley in the ED. Between August 2015 and July 2016, there was a consistent picture of around 45% of ambulance journeys with turnaround times over 30 minutes.
- The ED used Sepsis Six (UK Sepsis Trust, 2013, this is six steps to managing patients suspected of having severe sepsis, neutropenic sepsis or sepsis shock). We saw that the

department was taking part in a CQUIN (Commissioning and Quality Innovation frameworks) audit related to sepsis. Senior staff told us that as of October 2016, 90% of all nursing and medical staff had received training in the recognition and management of sepsis. We looked at five sets of records where patients had been identified as potentially having sepsis, and we found that in each case an accurate record of their care and treatment had not been recorded including administration of antibiotics. We asked senior staff about this and we were told that as we were looking at past records (the previous days) the sepsis proforma was only a photocopy of the top sheet and did not include all the data which would have gone to the ward with the patient. We tracked two patients who attended during our inspection with suspected sepsis from their arrival in ED, one patient received most tests and antibiotics within the specified timeframe; however, hourly observations were not recorded in line with guidance or the escalation process. This patient was immediately brought to the attention of nursing staff who made sure the checks were completed. The second patient had been referred by a GP as potentially having sepsis: we saw that the sepsis six pathway had not been started and observations were not conducted in line with guidance. We immediately highlighted our concerns to staff as the patient was about to be discharged with antibiotics. The nurse in charge ensured that the patient's observations were taken and recorded and within normal limits.

- We were not assured that adults or children presenting to ED with mental health conditions, who were at risk to themselves or others were being cared for in a safe or appropriate environment. The ED had no designated room for patients presenting with mental health conditions in line with Royal College of Emergency Medicine (RCEM) guidelines. The mental health risk assessment tool in use at the time of our inspection did not take into account all environmental and physical risks. During our inspection, we saw the notes from one patient who had an acute mental health episode; however, there was no mental health risk assessment in the patient's records and no description of the patient. From August 2015 to July 2016, there were two reported incidents of patients presenting with mental health illness and at risk of deliberate self-harm who had absconded from the department without staff knowing; on both occasions, other patients in the department had informed staff.
- Care plans in medical care did not always reflect the needs of patients and deteriorating patients were not always managed effectively. Patients were exposed to the risk of receiving

inappropriate care and treatment due to poorly written and incomplete care plans. For some patients, there were no individualised care plans; in some cases, the same written care needs were simply copied to a new sheet and changing needs had not been reflected or incorporated.

- The National Early Warning Score (NEWS) chart was used to assess patients whose condition was deteriorating. We noted the NEWS chart was used for every patient in the medical wards. We randomly checked 15 NEWS charts in various medical wards and found in four of these charts, the date and time were not legible. We found that nurses had not always escalated cases and informed the medical team appropriately. For example, in HC Pretty B (female) ward, we saw a NEWS chart for a high risk patient which showed a downward trend regarding oxygen saturation; the last recorded reading at 5.45am on 13/10/2016 showed 88% oxygen saturation. The nursing staff had not escalated their findings to a doctor at the time. Further, the patient's vital signs had not been recorded preceding the consultant ward round at around 10am. A doctor confirmed the results documented in the NEWS chart had been noted during the consultant ward round and that the consultant had examined the patient and was satisfied that the patient was not unduly affected. We highlighted this to the ward sister who said that there was a ward emergency at the time and added that the matter would be reported using the hospital's incident recording system for investigation. In Naseby A, we found that a patient's condition had deteriorated overnight, but there was no nursing documentation to reflect this and whether action had been taken to inform the doctors. The NEWS chart stated a score of 4 on 12 October 2016. One nurse told us the nurses at the time had made a decision not to escalate the case to the doctors because the doctors were already aware of the patient's condition: however, the records did not evidence this.
- The surgical service assessed and responded to patient risk by undertaking comprehensive risk assessments, and surgical safety checklists. However, the completion of the NEWS charts was inconsistent across the service as well as the review of patient on the maxillofacial waiting list. This meant there could be a delay in responding to a deteriorating patient or a patient not being informed of any consequences to having to wait for treatment. We saw the nurse sensitive indicators from April 2016 to July 2016. The records identified patients having NEWS

scores calculated and escalated as per the trigger algorithm. This included four hourly observations unless stated otherwise which included; heart rate, respiratory rate, temperature, blood pressure and oxygen saturations.

- We reviewed 17 patient charts. Of the 17 charts, seven had incomplete NEWS information. This concern was brought to the attention of the ward managers who confirmed they were currently reviewing the completion of NEWS records monthly due to the NEWS July 2016 audit highlighting the incompletion of these charts. They also confirmed the NEWS was discussed at ward meetings and additional training was being provided to staff as required. Staff spoken with confirmed they had received additional training in the completion of the NEWS charts. During our visit to Barnwell wards of the four records viewed, none had been fully completed. However, during our unannounced visit on 24 October, we reviewed a further four records and found no issues or concerns.
- The World Health Organisation (WHO) 'Five Steps to Safer Surgery' checklist was used. We attended a safer surgery briefing and observed the checklist being completed appropriately. The briefing sessions included for example, checking that all ordered equipment had been received, staffing arrangements and allocated responsibilities were understood. The WHO checklist was included in the pre-list huddle and post-list debrief which theatre staff attended. Operating theatre records included the "Five Steps to Safety Surgery" checklist, which had been appropriately completed. The 'Five Steps to Safer Surgery' checklist was audited, the results of which showed 100% compliance.
- The re-development business case for maxillofacial identified 594 patients on the oral surgery waiting list, including 35 waiting over 46 weeks. We asked senior staff how they managed the risk and potential harm to patients on the waiting list. They confirmed they were unaware of how the patient list was being reviewed but due to the length of time, confirmed patients may require other or additional treatment. This meant there was a risk of patients not being informed of any consequences to having to wait for treatment. The service were aware of the issue and taking steps to prioritise patients on the waiting list.
- The critical care service did not have dedicated pharmacy input at the time of our inspection. This had been recognised by the management team as a risk to the ward and recruitment was ongoing to try to improve pharmacy input. By the end of October 2016, the service would have a band 6 pharmacist, three times a week. However, this was still not compliant with guidelines for the provision of intensive care services (GPICS)

standards that state each critical care unit must have a dedicated pharmacist for a minimum of five days a week. On the Intensive Care Unit (ICU), patients were closely monitored so staff could respond to any deterioration. Patients were cared for by levels of nursing staff recommended in the core standards for critical care GPICS. Patients who were classified as needing intensive care (level three) were cared for by one nurse for each patient. Patients who needed high dependency type care (level two) were cared for by one nurse for two patients. We saw the appropriate staffing levels were maintained throughout the inspection period. The critical care outreach service was not fully established during our inspection. The outreach provision that was in place did monitor national early warning scores throughout patients within the hospital and responded where available to those patients who were deteriorating and requiring ICU input. Plans were in progress to increase this provision and provide a full service.

- The national early warning score (NEWS) was used to monitor acutely ill patients in ICU in accordance with NICE clinical guidance CG50. NEWS charts were used to identify if a patient was deteriorating. In accordance with the trust's deteriorating patient policy, staff used the NEWS charts to record routine physiological observations, such as blood pressure, temperature and heart rate, and monitors a patient's clinical condition. There were clear escalation processes in place to advise on what steps should be taken if there was an increase in NEWS scores. We checked NEWS documentation in all records we reviewed in the ICU. We found NEWS to be consistently completed and when they deteriorated this was appropriately escalated.
- For the maternity service, while there was evidence that risk information was being collated, this was being collated by a number of different people. For example, dashboard information was collated by the lead midwife, VTE data through the safety thermometer, still birth rate by the bereavement midwife and staffing via workforce papers. The information was not all available on one risk document, and as a result, we were not assured the service had oversight of all information to monitor the service.
- We were not assured the security system was adequate on the postnatal ward to minimise the risk of visitors accessing the ward without being challenged. This had not been identified as a risk on the risk register.
- Whilst the delivery suite had appropriate security arrangements in place, we were not assured the antenatal and post-natal

ward (Rowan ward) had sufficient security arrangements to prevent intruders from entering the ward and minimising the risk of visitors accessing the ward without being challenged. A video intercom entry system was used to identify visitors and staff requesting entry into the delivery suite and Rowan ward. We observed staff asking visitors who they were visiting before entering the wards.Access and from to the wards was gained via a set of double doors and once the doors had been released open through the buzzer entry system, the doors took 20 seconds to close which meant it was easy for someone to tailgate into the department some-time after the original requesting visitor had entered or left. This meant that there was a risk that someone could access the ward without being challenged.On the delivery suite, entry to the ward was managed by ward clerks who provided 24-hour cover. This reduced the risk of unauthorised access to the delivery suite. However, the ward clerk provision was not 24-hour on the postnatal/antenatal (Rowan) ward. There was a potential risk of visitors accessing the ward without being challenged. This had not been identified as a risk on the risk register. Staff said, and we saw members of staff who allowed visitors access to the unit, that they spoke to the visitor to check who they were visiting.

- NHS England's 'Saving babies lives' care bundle (2016) for reducing stillbirth recommends measuring and recording foetal growth, counselling women regarding foetal movements and smoking cessation, and monitoring babies at risk during labour. The maternity service used customised foetal growth charts to help identify babies who were not growing as expected. We saw evidence that symphysis-fundal height measurement was routinely performed from 24 weeks gestation, in line with national guidance.
- Maternity staff used the modified early obstetric warning score (MEOWS) to monitor women in labour and to detect the ill or deteriorating woman. MEOWS is a national assessment tool designed to recognise a deteriorating patient. Audits in June and July 2016 of nurse sensitive indicators showed that patients had had a full set of vital signs (heart rate, respiratory rate, temperature, blood pressure and oxygen saturations, fluid charts and pain) recorded four hourly unless stated otherwise. This had had been completed in 100% of patient records in this period. For maternity and gynaecological surgery, the service used the World Health Organization (WHO) 'Five Steps to Safer

Surgery', which is a surgical safety checklist. Completion of the checklist was audited, and, between April 2016 and June 2016, showed they had looked at a sample of over 1,000 patients. The overall compliance for the checklist was 100%.

- The paediatric department including NICU had adequate equipment to meet the needs of children and young people which was well-maintained. Portable appliances had been subject to relevant safety tests. However, some environmental aspects of the unit were unsafe and not monitored or managed; we raised this with the trust urgently who took immediate actions. There were ligature risks within the department, for example, shower rails. We were told that a ligature audit had been undertaken by staff when the paediatric ward was opened three years ago. We requested a copy of this audit but it was not provided. Patients with mental health problems including those who had self-harmed or made suicidal attempts were regularly admitted to the unit. Such patients were not always provided with one to one care and staff had not received training in mental health needs. Therefore, ligature points presented an increased risk for these patients. We raised this as an urgent concern with the trust, who provided us with assurance promptly to mitigate the risks. Action taken included introducing a new risk assessment to ensure the level of care required by patients was assessed on admission; this was developed in conjunction with the Child and Adolescent Mental Health Service (CAMHS). The service had also spoken with CAMHS regarding training and competency assessments which were being developed and we were told the lead matron would review all CAMHS assessments daily.
- The paediatric ward was on level two of the main hospital site. Outside the ward was a balcony, which overlooked the ground floor. There was a barrier above waist height to prevent accidental injury or death by falling. However, the barrier was not sufficiently effective to prevent someone who may intentionally plan to climb over the barrier. This also presented a risk to patients admitted to the ward with mental health concerns. During the inspection, we were told that a health and safety assessment had been undertaken when it was built and it had been agreed that the balcony was safe. Whilst this original risk assessment was not available, once we raised concerns about the potential risks the balcony presented, the trust carried out risk assessments urgently. We raised this as an urgent concern as on our unannounced inspection, as there had been an incident the previous weekend when a patient had attempted to climb over the balcony and was restrained by staff. The service and took immediate action to ensure the

doorway was manned by a security guard 24 hours a day, seven days a week until the area could be 'made safe'. We were given a copy of the revised risk register, which was updated following our inspection and included the balcony as an identified risk. The service took immediate actions to ensure the doorway was manned by a security guard 24 hours a day, seven days a week until the area could be 'made safe'. Longer term plans were drawn up to ensure this risk was addressed for all patients admitted to the ward.

- Risk to patient safety was not always appropriately managed. Arrangements for patients admitted with mental health needs were not suitable, acuity tools were not used and there were no criteria for which patients should be admitted to the high dependency unit (HDU) or a policy for their care and treatment. In the children and young people's service, risk assessments required completion for all patients on admission to the wards. We reviewed a sample of patient records and found these to be completed for their medical condition. There was a separate risk assessment for patients who had mental health needs and this was not always consistently completed and lacked detail. We raised our concerns with the service about the suitability of the risk assessment for patients with mental health needs. The hospital promptly revised their risk assessment with advice from a mental health nurse.
- Patients who were admitted to the ward with mental health concerns, for example, if the patient had self-harmed or attempted suicide, were not routinely provided with one to one care in accordance with hospital policy. During the announced part of the inspection, we identified that there was no formal risk assessment to determine whether one to one care was required, if the environment was suitable and whether adjustments were needed. It was expected this information was recorded in the patient's notes. However, we found from review of five sets of notes that such information had not been documented.
- When one to one care was required, it was provided by ward staff who had not received mental health training, or by the child's parent or carer. If the parent or carer provided one to one support, nursing staff provided care and treatment for any medical health needs.
- We raised our concerns with the trust at the time who took immediate action. A new risk assessment tool was devised. This was used to undertake an assessment of the child or teenagers risk of causing further harm to themselves, or others, as well as specialist one to one care requirements and environmental risks. The risk assessment was developed with the assistance of

a mental health nurse and included an assessment of their environment as well as requirement for specialist one to one care. At this time, the hospital also promptly deployed a security guard to sit outside the paediatric ward 24 hours a day, seven days a week. The hospital reported that further assessments and actions were being considered in relation to the safety of the environment as well as providing nursing staff with some basic mental health training.

- During our inspection in September 2014 'do not attempt cardio-pulmonary resuscitation', (DNACPR) forms were not completed appropriately. For example, some forms had not been signed by a consultant and it was not always clear whether discussions had taken place with the patient and their representative. We reviewed 17 DNACPR forms. All documentation had been signed and dated by the appropriate senior medical staff and there were clear documented reasons for the decisions recorded. Discussion with families was documented in the medical notes.
- During our inspection, we noted that IR(ME)R employers' procedures were in place and all documentation was available on a shared drive. The employer's procedures are required by the regulations to ensure that staff working in imaging departments provided safe care and gave the least amount of radiation to patients necessary for each examination. On review of these procedures, we saw that there was confusion over staff entitlements and whose responsibility it is to justify imaging examination to be undertaken. We saw that these procedures were largely out of date and reviewing of the procedures done on a bi-annual basis was not constructive, for example, there was a reference to films, the physical copy of images that were used a number of years ago.
- The imaging service did not always ensure that ionising radiation in plain film and fluoroscopy rooms had arrangements in place to control the area and restricted access. For example, we found controlled areas (a limited access area in which there was a small potential exposure to doses of ionising radiation) left unsecured with doors left open and unsupervised for approximately ten minutes. This meant that patients and visitors were able to access the rooms unsupervised with equipment left in a position were radiation might be emitted. When challenged, radiographers were unaware of the significance of this issue. This was not included on the risk register. Even though we did not think this was an

immediate health and safety risk, we felt that staff were not appropriately shutting doors and reducing access to rooms as appropriate. We raised this as a concern and found this had been addressed on our unannounced inspection.

- We found some equipment that was out of date in the storage room at Nene Park outpatients' clinic. There were six syringes that were out of date by one month and six surgical instruments, such as dermatology scrapers, that had expired. We raised this to nursing staff on site who removed the items from the store cupboard. Out of date equipment was noted in the previous CQC report published in November 2014. We found a scale in the diabetic unit, which was due for service testing in May 2013. We also found two blood pressure machines in the same department that were due for service testing in July 2016. During our unannounced visit, we found that the scale and two blood pressure machines had been serviced tested and the next service due date was in October 2017.
- In Nene Park outpatients' clinic, we found that the domestic storeroom had been left unlocked and a range of cleaning materials were not stored securely in line with the Control of Substances Hazardous to Health Regulations 2002 (COSHH). COSHH is the legislation that requires employers to control substances which are hazardous to health. The cleaning materials included chemicals that could be hazardous to health if not handled correctly. This meant that vulnerable patients and visitors could access these and this could lead to potential harm to patients. We raised this as a concern and the trust took action to ensure this room was locked when not in use.
- Radiation dose awareness in plain film by the radiographers was poor. We spoke with three members of staff and they were unable to describe a typical dose to a patient for a chest x-ray. Radiation doses in plain film were not manually inputted into the Radiology Information System (RIS) and were only recorded directly to the Picture Archiving and Communication System (PACS). At the time there was no way that this information was able to be collected or analysed. This meant that there was no evidence of optimisation of patient doses within the department in line with IR(ME)R. Doses of ionising radiation should be audited on a regular basis to ensure that patients are only exposed to radiation doses as low as reasonably possible. Dose audits were however being undertaken by the medical physics team through a small sample size of manually recorded doses, however due to the small sample sizes these would not

be representative of all the examinations carried out nor would the medical physics dose audits be carried out often enough for the hospital to monitor doses locally. At the unannounced inspection this was seen to be implemented.

- Comprehensive risk assessments were not always carried out for people who were waiting to use services in diagnostic imaging and outpatients. We found that some patients were waiting over 52 weeks for non-urgent appointments with no clear oversight yet in the service on the potential risks that could be posed to patients. For example, we found in ophthalmology outpatients that some patients were waiting for longer periods with the service not having a clear oversight on potential deterioration of patients' vision. During our unannounced visit, we spoke to staff who were unable to clearly articulate the process for managing deteriorating patients on the waiting list who had been referred to treatment. For example, the hospital relied on patients to contact their GP in case of any concerns. At the time of our inspection, there were approximately 300 children with problems with their tonsils, adenoids and grommets on ENT waiting list and the current waiting time was 52 weeks.
- Patients who had been on the waiting list for outpatient services for over 40 weeks were reviewed by consultants and prioritised as appropriate. The hospital was conducting clinical harm reviews of these patients. At the time of inspection, 978 patients had been reviewed with 397 outstanding. Of those reviewed, 533 had suffered no harm, 47 had suffered low harm and one patient had suffered moderate harm. This patient was sent for treatment at another local NHS hospital and a serious incident review took place. Whilst the service had a harm review process in place, not all patients waiting over 40 weeks had been reviewed at the time of the inspection.
- The diagnostic service had taken actions to address significant concerns about historical reporting of diagnostic images and scans, coupled with recent concerns about post "go-live" difficulties in transition to the new radiology information system (RIS) and picture archiving and communication system (PACS). The reporting backlog had been on the risk register since 2012. The imaging department had performed a risk assessment in 2012. Actions identified included reviewing of radiologist job planning, outsourcing to external reporting companies and increasing a hospital-wide agreement, where more images were reported outside of radiology, but referring clinicians. This was limited to ward and outpatient plain film x-rays where a formal radiology report would only be perform if specifically requested. There was a reporting backlog in

October 2015 with an estimated 22,000 delayed images. An action plan to reduce this backlog and reduce risk to patients from delayed diagnoses. Initiatives included a business case to increase sonographer establishments, which would free up radiologists to undertake more reporting sessions. There had also been an increase in the number of images outsourced to external reporting companies.

- Following an upgrade of the RIS and PACS, the hospital had experienced a large backlog of unreported images. In September 2016, the department reported a backlog of around 15,612 imaging examinations. This was closely monitored within the clinical business unit and the integrated governance committee. During the recent upgrade of the RIS and PACS, there was a period of approximately six weeks where there were some periods of disruption to the overnight tele-radiology service. The department had a work around and the service was maintained throughout, even though efficiency was reduced during this time. In September and October 2016, the service started undertaking a review of potential harm caused to patients due to a delay in image reporting. In October, the review had identified 56 patients where a pathology was found upon the reporting of images after a significant time period. The data we received gave us limited assurance of the effectiveness of the harm audit process and 29 of the identified patients had not been rated for harm.

Staffing

- The proportion of consultants reported to be working at the trust was lower than the England average; the proportion of junior doctors was the same as the England average.
- There were inadequate staffing levels to meet the needs of patients in ED, including children. Daily consultant cover did not meet national recommendations. Staffing levels, skill mix and caseloads were planned and reviewed by the lead nurse so that patients received safe care and treatment at all times, in line with relevant tools and guidance. The lead nurse acted in a supernumerary capacity to provide co-ordination and point of escalation for the nurse in charge of areas. Actual staffing levels did not meet the planned levels at the time of the inspection. Staffing levels were checked on a daily basis and escalated to on-site managers to try and cover the shortfalls through agency cover or re-deployment of staff; this was also discussed at daily safety meetings and bed management meetings.

Summary of findings

- During our focused inspection of the ED in February 2016, we highlighted that the staffing levels in children's ED were not adequate to meet the needs of the service. This inspection, we found that the situation had not improved despite the trust having taken a series of actions after the last inspection.
- At this inspection, the vacancy rate for nursing staff in ED was 31%, which equated to 31.41 whole time equivalent (WTE) vacancies. The funded establishment for ED nursing staff was 101.57 and at the time there were 68.1 WTE staff in post (this included healthcare assistants). A business case had been submitted in February 2016 to match the increase in demand over the last five years. The lead nurse for ED had developed the business case based on National Institute of Health and Care Excellence (NICE) draft guidelines (2015). The recommendation was to have one registered nurse (RN) for every four patients in majors and minors, dedicated triage nurses and two RNs for the resuscitation area.
- There was funding for six WTE RNs (children's branch) in the ED staffing establishment to provide a 24 hour children's ED. An RN (children's branch) is a registered nurse who has specific training and competencies to be able to assess and care for children. The staffing establishment for paediatric competent nurses in ED was not sufficient to ensure that there was at least one RN (children's branch) on duty 24 hours a day. This was not in line with RCPCH guidelines or Royal College of Nursing (RCN) guidelines 'Defining staffing levels standards for children and young people services, RCN, 2013' that recommends a minimum of two such nurses. The trust told us they mitigated this by having adult RNs cover the area when there was no RN (children's branch) on shift; however, adult RNs who covered this area did not always have paediatric competencies. The lead nurse had developed a paediatric competency framework in February 2016; however, staff that we spoke to told us that this was not monitored or signed off to show that staff were competent. On two occasions during our unannounced, we saw that the RN in children's ED did not have the necessary paediatric competencies in line with RCN guidelines.
- Daily consultant cover in ED did not meet national recommendations. Medical staffing cover for middle grade and junior doctors generally met the needs of patients.
- The proportion of consultants reported to be working at the trust was lower than the England average. The ED had one consultant on-site Monday to Friday 8am to 6pm (10 hours per day) and 8am to 2pm (six hours a day) Saturday and Sunday. Outside of these hours, a middle grade doctor who had access to an on-call consultant led the team. This did not meet the

RCEM (2010) recommendations to provide 16 hours of consultant presence for EDs seeing 80000+ patients annually. The lack of consultant cover was highlighted on the departmental risk register.

- In medical care, there were arrangements were in place to escalate concerns regarding staffing levels. Ward managers attended a safety huddle every morning where they went through every ward and asked if staffing numbers were sufficient. The service had a staffing escalation policy and process in place whereby any unfilled shifts were escalated to a matron or the clinical site supervisor at nights. Management staff flexed permanent staff from ward to ward to cover vacancies where possible. As at August 2016, in the service, there were 319.08 nursing whole time equivalents (WTE) and 227.46 other clinical WTE.
- During our unannounced inspection, we found that the Coronary Care Unit (CCU) and Oakley ward had staffing numbers that were below the recommended number stipulated by the British Cardiovascular Society. During the day, there were usually nine nurses covering the morning shift and the late shift. The nurses were supported by four HCAs. The trust information provided showed there were usually five nurses allocated to the 12 bed CCU and four nurses covering Oakley ward (16 beds). There was a nurse in charge of both wards. We found that during the night, Oakley ward had three nurses and two HCAs and in CCU, the number of nurses had been reduced to three with one of the nurses being the nurse in charge of both wards. This meant that one nurse was looking after four patients in CCU. Staff told us the night staff had to cover each other for breaks which lasted 30 minutes. This meant that CCU was left with two nurses for 1.5 hours when one nurse had their half hour break. Therefore, during break times, one nurse had to look after six patients in CCU and if the nurse was the nurse in charge, they had to cover six patients in CCU as well as Oakley ward, the step down ward for 16 patients. Patients in these wards and especially in CCU were potentially at risk due to an insufficient number of trained staff at certain times. Staff reported feeling under pressure due to the work intensity.
- As of August 2016, medical care reported that there were 146.63 WTE consultants and 258.17 WTE of medical staff across all other grades. The proportion of consultants/junior doctors reported to be working at the trust was about the same as the England average.
- There were not enough junior doctors to cover the medical wards, especially between 5pm to 9pm (Monday to Friday) and

at weekends. There were not enough junior doctors to cover the medical wards, especially between 5pm to 9pm (Monday to Friday) and at weekends. Staff told us the medical staffing consisted of only one registrar and one junior doctor covering 10 medical wards (some having separate A & B wards) and these doctors also covered medical patients using outlier wards such as the surgical and orthopaedic wards. However, there was a registrar and two junior doctors to cover the two acute medical wards. The CCU had its own medical cover, consisting of one registrar and one junior doctor.

- Clifford ward (medical short stay) and the MAU had a team of doctors (two registrars and three junior doctors) during the day and these doctors also saw medical patients in the emergency department on a rota system. The doctors were supported by the respective consultants covering the ward during the day. There was a consultant of the week to cover out of hours and weekends. However, the number of junior doctors was reduced to two out of hours for these areas. The registrar also had to cover the13 other medical wards after 9pm in rotation with other registrars out of hours.
- There was a second team of doctors covering the other 13 medical wards and medical outlying patients. In the geriatric medical wards, such as Naseby A (20 beds) and B (20 beds), the medical team for each of these A and B wards consisted of a registrar and two junior doctors during the day. There were two consultants for each of these wards during the day. The consultant of the week supported the doctors out of hours, at night and at weekends. However, there were only two junior doctors covering these 13 wards and medical outlying patients after 9pm.
- The registrars and junior doctors told us there was an insufficient number of junior doctors to cover out of hours, especially between 5pm and 9pm. The doctors at all levels confirmed there were only two junior doctors to cover 13 medical wards, including at least three medical outlier wards (the gynaecology ward and Barnwell B and C, the orthopaedic surgical wards).
- The hospital did not operate a multi-speciality hospital at night team and handover was focused on medical care wards. There was a senior nurse supporting the junior doctors at night. Their role was to hold the bleep for calls to the medical team and to triage calls and escalate to the doctors when required. Doctors reported this had reduced the number of calls at night from 60 to an average of 20 per night. Doctors said the service was looking at the introduction of a multi-specialty hospital at night team, but no defined timescales for this. The hospital had not

yet implemented the recommendations for improved, standardised handover protocols as detailed in the Royal College of Physicians "Acute care toolkit 1: handover" dated May 2011 but were planning to do so but doctors were not able to give any timescales for this.

- As at August 2016, the trust reported a vacancy rate of 14.7 % in surgery (13.6 WTE) and the Barnwell B and C ward (12.1 WTE). DASU reported the third highest vacancy rate (7.6 WTE). Consistently, the greatest vacancy rates were reported in urology (32.4%), general surgery (20.6%) and DASU (18.31%). However, urology and general surgery reported relatively small staffing bodies.
- Medical staffing in surgery was appropriate in almost all areas. Consultants worked throughout the week within the surgical services with support by specialist registrars during the weekend. A team of consultant surgeons and anaesthetists carried out surgical procedures. At the time of our inspection, the service, which included theatres and the pre-assessment team, had 119 qualified medical staff and 21unqualified medical staff. An additional 47 medical staff either had been offered a position and were waiting to commence their role or were new starters. The records as of July 2016 showed a vacancy rate of 39% for medical staff across theatres.
- During our last inspection, nurse staffing was raised as a significant concern within the ICU. However, there had been significant improvements in nurse staffing during this inspection. There were 65.5 whole time equivalent (WTE) nursing staff working within the ICU. There was one vacancy that had just been recruited to, and the service was waiting for finalisation of employment checks. In addition to this, there were four WTE healthcare assistants to provide support. Care in ICU was consultant led and delivered. There were eight consultants who worked in the department; all but one of these had fellowship from the Faculty of Intensive Care Medicine (FFICM). There was continuous consultant cover from staff with no other simultaneous commitment.
- The maternity department did not always have sufficient staff, to enable the effective delivery of care and treatment. On the days of our inspection, we saw all areas were fully staffed. Staff rotas we reviewed for July, August and September 2016 demonstrated there were reduced staffing levels particularly affecting the antenatal and post-natal ward and the clinics. However, there were plans in place to address the risk to care delivery. Staff were moved between wards to meet the demands of the service.

Summary of findings

- The maternity unit had provision for 60 hours of consultant presence, including in the daytime on week days, and mornings at weekends. Since there was no separate obstetric team to staff the elective caesarean section lists, this effectively reduced the consultant hours dedicated to cover the labour ward This had not changed since the last inspection. We found that the consultant obstetrician covering the delivery suite carried out the elective caesarean section list as well as cover for gynaecology. This would include undertaking a ward round on the antenatal in-patients. This meant there would be times the consultant obstetrician was not present on the labour ward as they were covering obstetrics and gynaecology and undertaking elective caesarean section list. We did not have any further information on the impact of this it had been raised with the executive board as a concern but it was not on the service's risk register. Staff on delivery suite said there was a business case in progress to increase consultant staffing: at the time of inspection there was no defined timescale for this. We fed this back to the trust as an area of concern. On our unannounced inspection staff confirmed that no extra consultant hours had been provided since feedback at last inspection and there had been no practical increase in consultant cover provided.
- There had been six incidents reported in June and July 2016 related to staffing not meeting staff acuity in maternity this had a an impact on care, for example, discharges had been delayed. There were also two incidents regarding staffing affecting the foetal health unit in May and June 2016 where staffing levels had impacted on the ability to provide care and appointments were delayed We asked the service what actions were taken in response to these incidents. The skill mix review had been carried out to look at staffing throughout the service. Staff were moved from other areas to support staffing.
- Staffing levels were planned and reviewed in advance based on an agreed number of staff per shift, however, staffing levels on the paediatric ward, assessment unit and the paediatric outpatient department did not meet the relevant guidance. An acuity tool was not used to determine staffing levels for paediatric inpatients. The trust had identified that staffing levels did not meet required guidelines and this was recorded on their risk register for the wards but not for outpatients. Staffing levels for NICU had also been identified as a risk. This was monitored on a daily basis and there were only a few shifts each month which were slightly short of the recommended number of registered nurses. It was the perception of staff that staffing levels met patient needs, but could be stressful for staff.

- In August 2016, the vacancy rate for the paediatric ward was 17% and 8% on NICU. We were told that vacancies had recently been recruited in to. Sickness rates for the previous year 2015/16 were 3% for paediatrics and 4% for NICU which was below the hospital target of 5%. We were told that agency staff were not used for the paediatric ward or NICU, instead regular bank nurses were used if cover could not be provided by permanent members of staff.
- The paediatric department had carried out a staffing needs analysis and determined that they were not meeting the recommended level of nurses in accordance with the Royal College of Nursing (RCN) safer staffing guidance. RCN guidance states that there should be a ratio of one nurse to three patients for children under the age of two years. A ratio of one to four, for patients over the age of two years, during the day and night shifts, and that an experienced band 6 should be on duty over the full 24 hour period. The guidance also stated that, 'the standard for a general inpatient ward should reflect the age of the child as well as acuity. Hospitals should therefore use a proven methodology to assess acuity of patient care that clearly reflects the needs of children, not adults.
- The ward had trialled, but was no longer using an acuity tool to assist in determining day-to-day staffing requirements. There were an agreed number of nurses and assistant practitioners (assistant practitioners are highly skilled healthcare assistants who have undergone additional training) working each shift and this varied depending on the number of beds open on the unit. At weekends and from Friday evenings until Tuesday mornings, there were 18 beds open and from Tuesday mornings until Friday evenings, there were 26 beds open. When there were 18 beds open, there were five nurses per shift during the day and four at night with up to one assistant practitioner. When there were 26 beds open, there were seven nurses and up to one assistant practitioner.
- A business case had been drafted to increase the number of nurses to support with winter pressures: this had not yet been approved. Additional nurses were required during the winder to cope with increased demand, particularly due to respiratory related illnesses. There were two healthcare assistants expected two work each day shift and one at night. This meant that the recommended ratio of 70:30 qualified to unqualified staff was not met. The paediatric outpatient department was run by adult nurses and was part of a different clinical business unit and were not line managed by and did not work closely with paediatric inpatients staff. There was a main paediatric outpatient department who saw the children and young people

for most specialities. There was also a specialist diabetes centre. Children seen by the ear, nose and throat, ophthalmology and maxillofacial teams, were seen within the main adult outpatient department. There were no paediatric trained nurses in any of the outpatient areas. RCN guidance states that, 'a minimum of one registered children's nurse must be available at all times to assist, supervise, support and chaperone children'. This had not been identified as a risk for paediatrics but had been recorded on the outpatient risk register.

- In the children and young people's service, Medical staffing levels and skill mix were not planned adequately in advance or in accordance with relevant guidance to ensure that patients received safe care and treatment. In August 2016, there were no vacancies; the turnover rate was 5.48%. Sickness reported in the previous year, 2015/16, was lower than the hospital's 5% target at 3%. There were eight consultants employed for children and young people's services. Consultant cover was provided Monday to Friday 9am to 5pm on the paediatric ward by one consultant, there was a second consultant who covered NICU from 9am to 1pm Monday to Friday. Outside of these hours, there was a consultant available on call and staff had the relevant contact details. During the day, there was one middle grade doctor who covered the paediatric ward and assessment unit and a second doctor based on NICU as well as a third based in clinic. Support was also provided by junior doctors: one was allocated to the paediatric ward, one allocated to NICU, a third was allocated to the paediatric assessment unit when open and a fourth covering NICU and postnatal wards. A FYI junior doctor was based on the paediatric ward during weekdays and a second was based in the assessment unit for afternoon and evenings. At night, there was one middle grade with support from a junior doctor and a consultant on-call.
- In the NICU, Staffing levels were not compliant with the British Association of Perinatal Medicine guidance, which refers to the Department of health toolkit 'Optimal arrangements for Neonatal Intensive Care Units in the UK 2014'. This states, 'The minimum staffing in any neonatal service is for resident out of hours care should include a tier one clinician or junior doctor ST1-3 and a tier two and experienced junior doctor ST4-8 or appropriately trained advanced neonatal nurse practitioner (ANNP)'. Guidance also recommends that all NICUs seek to extend consultant presence on the unit to at least 12 hours per day.
- Consultant cover was provided eight hours a day Monday to Friday and on-call arrangements were in place. This did not

meet the recommended BAPM guidance of 12 hours daily cover and meant that not all children admitted to the ward with an acute medical condition could be seen by a consultant within 14 hours of admission as recommended by Royal College of Paediatrics and Child Health (RCPCH), 'Facing the Future' guidance. We reviewed 12 sets of notes and saw that most patients had been reviewed by a consultant within 14 hours, with exception of one child who had been admitted over a weekend.

- The transformation end of life care lead nurse represented the hospital locally and at countywide forums to work collaboratively to deliver improved patients pathways and service. This was a whole time equivalent post (WTE), funded for two years by Macmillan Cancer Services. A business case for continued funding of the post was being developed by the hospital. Following the CQC inspection in September 2014, the hospital had implemented the recommendation to directly employ the specialist palliative care nursing service, previously provided through a third party agreement with another NHS provider. The SPCT, led by the deputy director of nursing, was established for 2.7 whole time equivalent (WTE) specialist palliative care nurses and 0.43 WTE administrative support.
- There had been a designated medical lead for end of life care in the hospital since 2015. Two specialist palliative medicine consultants (through a third party agreement with a local hospice) provided care for patients at the end of life. The consultants visited the hospital for four to five hours, four days a week and for a minimum of two hours on the fifth day. A specialist registrar (from the hospital) provided additional support over two to four days a week. Out of hour's advice and symptom control was provided by a local hospice.
- At the time of our inspection, nurse staffing in outpatients generally met the needs of patients. We found across the outpatient departments that agency and bank staff were not frequently used to fill vacancies. In the event where agency staff was required, a local induction would be given to the agency staff. We looked at two sample induction records for both agency staff and a new starter and both were accurate.
- As of August 2016, the hospital reported a vacancy rate of 12.2% in outpatient for both staff nurses and healthcare assistants. While the highest rate was seen in blood transfusion (50%), this unit only had a staff of 1.19 WTE. There were ongoing recruitment plans. The nursing vacancy rate for Nene Park was 13% at the time of inspection. They had vacancies for 1.28 WTE Band 5 nurses. Senior nursing staff we spoke with told us that they found it difficult to recruit to that location. They told us

Summary of findings

that the recruitment process took months and candidates often found jobs elsewhere in that time. Managers and matrons worked clinically every week to cover the vacant posts. Nurses from Kettering main outpatients department were also flexed to Nene Park to provide cover.

- There were no registered children's nurses at Nene Park. Nene Park had a minimum of three general paediatric clinics per week that were staffed by consultants and healthcare assistants. They also saw children in some adult clinics, such as ENT. This was a risk as it meant nurses who were not specifically trained to do so were caring for children. The service recognised that this was a risk and it was included on their local risk register. Their mitigating actions were to run paediatric clinics from Kettering general hospital where they had registered children's nurses; however, this did not always happen.
- Radiographer vacancies in the diagnostic imaging department remained a large risk to the trust. The inability to recruit experienced radiographers appeared three times on the risk register with catheter laboratory specialist radiographers being a risk since January 2015, CT and MRI radiographers since April 2015 and general radiographers since May 2015.
- Medical staffing was provided by the specific specialities that were holding the clinics such as rheumatology, cardiology, ophthalmology, and ENT. Consultants arranged outpatient clinics directly with the outpatients department to meet the needs of their speciality.
- The hospital reported 146.63 WTE consultants or equivalent and 258.17 WTE medical staff (other grades) in August 2016. Where appropriate, consultants were supported by junior doctors and locum doctors in some clinics.

Are services at this trust effective?

Requires improvement

We rated effective as requires improvement because:

- Information about the outcomes of people's care and treatment was routinely collected to identify areas for improvement. However, actions following audit outcomes were not always monitored in all services to embed improvements in the service to achieve better outcomes for patients.
- There was not an effective cyclical audit programme to monitor the consistency of practice against evidence-based guidance in all services. This meant that areas for improvement and opportunities for identifying best practice were not always identified.
- Care was not always delivered to national recommended guidance.

Summary of findings

- There were not effective processes in place to ensure that all staff had the correct skills, knowledge and experience to undertake all the duties they were tasked with, for example, competency frameworks in children's ED and streaming area were not routinely checked or monitored.
- There were mixed patient outcomes in medical care and surgery and not always an action plan and effective ongoing monitoring of changes to ensure improvements.
- Patient's care was not consistently planned and delivered in line with evidence based guidance in maternity and children and young people's services.
- Formal transition arrangements were no in place for all specialities when patients transferred from paediatric to adult services.
- Patient records were not always available on the children's ward and there was high usage of temporary notes. GP discharge letters were not sent out on a timely basis.
- The trust performed worse than the England average for the five clinical outcomes in the End of Life Care Audit: Dying in Hospital (NCDAH) 2014/15, published 2016.
- Not all staff treating children in outpatient clinics at both the phlebotomy department in Kettering general hospital and Nene Park outpatient sites were able to evidence that they had paediatric competencies in line with national guidance.
- Diagnostic reference levels (DRLs) were not displayed in the imaging areas and not all staff we spoke with knew how DRLs were to be used.

However:

- The trust's Hospital Standardised Mortality Ratio (HSMR) performance was as expected compared to the England average. The weekend HSMR was within expected range for this time period.
- Patients received care in surgery and critical care was assessed and delivered in line with national and best-practice guidelines.
- Pain of individual patients was generally assessed and managed appropriately. The trust had introduced SAFER care bundles in medical care wards.
- Patients' nutritional and hydration needs were generally appropriately assessed and the food and fluid charts were well maintained.
- Staff generally had the right qualifications, skills, knowledge and experience to do their job.
- A multi-disciplinary team approach was evident across most services.

- Senior staff said the medical care service was looking at ways to fully adopt a seven-day a week working practice for doctors. Newly admitted patients were seen by the on call consultant at weekends as required, but there were not generally full ward rounds at the weekends.
- The ED was a part of the Central England trauma network and took part in regular peer reviews.
- The trust had received the UNICEF Baby Friendly Initiative full accreditation for its maternity department.
- The trust had addressed issues around the replacement of the Liverpool End of Life Care Pathway, had instigated and embedded a new end of life care pathway.
- There were multidisciplinary one-stop clinics, such as in urology and the breast clinic, where patients could access consultations, diagnostics, results and clinical nurse specialists in one appointment.
- Generally, staff said all the information needed to deliver effective care and treatment was available to in a timely and accessible way.

Evidence based care and treatment

- Care was not always in line with recommended national guidance for emergency departments and medicine. The ED did not meet the Royal College of Paediatrics and Child Health (RCPCH) intercollegiate documents 'Standards for children and young people in emergency care settings (2012)'. For example, there was no robust process in place to ensure that all children received an initial clinical assessment (including pain score) within 15 minutes.
- The ED did not meet all of the standards of the RCEM guidance for minimum requirements for units that see less seriously injured people 'Unscheduled care facilities (2009)'. For example, there was a lack of safeguarding training and no robust processes in place to ensure that all patients were seen in a timely manner.
- The ED used specific pathways for patients presenting with head injuries, sepsis and fractured neck of femur. The department had recently updated their pathways for patients presenting with non-traumatic chest pains based on NICE guidelines (NICE CG95, 2016).
- The department used the 'sepsis six' care bundle and active cancer sepsis care bundle pathways in line with NICE (2016) guidelines and the UK Sepsis trust (2013) for adults and children. These pathways are to aid those delivering care with

the rapid recognition and treatment of severe sepsis. There were proformas in place for staff to record their actions within defined guidelines and the department had a dedicated clinical lead for sepsis.

- The trust had introduced SAFER care bundles in medical care wards based on national evidence based care pathways with the focus on early recognition and treatment of patients at risk.
- The medical care service had implemented a dementia care bundle in line with the implementation of the National Dementia Strategy (Department of Health 2009, 2010). A care bundle is a structured way of improving the processes of care and patient outcomes: a small, straightforward set of evidence-based practices, generally three to five that, when performed collectively and reliably, have been proven to improve patient outcomes.
- The medical care service had recently implemented a revised sepsis care pathway in line with the national 'sepsis six' care bundle. Ambulatory care bundles had been implemented following national guidance and included specific care pathways for first seizure, new onset atrial fibrillation, painless jaundice and suspected pulmonary embolism. The national stroke care pathway was followed by the occupational therapists, the physiotherapists and the speech and language therapists before patients were transferred to rehabilitation units.
- Emergency surgery was managed in accordance with National Confidential Enquiry into Patient Outcome and Death (NCEPOD) recommendations and national guidelines, including RCS standards for emergency surgery. The pre-operative assessment clinic assessed and tested patients in accordance with NICE guidance for someone due to have a planned (elective) surgical operation. Examples included MRSA testing.
- The service used the World Health Organisation (WHO) 'Five steps to safer surgery' checklist, designed to prevent avoidable harm was audited and findings shared with the appropriate teams. The WHO safer surgery checklist audit from April 2016 to June 2016 looked at a sample of over 1,000 patients. The overall compliance for the checklist was 99%. The pre-list compliance was 99% and the post-brief compliance was 98%. The audit identified the areas of non-compliance, which included; surgeon arriving late for theatres due to ward rounds and failed equipment required replacement so theatre over-ran. Staff confirmed audit feedback was given at monthly meetings and we saw results graphs displayed in theatre. Staff received letters to highlight any non-compliance when completing the checklist.

Summary of findings

- Patients' care and treatment in critical care was assessed and delivered in line with national and best-practice guidelines. For example, the National Early Warning Score (NEWS) with a graded response strategy to patients' deterioration complied with the recommendations within NICE Guidance 50 Acutely ill patients in hospital and the Guidance for the Provision of Intensive Care Services 2015 (GPICS).
- Patients were ventilated using recognised specialist equipment and techniques. This included mechanical invasive ventilation to assist or replace the patient's spontaneous breathing using endotracheal tubes (through the mouth or nose into the trachea) or tracheostomies (through the windpipe in the trachea). The unit also used non-invasive ventilation to help patients with their breathing using masks or similar devices. All ventilated patients were reviewed and checks made and recorded hourly.
- The critical care service met best practice guidance by promoting and participating in a programme of organ donation, led nationally by NHS Blood and Transplant. In the NHS, the number of patients suitable for organ donation is limited for a number of reasons. The vast majority of suitable donors would be cared for in a critical care unit. There was a link nurse for organ donation working alongside the ICU. They directly supported the organ donation programme and worked alongside the clinical lead. We saw visible information for staff to advise them on how to contact the organ donation team and what information would be required.
- During our last inspection, we found the maternity service could demonstrate that there was a process for identifying relevant legislation, current and new best practice, and evidence-based guidelines and standards, which were reviewed and approved through the women and children clinical management team obstetric scrutiny committee. However, although doctors approved and signed off guidelines, staff told us that there was a lack of medical input and scrutiny in the development of some guidelines, and limited evidence that NICE guidance was being audited and followed. The compliance rate for NICE guidelines in the women and children's directorate was 67% in June 2014. On the current inspection, we saw evidence that the scrutiny meeting were held monthly, however, it was noted five antenatal clinical guidelines we reviewed on the delivery suite had overdue review dates.
- The care of women using the maternity services was not always in line with Royal College of Obstetricians and Gynaecologist Guidelines (RCOG) including Safer Childbirth: minimum

standards for the organisation and delivery of care in labour. These standards set out guidance for the organisation, which included safe staffing levels, staff roles and education, training and professional development, and the facilities and equipment to support the service. We saw evidence the service had monthly meetings to review perinatal and maternal mortality and morbidity an equipment recommended by the safer childbirth document and the mandatory training provided by the service met with the recommendations. However, the midwife to birth ratio was 1:29 where the 'Safer Childbirth' recommends that there should be one midwife employed for every 28 births. The dashboard data compared safety-related targets on a monthly basis did not meet guidance and the service did not have a consultant midwives were recommended.

- Patient's care was not consistently planned and delivered in line with evidence based guidance in the children and young people's service. Guidance had not been developed for all care requirements and some did not reflect the most up to date guidance. Audits were not used to effectively monitor the standard of care provided. There were a range of hospital wide policies as well as those specific to neonates and paediatrics. We reviewed a sample of policies including 'early care of the pre-term infant, 'neonatal jaundice', 'neonatal sepsis', 'gastroenteritis in children younger than five years' and paediatric early warning system and found that they reflected relevant national guidance, for example, National Institute for Health and Care Excellence (NICE) and Resuscitation Council guidance. We noted that there were a number of policies available to staff on the intranet which had exceeded their review date. For example, the 'Guideline for Epilepsy management in Children', which had been developed in December 2011 and was due for review in December 2014. NICE guidance had been updated in January 2016: therefore, the hospital's policy had not taken this into account.
- There was a clinic audit plan in place, although this only included two audits for 2016/17 and four for the previous year. Three of the 2015/16 audits had not been completed. One of the 2016/17 audits was in progress (diabetes paediatric audit), but the second audit had not commenced (improving the parental experience in the neonatal unit). We were told that audits had not received the attention they required due to insufficient medical staff.
- The trust participated in the End of Life Care Audit: Dying in Hospital (NCDAH) 2014/15, published in 2016. The trust scored worse than the England average in all five of the clinical audit

key performance indicators (KPIs). The trust had produced an action plan to address the shortfalls and issues raised by the NCDAH 2016, monitored by the transformation lead nurse and the SPCT and reviewed bi-monthly by the End of Life Care Forum (EoLCF).

- Following the CQC inspection in September 2014, the hospital had implemented and embedded an end of life care pathway to replace the Liverpool Care Pathway (LCP), 'Guidance to implement care for a dying patient and their family and friends'. The multidisciplinary care record was in line with the recommendations published in June 2014 by the Leadership Alliance for the Care of Dying People (LACDP 2014), National Institute for Health and Care Excellence (NICE) QS13 End of Life Care for Adults and the Palliative Care Formulary (2011).
- Diagnostic reference levels (DRLs) were not displayed in the imaging areas and three members of staff in the plain film service we spoke with did not know how DRLs were to be used. DRLs are typical doses for examinations commonly performed in Radiology departments. They are set at a level so that roughly 75% of examinations will be lower than the relevant DRL. They are not designed to be directly compared to individual doses. However, they can be used as a signpost to indicate to staff when equipment is not operating correctly or when the technique is poor. There is no national guidance on this.
- Local CT protocols were seen to be out of date and due for review in 2014. This meant that best practice relating to a more recent evidence base was not being adopted and they may no longer reflect practise within the hospital.

Patient outcomes

- Information about the outcomes of people's care and treatment was routinely collected to identify areas for improvement. However, actions following audit outcomes were not always robustly monitored to embed improvements in services to achieve better outcomes for patients.
- The Royal College of Emergency Medicine (RCEM) invites emergency departments to take part in national clinical audits annually that evaluate care based against agreed standards. We saw that the ED participated in relevant audits annually, which allowed them to benchmark their performance against national performance. We saw that the ED was identifying good practice and areas for improvement through participation in national audits; however, there was not always capacity or robust process to support continued review of the effectiveness of the changes implemented.

Summary of findings

- In the 2013/14 RCEM audit for asthma in children, the trust performed worse compared to other trusts for eight of the ten measures. This included seven measures relating to recording initial observations within 15 minutes. In the 2013/14 RCEM audit for paracetamol overdose, the trust was in the bottom percentage compared to other trusts for two of the four measures, and in the upper percentage for two of the four measures. In the 2014/15 RCEM audit for initial management of the fitting child the trust was in the lower percentage compared to other trusts for one of the five measures and was in the between the upper and lower percentages for two of the five measures. In the 2014/15 RCEM audit for mental health in the ED, the trust was in the lower percentage for one measure and in the upper percentage for one measure compared to other trusts. In the 2015 RCEM 'procedural sedation' audit, there were seven standards and five were classed as fundamental. The department scored worse than the England average in five of the fundamental standards. In the 2015 RCEM 'vital signs in children' audit, the department scored worse than the England average and in the bottom 5% for the two standards relating to all children receiving an initial clinical assessment in 15 minutes.
- From June 2015 to May 2016, the department's unplanned re-attendance rate within seven days of discharge was an average of 7% for the specified period. This was better than the England average for the same period, which was 9%, however this was below the national standard of 5 %. Unplanned attendance rates were monitored on the urgent care performance dashboard on a weekly basis and were a part of the urgent care improvement plan.
- The department had undergone a peer review in July 2015 as part of their role in in the Central England trauma network. Serious concerns were identified in regard to the availability of suitably trained medical and nursing staff, lack of comprehensive network guidelines and that NICE guidelines for paediatric Computerised Topography (CT) scanning had not been embedded. During a further peer review in September 2016, the department had made improvements with establishing comprehensive network guidelines and embedding NICE guidelines for paediatric CT scanning. However, there were some concerns: the adult CT scanning guidelines were out of date and the department was still in the process of securing funding to have the sufficient amount of

suitably qualified staff (these were not noted as serious concerns). The department were monitoring their collection of data and targets on a quarterly basis using a specific 'trauma unit' dashboard and had on-going plans to recruit suitable staff.

- The trust's Hospital Standardised Mortality Ratio (HSMR) performance was as expected compared to the England average. The HSMR is an indicator of healthcare quality that measures whether the mortality rate at a hospital is higher or lower than you would expect. The national expected HSMR score is 100. For the 12 month period from January 2015 to December 2015, HSMR was as expected with a value of 94 (compared to 100 for England) and 971 deaths compared to an expected 1,028 deaths. The weekend HSMR was within expected range for this time period.
- The trust also participated in the Summary Hospital-level Mortality Indicator (SHMI). The SHMI is a nationally agreed trust-wide mortality indicator that measures whether the number of deaths both in hospital and within 30 days of discharge is higher or lower than would be expected. For the 12 month period from January 2015 to December 2015, the SHMI was as expected with a value of 1.08 (compared to 100 for England) and 1,587 deaths compared to an expected 1,475 deaths.
- The trust participated in the Sentinel Stroke National Audit Programme (SSNAP), the Lung Cancer Audit, the Heart Failure Audit, the National Diabetes Inpatient Audit (NaDIA) and the national Myocardial Ischaemia National Audit Project (MINAP) audit. The hospital did not provide a stroke thrombolysis service (this is a treatment where drugs are given rapidly to dissolve blood clots in the brain), as this was provided by another local NHS hospital.
- The trust was participating on an ongoing basis in the SSNAP. An SSNAP level is assigned of A to E, A being the best. For the last audit, covering the period from January 2016 to March 2016, the hospital scored E. In the three preceding quarters, the hospital scored D or E. The hospital scored particularly poorly in team-centred key indicators. Patient-centred key indicators were poor for the stroke unit and multidisciplinary team working. Part of the service's plans to address this poor performance was a stroke nurse specialist who worked on Cranford ward (stroke ward) five days a week (Monday to Friday) to support patients; the nurse specialist also supported staff to provide appropriate care to patients.
- The trust's results in the 2015 Heart Failure Audit were better than the England and Wales average for three of the four of the standards relating to in-hospital care, and slightly higher for the proportion of patients receiving an echo. The hospital's results

were better than the England and Wales average for four of the seven standards relating to discharge, worse for two and the same for one. In comparison with the England and Wales average scores, the hospital performed best for input from specialists at 99% compared to the England average of 78%. The lowest score were for the referrals to cardiology follow-ups at 59%, which was better than the England average at 54%.

- The trust participated in the 2015 NaDIA. The hospital was better than the England and Wales average for two out of 15 indicators and worse for 13, including medication errors at 44%, worse than the England average of 38% and patients having a foot risk assessment during the hospital stay at 14%, worse than the England average at 34%.
- The trust participated in the MINAP audit in 2012/13 and 2013/14. In both years, the hospital scored better than the England and Wales average for all three indicators. Thrombolytic treatment time was not submitted as KGH is a tertiary cardiac centre and the treatment of choice is PCI and no patients were thrombolysed during the stated period.
- The trust participated in the 2015 Lung Cancer Audit and the proportion of patients seem by a cancer nurse specialist was 91%, which was better than the audit minimum standard of 90%. The 2014 figure was 93%. The proportion of fit patients with advanced non-small cell lung cancer (NSCLC) receiving chemotherapy was 80%, this was significantly better than the national level. The 2014 figure was 85%. The proportion of patients with small cell lung cancer (SCLC) receiving chemotherapy was 53%; this was not significantly different from the national level. The 2014 figure was 56%.
- The hospital was accredited as the maximum grade A by the Joint Advisory Group on Gastrointestinal Endoscopy (JAG). This meant the endoscopy unit and its staff was assessed and monitored for quality performance and clinical safety against established international benchmarks. JAG accreditation was monitored through quality checks annually.
- Endoscopy and bowel screening services achieved very positive outcomes and strongly positive patient feedback. The bowel screening service was one of the first wave bowel scope centres. The diagnostic performance for endoscopy procedures delivered 99% of test results within 6 weeks.
- The hospital's annual Patient Reported Outcomes Measures (PROMS) from April 2015 to March 2016 looked at primary knee replacement, hip replacement and groin hernia. All indicators were in line with the England averages with the exception of one area regarding groin hernia, which showed fewer patients' health improving and more patients' health worsening.

Summary of findings

- We saw the non-operative management of acute achilles tendon rupture audit report for June 2016. This was based on the national evidence of non-operative management of acute achilles tendon rupture (Holm et al 2015). The report found lack of consistency in the management of acute achilles tendon ruptures with no local guidelines to follow. The action plan identified the creation of new local guidelines and pathway with a completion date of July 2016. However, the action plan did not have any identified outcome or how this was monitored within the service.
- From March 2015 to February 2016, patients at the hospital had a similar expected risk of readmission for non-elective admissions and a similar expected risk for elective admissions with the exception of ophthalmology.
- In the 2015 hip fracture audit, the risk-adjusted 30-day mortality rate was 6%, which was within expectations. The proportion of patients having surgery on the day of or day after admission was 78%, which did not meet the national standard of 85%. The perioperative surgical assessment rate was 82%, which did not meet the national standard of 100%. The proportion of patients not developing pressure ulcers was just below at 98%. The length of stay was 22 days, which made the trust in the worst 25% against other trusts.
- In the 2015 bowel cancer audit, 64 % of patients undergoing a major resection had a post-operative length of stay greater than five days. This was worse than the national aggregate of four days. The risk-adjusted 90-day post-operative mortality rate was 4%. This was within the expected range against the national average of between 2% and 6%. The risk-adjusted 90 day unplanned readmission rate was 19%, which fell within the expected range of between 60% and 40%. The risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major resection was 44%, which was within the national average.
- During our visit to theatre, we observed hospital surgical dashboards on display and the theatre productivity board action plans which included the consolidation of reviews regarding pre-operative assessments and a collation of all “to come in” TCI letters to create a document library of communication to patients as well as an audit of TCI letters to provide a clear understanding of variance across all specialities. These actions had a deadline of November 2016.The hospital did not record their theatre utilisation but provided us with a projection as set out in the theatre delivery plan with a target of 85%. This was also highlighted in the anaesthesia CBU business and governance meeting of May 2016. The October 2016 theatre

productivity operational board report had recorded plans to improve the list utilisation within theatres. Examples included the development of an electronic waiting list proforma, which would ensure that staff had all the relevant information available when scheduling patients and a weekly review of these actions to ensure delivery. We saw the service had introduced training to staff regarding the use of the scheduling tool. The trust informed us they were undergoing a review of its data systems. This meant that we could not be assured that the hospital could assess the performance of its operating theatres for the benefit of patients on their waiting lists.

- The Intensive Care National Audit and Research Centre (ICNARC) annual report from 2015/16 showed that the critical care service was performing as expected (compared to other similar services) in all indicators apart from one which showed the unit had a higher than national average for delayed discharges of 12.2% compared to the national average of 5.3%. The unplanned readmission rate within 48 hours was 0.8%, which was better than national average of 1.2%. Within the ICU, the risk adjusted hospital mortality ratio was 1.03. This was within the expected range.
- Patient outcomes in maternity were variable: in the 2015 National Neonatal Audit Programme (NNAP), the trust was below the NNAP standard for four of the five indicators. The caesarean section rate for 2015/16 was 30%, which was higher than the national average of 26.5%. The ventouse delivery and forceps rate was 10%, which slightly above the trust target of between 8% to 9%. The locally agreed standard for third and/or fourth degree tears was an occurrence of less than 9% per month.
- The children and young people's service took part in the national diabetes audit, which showed that the percentage of patients with controlled diabetes was slightly better than or similar to other trusts in England for different aspects measured, although they performed worse than the England average for multiple admissions for patients with diabetes. The trust had developed an action plan in response to the audit; four actions were identified: including initiating more user involvement and feedback, to hold regular events for young people with diabetes and to hold regular catch-up sessions. The actions lacked detail and had not been clearly defined; deadlines for completion had not been recorded.
- The national 'epilepsy 12' audit, which was a national clinical audit established in 2009, with the aim of helping epilepsy services, to measure and improve the quality of care for children and young people with seizures and epilepsy. The

service last took part in this audit in 2014 where a total of 12 actions were agreed. Five of these were outstanding and no evidence these had been followed up. For example, one action was for 65% of children with convulsive seizures to have an electrocardiogram (ECG) within one year, there was no evidence whether this had been achieved or not. This had not been identified as a risk and placed on the trust's risk register.

- The specialist palliative care team (SPCT) had received 923 referrals in the reporting period April 2015 to March 2016. The trust had broken this down into patients with cancer and patients without cancer related referrals. Of the 923 people referred to the SPCT, 100% were seen in the trust target time of two working days from referral between April 2015 and March 2016.
- The trust participated in the End of Life Care Audit: Dying in Hospital (NCDAH) 2014/15, published in 2016. The hospital achieved seven out of eight organisational indicators. The one not achieved related to the lack of face to face care from the specialist palliative care team seven days a week. In all five of the clinical audit KPIs of the NCDAH, 2014/15 the hospital had performed worse than the England average.
- Clinical staff in outpatients had been involved in a national audit for chronic obstructive pulmonary disease (COPD) patients.
- The imaging department was not participating in the Imaging Services Accreditation Scheme (ISAS). This was due to the department having other priorities, such as improving staff establishments and image report turnaround times. Following the upgrade of the RIS and PACS on 5 June 2016, there was evidence of a developing backlog of reporting of images due to IT downtimes and unreliability of the systems. While this issue was improving at the time of the inspection, there was a period of time when patients experienced long delays in receiving reports on their images (in some cases a number of months). These report delays affected the entire trust and as a consequence patients waiting significant lengths of time either received a delayed diagnosis or treatment.
- During the installation and the four months following the change over to the new PACS (Picture Archiving and Communications System) and RIS (Radiology Information System), the service had been experiencing severe issues with the stability of the PACS, RIS and reporting systems. This had meant the IT systems at times were unavailable to various members of staff across the trust to review or report upon

images in a timely manner. At the time of the inspection, this had appeared to be mostly resolved due to a software upgrade carried out by the supplier and the upgrade of the trusts network connection.

- Figures from July 2016 show that 5% of patients were seen in outpatient clinics without their full medical record available. The trust mitigated missing notes by using letters from the last clinics and electronic systems to obtain relevant results. However, this was not always possible at Nene Park outpatients' clinic due to problems with the internet connection, meaning appointments could be cancelled at short notice. The trust conducted audits on the availability of notes in outpatient appointments twice a year. In February 2016, their audit showed that 92% of patients' medical notes were available for their appointments at Nene Park and five patients had their appointments cancelled due to missing notes. In September 2016, 94% of patients' notes were available at Nene Park. The action plan from this audit was to continue to report missing notes as incidents and conduct another audit in March 2017.

Multidisciplinary working

- We saw that the ED team worked with other teams within the trust to assess, plan and deliver treatment for patients. We observed effective communications between nursing and medical staff when patients were transferred from ED for further care as in-patients. The ED had access to a psychiatric and acute mental health liaison team 24 hours a day, seven days a week; however, staff said that there were sometimes delays for the psychiatric liaison team to attend the ED. This was highlighted in the RCEM 2014 audit 'Mental Health in the ED' and similar to national performance. We saw that patients had access to services such as alcohol or substance misuse services through the psychiatric and mental health liaison team.
- A multi-disciplinary team (MDT) approach was evident across medical care wards. We observed effective MDT working in the wards we inspected. MDT meetings took place on the wards on a regular basis to review the progress of each patient towards discharge.
- All the medical wards held their own internal MDT meeting every morning (9am to 9.30am). We attended one of these meetings in HC Pretty ward which was led by one of two consultants. Among those who attended were the registrar and the junior doctors, a ward staff, the occupational therapist and the physiotherapist and, on this occasion, the safeguarding

lead. Matters discussed were patients on the prioritised list due to changes in their care and treatment and patients due to be discharged. There was a comprehensive discussion about patients, the assessments they needed and the plan for their discharge.

- In surgery, there was daily communication between the pre-operative assessment staff and ward and theatre staff, so patient care could be coordinated and delivered effectively. Staff described the multidisciplinary team as being supportive of each other. Staff told us they worked hard as a team to ensure patient care was effective and that their contribution to patient care was valued. Patient records also showed that there was routine input from nursing, medical staff and allied health professionals, such as physiotherapists. We observed effective team working among heads of departments, administrative, clinical, nursing, pharmacy, therapists and ancillary staff during our inspection.
- There was unsatisfactory pharmacy input into the intensive care unit. At the time of our inspection, there was no dedicated pharmacist and support provided by pharmacy did not meet national guidelines. Multidisciplinary meetings did not occur within the service. This was not in line with national guidance. Most staff felt this was an area for improvement.
- We saw effective communication between consultants and midwives. Communication with community maternity teams was efficient. A multidisciplinary handover took place twice a day on the delivery suite and included an overview of all maternity and gynaecology patients. The handover also included discussion regarding women who were on the antenatal ward who may later require care on the delivery suite, for example: inductions of labour, raised blood pressure at term, planned caesarean sections and women in early labour.
- The Child and Adolescent Mental Health Service (CAMHS) were employed by another trust and called the children's ward each morning Monday to Friday to ask whether anyone had been admitted overnight. The CAMHS team attended the ward as required to conduct assessments on patients. Out of hours, the adult crisis team made assessments if it was assessed that a child could not wait to be seen by a member of the CAMHS team within their working hours. There were no mental health nurses employed by the ward. We raised our concerns with the trust who took prompt action. A new risk assessment was developed and introduced with support from a CAMHS patient,

1:1 care from a registered mental health nurse was then arranged depending on the outcome of the assessment. Training on mental health for ward staff was also being introduced.

- End of life care champions had information folders on all the wards we visited, containing information on the Five Priorities of Care for the person who is thought to be in the last weeks and days of life. Information folders contained train the trainer records for staff who had attended the training sessions run by the champions.
- The transformation lead nurse, medical lead and the SPCT had established close links with other providers of end of life care in the local area, including the local hospice, charitable organisations, primary care providers and community nurses. The aim of this was to improve patient's experience as they moved across care settings. We saw documented evidence of a multidisciplinary approach to care. We reviewed 10 sets of notes and saw documented examples of communication around care planned between health care professionals. Medical staff told us they sought guidance and acted upon advice from the SPCT.
- Chronic pain clinicians in the outpatients' service were part of the Midlands Pain Group that was comprised of staff from neighbouring trusts. They met quarterly to discuss service designs and improvements. Staff told us that this meant they knew where to send patients who could benefit from a treatment not offered at their trust. This was confirmed by speaking to patients who had been informed about treatment options at other hospitals.
- There were multidisciplinary one-stop clinics, such as in urology and the breast clinic, where patients could access consultations, diagnostics, results and clinical nurse specialists in one appointment.

Consent, Mental Capacity Act & Deprivation of Liberty safeguards

- Patients' consent to care was generally sought in line with legislation and guidance in the ED. However, staff had not had sufficient training in the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and patients who lacked capacity to consent did not always have decisions made in line with legislation. At the time of our inspection, 76% of nursing staff and 53% of medical staff had received mental

capacity awareness training. This was below the trust target of 85%. Not all staff were able to describe instances when they would use 'best interest decisions' in line with legislation if the patient lacked capacity.

- The medical care service showed 91% compliance with MCA training in June 2016, which was better than the trust target of 85%. Patients told us staff asked their permission before providing care and treatment. Consent was taken from patients appropriately. We saw documents were in place for consent to treatment and interventions. Patients were supported to make decisions. We saw posters displayed providing contact details for Independent Mental Capacity Advocates (IMCA) for patients who lacked capacity and supported and represented the patients in the decision making process. A DoLS authorization had not been completed for a patient on Cranford ward for 10 days and a mental capacity assessment had not been done. We raised this as a concern and the nurse in charge took action urgently to resolve this matter.
- We looked at 17 patient records in surgery and found consent forms had been completed appropriately. Staff confirmed that if they had concerns regarding a patient's ability to understand any decision or information provided they would refer to their senior manager or the consultant in charge of the patient. Staff confirmed the patient's capacity to consent was discussed at their pre-assessment and they were made fully aware of the patient's individual needs. They confirmed for example; that some patients with learning difficulties had prior access to the theatre area so they could become used to the environment.
- Staff in critical care understood consent, decision making requirements and guidance. Staff received training regarding the Mental Capacity Act 2005 as part of their mandatory training at the trust. 93% of staff had completed this training which was in line with the trust target.
- Staff we spoke with in the maternity service, including community based midwives, and the children and young people's service demonstrated a clear understanding of Fraser Guidelines and Gillick competencies. (Gillick and Fraser competency is used to help decide whether a child is mature enough to make their own decisions. The Gillick competency and Fraser guidelines helps to balance children's rights and wishes with the trust's responsibility to keep children safe from harm. Gillick competence is concerned with determining a child's capacity to consent. Fraser guidelines are used specifically to decide if a child can consent to contraceptive or sexual health advice and treatment.) Completion of certificates

for terminations, in line with the Abortion Act (1967) and Abortion Regulations (1991), was carried out by two clinicians, which was in line with the legislation. We saw this was completed in the five sets of TOP notes we reviewed.
- DNACPR documentation on all wards we visited had improved since the previous inspection in September 2014. During this inspection, we reviewed 17 DNACPR forms from across all ward areas. All forms were completed in line with national guidance published by the GMC and the Resuscitation Council UK. All the forms reviewed included a summary of why cardio-pulmonary resuscitation was not in the patient's best interests and were completed in line with the trusts policy and the Mental Capacity Act (MCA).
- Nursing, diagnostic imaging, therapy and medical staff in outpatients and diagnostic imaging understood their roles and responsibilities regarding consent and were aware of how to obtain consent from patients. Patients told us that staff were very good at explaining what was happening to them prior to asking for consent to carry out procedures or examinations.

Are services at this trust caring?

Good

We rated caring as good because:

- We rated all core services as good for caring. Feedback from patients and relatives was very positive about the caring nature of staff.
- Staff displayed compassion towards their patients and those close to them.
- All patients that we spoke to during our inspection told us that they had been treated with kindness and staff were friendly.
- Privacy and dignity was generally maintained during all interactions and assessments with patients in areas visited
- Staff recognised when patients needed extra support to understand their care and treatment and adjusted their communication styles when necessary.
- Bereavement and mortuary services staff supported families of the bereaved with kindness, sensitivity and respect.

Compassionate care

- Patients and those close to them were treated with respect in almost all interactions that we observed. Staff were respectful, polite and compassionate to patients despite the limited space and restrictions of the environment in some areas.
- Staff took the time to interact with patients, relatives and those accompanying them in a caring manner. We saw staff treating patients and using humour to calm anxious patients.

Summary of findings

- The hospital used the “Hello my name is” scheme. The aim of the introduction was to help preserve patients’ dignity, promote respect and the best practice in the way they were approached. However, it was unclear if this campaign was well embedded within the service. For example, staff wore their photo identities clipped to their hip pockets. We did not observe staff wearing a name badge so they could be easily identified. Also, staff did not introduce themselves to patients for example; when entering a side room and conducting a handover.
- Patients we spoke with told us ‘the staff are always smiling’ and that the staff had introduced themselves by name. Patients told us that the nursing care was excellent. They said the staff worked hard and were kind, gentle and courteous. A patient commented they were always treated with respect and dignity.
- Staff took the time to interact with children and young people and those close to them in a respectful and considerate manner
- Privacy and dignity was generally maintained during all interactions and assessments with patients in areas visited. All staff showed an awareness of respecting their patient’s privacy and dignity by closing curtains around all cubicles. We observed doctors drawing the curtains before they examined a patient and nursing staff drew the curtains before personal care was provided.
- We observed numerous acts of kind and compassionate care by staff in critical care including staff taking extra time with patients to support them making their own meal choices by ensuring they had their glasses if required and talking slowly through menu choices. Staff often remembered patients favourite meals and told them when these items were on the menu. We observed staff repositioning patients who were unconscious and ventilated, staff talked to the patients despite this and still explained what they were doing and were gentle and considerate during movements.
- Women, partners and patients’ relatives we spoke with were positive about the care they had received on the delivery, maternity and gynaecology wards. One woman said, “The staff here are very caring towards us, I have no complaints about my care here”.
- We observed staff supporting and treating patients in a kind and caring manner. We followed one child who was undergoing surgery that day on their journey to the operating theatre. We saw that they were supported by a play specialist and that good distraction techniques were used to minimise any distress to the child.

Summary of findings

- Nurses, doctors and the specialist palliative care team (SPCT) demonstrated compassionate patient centred care throughout the inspection. Patients said staff were caring and compassionate and treated them with dignity and respect. Patients told us staff discussed pain relief and their nutritional requirements with them regularly. They told us the SPCT had been approachable and friendly and had spent time with them and their relatives to answer any questions and concerns they had.
- Patients said the nurses had a good understanding of their care needs and were very 'kind.' Nurses would spend time with them whatever time of day or night it was and went the 'extra mile' to ensure care was meeting their needs. A patient said, "The nurses and doctors are very caring and kind and are always available to answer my questions. If they cannot answer them straight away, they will find someone who can and always come back to me with an answer".
- We spoke with 36 patients and relatives from outpatient clinics including fracture, dermatology, ENT, ophthalmology, medical oncology, x-ray, ultrasound and chronic pain clinics. They all spoke highly of the care they had received and described staff as 'brilliant' and 'supportive'.
- The results of the Care Quality Commission A&E survey 2014 (published in March 2015) showed that the trust scored about the same as other trusts in all of the 24 questions relevant to caring.
- The response rate for medical care for the Friends and Family Test (FFT) between August 2015 and July 2016 was 19%, which was worse than the England average of 26%. The response rate analysed by wards varied from 2% for Ambulatory Care to 59% for Clifford Ward and Lilford Ward. The percentage of respondents saying they would recommend the service was in the range 90-100% for the Cardiac Centre, Clifford Ward and Lilford Ward. The other wards had lower scores but were mostly above 70%. The lowest scores were reported by Ambulatory Care and Naseby Ward B.
- The PLACE audit 2016 score for ensuring patients were treated with privacy and dignity ranged between 50% and 80%. For example, the audit showed Ashton ward at 50% and Geddington ward at 80%.
- The hospital submitted data to the FFT. The data provided showed the average FFT response rate was 14% which was worse than the England average of 29% from August 2015 to July 2016. However, between 93% and 100% of patients said they would recommend the service provided by the trust.

Summary of findings

- The ICU carried out internal patient and relative surveys as friends and family tests are not always well responded to following a patient's discharge from the ICU due to its nature. The most recent internal surveys showed that 100% of patients felt they were treated with dignity and respect. Comments within the surveys included, 'Everyone has been very helpful, friendly, chatty and sympathetic when required.'
- The maternity service performed the same as other trusts in the three main areas; labour and birth, staff during labour, and care in hospital after birth in the CQCs Maternity Survey of Women's Experience of Maternity Services 2015. Between August 2015 and July 2016, the trust's maternity FTT performance (% recommended) was generally better than the England average in all four areas of maternity.
- The FFT score for the gynaecology service in July 2016 was 97% of patients recommending this service, which was better than the national average of 95%.
- Feedback from the children and young people's survey 2014 scored positively against the 14 questions asked in relation to staff care and was largely similar to other trusts in England. For example, when asked, 'did you feel that your child was well looked after by hospital staff', an overall score of 9.08/10 was achieved and when asked, 'were you treated with dignity and respect by the people looking after your child' the trust scored 9.22/10 overall.
- The outpatients' department regularly scored above the England average in the NHS Friends and Family Test. The NHS Friends and Family Test asked people if they would recommend hospital services. Positive recommendation results had been at 95% or above since October 2015. In August 2016, 97% of respondents said they would recommend the outpatient services at this trust. There were 1,452 responses of an eligible 15,645 patients, equating to a 9% response rate. This was above the proportion of responses received across England, which was 6%. Patient comments from the NHS Friends and Family Test praised the friendly atmosphere, thanked staff for their help and noted their 'polite manner' and 'lovely attitude'.
- The hospital was part of the National Cancer Patient Experience Survey 2015. Results for the outpatient department were in line with or better than the England average. Questions covered aspects such as receiving understandable information, staff explaining test results and being able to contact a clinical nurse specialist for support. For example, 94% of respondents said they knew who to contact if they were worried about their condition or treatment after they left hospital.

Summary of findings

Understanding and involvement of patients and those close to them

- Patients that we spoke to told us that they had felt involved with their care and understood the treatment they were receiving.
- All patients we spoke with told us they were informed of their treatment plan and potential diagnosis throughout their visit. They said the doctors were thorough in taking down all the information needed from the patients. Most patients knew the name of their doctor.
- A patient told us the doctors gave them the success rate of a procedure and informed the patient of the possible complications. Another patient said the doctors spoke concisely and responsively.
- Patients said doctors and nurses kept them informed of what was happening during their time within the ED. Relatives felt welcome and were able to sit with their family member. They were kept informed if the patient consented.
- Staff recognised when patients and those accompanying them needed additional support to help them understand their care and treatment; this included access to translation services.
- We observed relatives being met at the intensive care unit (ICU) entrance when their relative had first been admitted; staff explained the ICU processes and what they could expect when visiting their relative. Relatives we spoke with said they had been given time with the nurses and doctors to ask questions.
- We saw staff communicated well with women when attending their gynaecological appointments and on arrival to the delivery suite so that they understood their care, treatment and condition. Women and their partners we spoke with on the maternity ward told us they felt involved and reported that communications with staff were good throughout their stay.
- A relative said “The SPCT have been wonderful and are keeping me involved in the care of my relative so I know what is happening which takes some of my anxieties away”.
- The results of the National Care of the Dying Audit of Hospitals (NCDAH) 2014/15 and published in 2016 showed that 71% of patients had been recognised as dying at the end of their life and this had been discussed with the patient’s nominated individual. This meant in most cases there was documented evidence that a professional had informed a relative that the patient was expected to die in the coming hours or days. However, this was worse than the England average of 79%.
- We saw examples of carers and relatives in outpatients being actively involved in patient care. For example, the chronic pain

service offered appointments solely to provide advice and education to patients' relatives. Staff, patients and their families spoke highly of this and felt that it had improved their treatment outcomes.
- We observed staff changing their communication styles and speaking slower for patients who appeared to have difficulty understanding what was being said.

Emotional support

- Staff showed patience and understanding when interacting and treating patients. We saw and were told by patients they provided timely support and information to help patients to cope emotionally with their care and treatment.
- With young patients and parents, we saw that staff were sympathetic and reassuring when they were nervous and this helped to put them at ease.
- Staff had good awareness of patients with complex needs and those patients who may require additional support should they display anxious or difficult behaviour during their visit to the service. Staff monitored patients for signs of anxiety and depression.
- Staff directed patients and those accompanying them to services that provided counselling and support for patients with specific conditions.
- Staff monitored patients for signs of anxiety and depression.
- We observed staff assisting relatives following the unexpected death of a patient, they allowed relatives as much time as necessary on the ward and a member of staff ensured they were available to answer questions and provide emotional support.
- A dedicated bereavement midwife led on bereavement services for women who had experienced pregnancy loss.
- Midwives provided support for women who had experienced pregnancy loss to collect keep sakes such as photographs. This was in line with the Sands guidelines 'Pregnancy loss and death of a baby' 2016. (Sands is a stillbirth and neonatal death charity aims is to improve the quality of care offered during pregnancy and in the event of a baby dying. They work in partnership with health professionals and others to minimise the risks of stillbirth and to ensure the families of those babies who do die receive the best possible care.)
- The trust bereavement survey 2014 to 2016 identified that 23% of relatives reported their family member's spiritual needs were being met; 5% of relatives said, no - their family members spiritual needs were not being met but wished they had been,

Summary of findings

and 49% of relatives said no, as it had not been required. Twenty six per cent of relatives said they would find a bereavement follow up service helpful, 64% said it had not been necessary in this instance but they would find it helpful in the future. The chaplain said he was exploring the possibility of developing a bereavement service for relatives at the trust.

- Staff understood the impact that a patient's care, treatment or condition had on their wellbeing and on those close to them emotionally. The SPCT told us emotional, psychological and bereavement support and advice for families was an important part of the service. Patients and relatives we spoke with told us the SPCT had provided them with emotional support.
- Patients we spoke with said that they had been encouraged by staff to contact external agencies for further support outside of the hospital. For example, MacMillan support groups and the 'Heart to Heart Cardiac Support Group'. Staff in the chronic pain service were in contact with a local independent chronic pain support group and encouraged patients to contact them.

Are services at this trust responsive?

Requires improvement

We rated responsive as requires improvement because:

- Bed occupancy at the trust had been consistently higher than the England average over time. Patient flow and bed capacity to meet demand had been a significant pressure for the trust for a number of months. Bed occupancy was reported as 104% and the trust had 82 delayed transfer of care (DTOCs) patients on the day of our unannounced inspection. Discharges were sometimes delayed due to patients having to wait for ongoing care packages.
- The emergency department (ED) was not consistently meeting national targets for service delivery but it had shown improvements in the last three months with performance better that the England average. From July 2016 to October 2016, the average performance against the target was 88%. The percentage of patients waiting between four and twelve hours after a decision had been made to admit was comparable to the England average.
- Patients were unable to access the majority of services in a timely way for initial assessments, diagnoses or treatment. At the time of inspection in October 2016, the service had 18,816 patients on the waiting list for new appointments in outpatient services. Trust data showed that 413 patients had been waiting over 52 weeks; however, this data had not been validated so we

could not be assured of how many patients waited for long periods of time. The services' own figures from October 2016 showed that 69% of patients were seen within 18 weeks (for incomplete pathways) against the national standard of 92%.

- The services' own figures from October 2016 showed that 69% of patients were seen within 18 weeks (for incomplete pathways) against the national standard of 92%.
- The hospital was not nationally reporting referral to treatment time (RTT) performance for incomplete pathways at the time of inspection due to historical problems with the validity of data.
- At the time of inspection, there were 11,733 images awaiting a radiology report. These were classified as non-urgent images and scans. The service was meeting performance standards for urgent images and scans.
- From April 2015 to March 2016, the "did not attend" (DNA) rate for the hospital was 8%, which was higher than the England average of 7%. The DNA rate remained above the England average and at the time of inspection was 10%.
- The hospital reported a total of 143 cancelled clinics were cancelled within six weeks of the clinic date in October 2016. This was 3% of clinics were cancelled that month.
- In surgery, there were currently 218 patients who had to be re-assessed due to having exceeded the three month pre-assessment period. This meant that these patients would have to be re-assessed prior to coming in for their surgery. Referral To Treatment (RTT) performance for November 2016 showed 85 ENT patients were waiting in excess of 18 weeks, with seven patients waiting for over one year, 68 patients waiting for maxillofacial treatment in excess of 18 weeks with five patients waiting in excess of one year, 40 patients waiting for urology treatment in excess of 18 weeks with two patients waiting longer than one year. Figures from October 2016, showed gynaecology was performing below the national standard of patients being seen within 18 weeks.
- Timeliness of discharges from the critical care was worse than the England average; this was mainly due to flow within the rest of the hospital. We saw that three patients had their admission to the ICU delayed due to capacity. These patients were cared for either in the emergency department or within theatre recovery.
- The trust did not collect data on the percentage of patients at end of life discharged within 24 hours to their preferred location.

Summary of findings

- In the children and young people's service, there was limited support from a psychologist for patients diagnosed with long-term conditions. There was limited support for patients with a learning disability. Communication tools for patients who were unable to communicate verbally lacked detail.
- Patients admitted to the ward with mental health needs or who required a musculoskeletal survey had long delays in waiting to be assessed and discharged.
- Some patients also experienced long delays waiting for treatment, specifically for urology, maxillofacial and ear, nose and throat (ENT). In some cases waits were in excess of 52 weeks.
- Outpatient services were not always provided in an environment that met people's needs. It was not always possible to run additional clinics to meet demand due to staffing and availability of facilities. This was raised as a concern in the previous CQC inspection in September 2014.
- Patients told us that it was difficult to contact the department to book, rearrange or cancel appointments.
- Reasonable adjustments were not always provided in ED to accommodate patients when receiving care and treatment.
- Maternity and gynaecology services were not always responsive to patient's needs
- Compliance with dementia awareness training was variable across wards.
- Complaints were not responded to on a timely basis or in line with policy but this was improving. No annual complaints report was produced for 2015/16.

However:

- The emergency department (ED) had introduced a frailty and therapy team to aid discharge for patients with complex medical needs and could be cared for in the community.
- From June 2015 to May 2016, the percentage of patients that left the ED before being seen was consistently better than the England average for that period.
- The 'butterfly' scheme was used to discreetly identify patients living with dementia. Staff had access to an Admiral Nurse to provide support when required.
- In surgery, private providers had been contacted to support the treatment of some of the trust patients on the waiting list. The cancer 62 day standard showed the trust had met 92% of urgent GP referrals.
- The trust recognised that performance against the nationally mandated cancer pathways was not as it should be. In January 2016, this became a key focus for improvement and a recovery

programme was initiated. Since April 2016, the trust had consistently delivered six of the seven cancer targets demonstrating sustainable improvement. The outstanding target to be achieved was 86.7% against a 90% trajectory.

- The trust's percentage of cancelled operations has remained below the England average since quarter one 2015/16.
- The ambulatory care unit included a consultant-led service to provide suitable patients with fast access to an assessment or intervention, without the need for an overnight stay in hospital.
- The majority of patients were admitted to critical care within four hours of the decision to admit and data showed there had been no patients transferred for non-clinical reasons.
- Refurbishment of the Rockingham wing was underway at the time of the current inspection to provide facilities to better meet needs of patients.
- There were overnight facilities for parents to stay on both the paediatric ward.
- The specialist palliative care team (SPCT) saw all referrals within 24 hours.
- A rapid response service discharge service enabled patients in the last eight weeks of life to be supported to die in their preferred location.
- Some specialities in outpatients had introduced one-stop clinics, which reduced the number of appointments patients had to attend and facilitated timely access to care.
- The trust had taken action to minimise the delays in diagnostics and imaging reporting by outsourcing their radiology reporting. At the time of inspection, there were 11,733 images awaiting a radiology report. There was a backlog of 337 images outstanding for plain film appendicular skeletal A and E films. The most outstanding image was ten days old.

Service planning and delivery to meet the needs of local people

- Services in ED were not always delivered in a way that took into account the needs of different people, in relation to age, gender, religion and disabilities. The waiting area in the children's ED had limited space, which meant that patients waited in the main waiting area and we observed those accompanying children standing in the children's waiting area.
- We saw that the ED was working closely with commissioners and other external providers to increase the provision of urgent care facilities to meet the needs of the local population. The urgent care improvement programme, which had started in 2015, focused on a number of aspects including time to

treatment, ambulance turnaround times, integrated discharge planning, patient flow and frailty services. The programme was on-going and included negotiations with the local authorities, other NHS trust and the CCGs.

- Senior managers within the ED recognised that the facilities were not adequate to meet the needs of the local people. Following discussions with the local commissioners, the ED had expanded the majors' area by the installation of a temporary 'pod' in May 2016 that increased the number of cubicles in the majors' area to 13. The ED also introduced the ambulance streaming bays to allow rapid access to treatment for patients. However, minutes from departmental meetings and conversations with staff at all levels confirmed that the children's ED area did not provide an adequate waiting area. There was limited space for seating and staff did not always have direct vision of children waiting in line with national recommendations. The risk related to staff not having direct vision of patients was highlighted on the departmental risk register; however, the lack of space had not been highlighted. At the time of our inspection, there were no firm plans for increasing space in the children's ED, whilst staff at all levels acknowledged that more space was needed. Senior staff were aware of the requirements and we saw that a number of options were being considered at the time of our inspection to re-design the ED. This included relocating to another floor in the hospital or expanding the existing area.
- Commissioners, other providers and relevant stakeholders were involved in planning services. The service did not provide a hyper-acute stroke service as they did not carry out thrombolysis, which is where blood clots are dissolved by infusing an enzyme into the blood. Patients requiring this treatment were transferred to another local NHS trust.
- Staff working in the medical care service felt they had worked well with local GPs, the local authorities, other healthcare providers and local charitable organisations, such as Dementia UK, to meet the needs and improve the health of the local community. Staff felt the communication within the multidisciplinary team was effective.
- The Ambulatory Care Unit provided a consultant-led facility for suitable patients to have advanced assessments and interventions that could safely be completed in a day, without the need for an overnight stay in hospital. This service was appealing to patients because they were able to make an appointment to see their consultant and have the assessment

or intervention done with less waiting than before, and were able to return home the same day. It was also cost-effective for the trust because it eliminated the cost of a bed and freed up beds.

- The waiting area within the maxillofacial surgical service was very congested. The department provided emergency treatment for all patient groups including regular attendances from prisoners and patients with severe facial disfiguration at various stages of their cancer treatment. There was no waiting room to provide privacy for these patients. However, the service had prepared a business case that had not yet been approved by the trust board at the time of the inspection that would redesign the service in a new more spacious location. This area had been highlighted as a concern within the local surgical risk register.
- In autumn 2015, the hospital had introduced a new laser operation to support patients who required treatment for benign enlargement of the prostate by using a light laser to reduce the size of the prostate. This process reduced the surgical time and the length of stay was no more than one day. The trust continued to provide this service through a day case procedure.
- The trust had put forward a business case (in May 2016) to enhance the service it offered to spinal patients by working collaboratively with other local hospitals. The proposed partnership arrangement would include a combined spinal on-call rota which would support the hospital's patients having access to an on-call spinal consultant 24 hours a day, seven days a week. As of November 2016, the business case was currently under negotiation with a local hospital with a view of ascertaining how they can reduce the financial cost of the scheme.
- There was no midwife led birthing unit (MLU) at the hospital. All babies delivered were on the consultant led delivery suite. Midwifery-led models of care were offered to women with an uncomplicated pregnancy as recommended by NICE CG 62. As part of its business planning strategy, the trust was reviewing whether to have an MLU.
- During our last inspection, we found the provider was aware that the current shower and toilet facilities in some of the maternity wards were not fit-for-purpose, or compliant with disability requirements. Refurbishment of the Rockingham wing was underway at the time of the current inspection to provide facilities to better meet needs of patients
- Priorities and proposed developments for paediatrics lacked detail and evidence and it was not always clear what the

priority or aim was. For example one priority was listed as, 'neonatal block contract', aim to increase profitability, but there was no detail as to how this would be delivered, whether there was demand for this, there were no agreed actions or timescales. A proposed service development was to 'tailor paediatric work to accommodate medical/surgical demand'; there was no detail as to what the current issues were, why this was needed or how and when it would be delivered. For resources, equipment was listed for purchase, but there was no justification or reason as to why equipment was required. The plan included recognition to improve the care pathway for asthma patients, this also lacked detail and it was unclear from the information within the plan what had led to this as a priority.

- The plan did not include an analysis of capacity and demand for the previous year, or any assessment of operational data and performance for example, the number of emergency and non-emergency admissions, did not attend (DNA) rates, referral to treatment time (RTT) rates, length of stay (LOS) for specific conditions. Information which is essential in monitoring performance for the previous year as well as informing objective setting and agreeing suitable actions to develop and improve the service.
- The SPCT saw 923 patients in the reporting period April 2015 to March 2016. The trust did not routinely collect separate data on patients who had cancer or did not have cancer. However, data was captured by the SPCT and recorded on monthly referral sheets. In June 2016, of 43 referrals to the SPCT, 29 had a diagnosis of cancer. All patients were seen within 48 hours of referral to the SPCT in the reporting period, April 2015 to March 2016. Patients who were identified as requiring end of life care were referred to the SPCT by individual consultants, ward staff or the lead chaplain. The hospital did not have any designated beds for end of life care, staff delivered end of life care in most wards and were supported by the SPCT.
- The facilities and premises were not always appropriate for the services that were delivered. For example, the environment in the outpatient department at Kettering general hospital did not always allow patient confidentiality to be maintained; clinic rooms in the haematology department were not all soundproof and patients could be overheard when in consultations. In addition, patient consultations took place in in open cubicles without doors in the ophthalmology department.
- We saw occasions where the environment and lack of space had a negative impact on patients' privacy and dignity. For example, inpatients waiting for x-rays in their hospital beds

were in view of the outpatients' waiting area. Also, patients in the ophthalmology clinic were given eye drops in the corridor where other people were waiting because there were no other rooms available.

Meeting people's individual needs

- There was an effective system in place to flag patients with a learning disability who may be admitted or who might attend an outpatient clinic. Any member staff above Band two could add such a flag and there was a facility for additional comments. The standard was for all inpatients to be flagged within 24 hours of admission; compliance with this was between 94% and 98%.
- A specialist learning disability nurse was employed to work at a strategic level by the local clinical commissioning groups: they were based at Kettering General Hospital. They had access to hospital database and were able to produce a report at any time of inpatients with a learning disability.
- Each patient with a learning disability should have had a 'helping me in hospital book' or patient passport which was a short four page booklet about the patients with the aim to help staff to meet their needs appropriately.
- Learning disability awareness was included in the trust induction programme, although not on the one for medical staff. However, the learning disability nurse had attended 'grand rounds' to spread learning. Mortality reviews were completed to all patients with a learning disability using the route cause analysis process. A lack of mental capacity assessments had been identified as a theme. A patient feedback tool using felt pictures had been developed to capture the experiences of patients with a learning disability, whilst the numbers were too low to draw out themes it was an example of inclusiveness.
- Reasonable adjustments were made in medical care wards so that disabled people could access and use services on an equal basis to others. In the endoscopy unit, we were told that carers were allowed to sit with learning disability patients until their procedure time. This meant that patients were kept calm and anxiety was reduced prior to their procedure. Staff were able to articulate how they managed patients with dementia and learning disability. We were told that if patients were known to have either dementia or learning disability, their time slot would be prioritised.

Summary of findings

- In ED, reasonable adjustments were not always provided to accommodate patients when receiving care and treatment. The department did not have clear pathways in place to support patients with complex needs such as people with a learning disability and people living with dementia.
- The children's waiting area had limited distraction items for all ages and no access to a play specialist. The intercollegiate document 'Standards for Children and Young People, 2012' recommends that EDs that see 16,000 children a year should employ or have access to a play specialist to ensure that the environment is child-friendly. Staff told us that they did try to make the environment more suitable for children by designing their own artwork and decorations for the department.
- Deene B (surgical ward) had introduced a patient diary that involved patients in their own recovery. The diary provided advice and set out expectations which included the importance of exercise, and what to do after discharge such as eating nourishing foods and drink.
- Gynaecology services were not always responsive to patient's needs for example; there were no side rooms on the gynaecology ward. This meant that women who were having a termination due to abnormalities were cared for on the delivery suite in rooms next to women delivering healthy babies. The issue was on the trust risk register.
- We found that the antenatal clinic was also used as a gynaecological clinic, and we observed both maternity and gynaecology clinics running concurrently. This meant gynaecology and obstetrics patients and women attending for these appointments shared the same waiting room and clinic times this meant that patients who may be having difficulty in conceiving or had experienced miscarriage were sharing the same area with pregnant women and this was not sensitive to their needs. This risk had not been identified by the service.
- Staff provided women who had undergone termination of pregnancy (TOP) with an information leaflet about the disposal of pregnancy remains. Women were asked their preferred option for the dignified option of disposal. This ensured that women were given the opportunity of making informed individual choice. We saw completed documentation in TOP notes we viewed. There was guidance on the disposal of pregnancy remains following pregnancy loss or termination, which were in line with guidance provided by the Human Tissue Authority Guidance on the disposal of pregnancy remains following pregnancy loss or termination March 2015 and RCN guidance about managing disposal of pregnancy remains October 2015.

- The paediatric ward had a dedicated sensory room, which was used for patients with visual impairment as well as other patients who may benefit from this. We observed children and their parents in this room and the children found this a wonderful and exciting experience.
- There were arrangements in place with the Child and Adolescent Mental Health Service (CAMHS), which was provided by another local NHS trust. CAMHS telephoned the ward each morning (Monday to Friday) to establish whether children had been admitted overnight or during the weekend. A member of CAMHS staff then visited the ward to make a psychological assessment of the child.
- End of life care champions had received training in the care of patients with a learning disability or with a diagnosis of dementia. We saw evidence of where that training had been cascaded by the end of life care champion to staff on wards and in clinical departments.
- Staff had access to language translation services and interpreters. Information on how to access these services was in all departmental policies and on display in staff areas. All staff we spoke with knew how to access the translation services. Staff had access to a range of appropriate leaflets for a variety of support services in the community, which they could give to patients and relatives if required.
- There was a bereavement counselling service available for patients' relatives.
- We were told assistance was provided for believers of most faiths. There was access to a chaplaincy service. The chaplain provided services and was assisted by many lay ministers including 60 chaplaincy volunteers and 48 ward-based volunteers.

Dementia

- The trust had an electronic flagging system for patients living with dementia from which they could view how many inpatients there were who were living with dementia at any time.
- An action plan to deliver improvements to the care of patients living with dementia had commenced with particular focus initially on the dementia wards. Referrals to the dementia nurse were completed by the ward staff. Many of the patients living with dementia were cared for on Naseby wards where activity co-coordinators were employed to help keep patients occupied and calm. There was also a lead consultant for dementia care.
- The trust worked closely with Dementia UK who provided an Admiral Nurse (a dementia specialist nurse) to assist patients

and their families, and support and advise staff in the care of patients living with dementia. The "This is Me" assessment booklet was used to support staff's understanding of the needs of patients. The 'butterfly' scheme was used to discreetly identify patients living with dementia. Staff had access to admiral nurses to provide support when required.

- In Naseby ward, we observed patients living with dementia were encouraged to get involved in therapeutic activities. The ward had an activity co-ordinator who organised social and therapeutic activities for people living with dementia and older people in the ward who wished to join in. Group activities were held in Naseby A either in the ward area or in the activity room depending on the type of activities held. Patients from Naseby B would share in the group activities. The activity co-ordinator also arranged to take individuals for walks in the hospital grounds as they preferred. In Harrowden A, there was a designated activity corner for patients living with dementia. This had memory pictures and items for the patients to explore.
- Compliance with dementia awareness training was variable across wards. According to the nurse sensitive indicators for June 2016, Harrowden C had no staff that had had training with the trust target being 80%, whereas Twywell ward showed 100% of staff had had this training.
- Not all staff were in ED aware of the trust's dementia strategy. Staff were not able to direct us to any specific 'distraction items' or tools used to support patients living with dementia. The department's urgent care dashboard in July 2016 showed that 25% of staff in ED had received dementia awareness training against a target of 80%.
- A trust dementia steering group had been implemented.

Access and flow

- Bed occupancy at the trust had been consistently higher than the England average for the last seven quarters up to quarter one of 2016/17 where it was 98.5% compared to the England average of 90.1%. When the level rises above 85% it is generally accepted this could start to affect the quality of care provided to patients and the orderly running of the trust.
- The Department of Health target for emergency departments is to admit, transfer or discharge 95% of patients within four hours of arrival at ED. From August 2015 to July 2016, the ED did not meet the target and was worse than the England average. We saw that the ED had been making improvements with compliance with this target since January 2016 when the performance was at 77%. We saw they had worked with commissioners and stakeholders to develop an action and

recovery plan to improve performance in this area. This had included the extension of the majors' area to provide a dedicated escalation area and the introduction of the ambulance streaming bays. From August 2015 to July 2016, the hospital did not meet the 95% target. The hospital's performance fell to 77% in January 2016 before climbing up to 91% in June 2016. During our inspection, we saw that the ED was regularly achieving above 80% performance since June 2016, better the England average. The department achieved 91% in September 2016. In October 2016, the average performance against the target was 88% which was better than the England average of 84%. However, they were not consistently meeting the national target.

- Between August 2015 and July 2016, the hospital's monthly percentage of patients waiting between four and 12 hours from the decision to admit until being admitted for this hospital was generally worse than the England average. Between December 2015 and March 2016, performance against this metric showed an improvement, falling below the England average. April 2016 saw a sharp increase to 35% and although this fell back to 13%, it still remained worse than the England average up to July 2016. From July to September, the hospital performance against this metric remained worse than the England average at 12%, whilst the England average was 7%.
- Staff in the ED told us that they did not feel as there was a whole system approach to managing overcrowding in the ED. The trust used a live computerised system to monitor bed availability and staff told us there had been discussions related to individual wards and specialities entering bed availability directly onto a live system to avoid delays and ensure that ED were aware when a bed became available; this was not in place at the time of our inspection. The ED used an electronic system to visually display how many patients were in the department, number of patients waiting to be seen and who was waiting for a bed. This was a good visual aid to ensure safe tracking of patients and that they could be treated in a timely way. The site managers also knew how to use this system.
- From June 2015 to May 2016, the hospital's monthly median total time in ED for admitted patients was similar to the England average at around 150 minutes. Performance against this metric showed an overall trend of decline, with patients pending longer in the ED between June 2015 and August 2016. From June 2016 to August 2016, the ED performance against this standard was similar to the England average at 233 minutes.

Summary of findings

- The ED had an emergency decisions unit (EDU) for patients that attended ED and required a period of observation of no longer than 24 hours before they could be discharged. This function meant that admissions could be avoided for patients where a definitive decision to admit or discharge could be made after a specified period time; for example, patients who had sustained head injuries and were stable but awaiting the results of an x-ray or CT scan.
- From June 2015 to May 2016, the percentage of patients that left before being seen was consistently better than the England average for that period. The England average ranged between 3% to 4% and this hospital ranged between 2% and 3%.
- Not all necessary staff were aware of the organisation's escalation policy for the ED.
- Patient flow and bed capacity to meet demand had been a significant pressure for the trust for a number of months. Bed occupancy was reported as 104% and the trust had 82 Delayed Transfer of Care (DTOCs) patients on the day of our unannounced inspection. The DTOC patients comprised of 47 patients for further medical rehabilitation, 19 patients waiting for social care assessments and 16 patients awaiting further input from both health and social care. Senior managers were in ongoing discussions with commissioners and stakeholders regarding the most appropriate ways of managing the DTOC position as the medical care beds being used were placing a significant pressure on the effective patient flow through the service. The service was in the process of carrying out a bed remodelling exercise designed to improve patient flow. The medical care service had a robust escalation procedure in use for supporting demand for beds and at the time of the unannounced inspection, 23 escalation beds were being used. Staffing was flexed to these areas in accordance with the deflation procedures and the clinical site supervisors ensured all patients' needs could be appropriately met in these escalation areas and had been risk assessed by their relevant consultants.
- At times, medical care patients were placed in 'outlying wards' (such as the surgical wards): we saw robust policies and admission criteria in place governing this process. At the time of the unannounced inspection, there were nine medical outlying patients. Staffing and facilities were appropriate to meet those patients'' needs.
- We observed the site supervisors bed capacity meeting during one evening and saw that there was a clear, structured focus on patient safety and ensuring that appropriate staffing levels and skill mix were in place despite significant pressures on bed

capacity, due to a significant number of new admissions that day. The hospital was using a bed predictor model to forecast bed demand and capacity and the senior manager on call and clinical site supervisors liaised with all relevant wards and the emergency department to ensure patient flow and safety was maximised.

- The number of moves depended on the patients' medical conditions and the type of specialist care needed. Between July 2015 and June 2016, 75% of individuals did not move wards during their admission, and 25% moved once or more. These figures were trust wide. Separate data was not available for medical care. The number of bed moves after 10pm in July 2016 for the service was 146, which equated to about five patients being moved at night each day of the month. However, we did not have a breakdown of how many of these patients had been moved to clinical reasons, as opposed to bed capacity pressures.
- Between April 2015 and March 2016, the average length of stay for medical elective patients at the hospital was 5.4 days, which was worse than England average of 3.9 days. For medical non-elective patients, the average length of stay was 6.5 days, which was similar to England average of 6.6 days.
- The trust recognised that performance against the nationally mandated cancer pathways was not as it should be. In January 2016, this became a key focus for improvement and a recovery programme was initiated. Since April 2016, the trust had consistently delivered six of the seven cancer targets demonstrating sustainable improvement. The outstanding target to be achieved was 86.7% against a 90% trajectory.
- The hospital had a RTT recovery programme with a trajectory of validating 202,000 pathways by the end of November 2016. The data for October 2016 showed the hospital remained ahead of its performance improvement trajectory with a performance of 68% and was on plan to achieve the agreed 77% target level by the end of November 2016. A further 1,038,270 pathways were safely closed which equated to 95%. There were five low harms identified as of November 2016, one in ophthalmology, two in ear, nose and throat, one in trauma and orthopaedic and one in general surgery. In order to manage the recovery programme the hospital had increased the number of validators to 81, with 21 new validators joining the hospital at the beginning of October 2016. Weekend working had been implemented to maximise the management of "business as usual" (BAU) against

backlogs. As of October 2016, 100,704 patients had been validated; this was higher than the projected figure of 88,475. This meant the hospital's performance was running above the expected levels of 11,000 per week.

- The elective waiting list volume remained stable from March 2016 to October 2016. The records showed that the trajectory was to be agreed to support the active reduction of this list to 3,240 patients. Currently there were 5,573 patients with the highest being ophthalmology at 1,269. Ophthalmology remained the speciality with the greatest growth in waiting list volume with 25% more patients than at the start of the year (2016). Actions to manage the volume of ophthalmology patients had been created by the theatre productivity operation board. This involved process mapping the service and exploring off site facilities, equipment and resources to support the activity required within the speciality. They had an action date of November 2016 to review these plans.
- For the period (quarter two 2014/15) to (quarter one 2016/17), the hospital cancelled 537 operations. This was similar to the England average. Of the 537 cancellations, one was not treated within 28 days. As a percentage of elective admissions, cancelled operations fell during 2015/16, before peaking in quarter four. The hospital's percentage of cancelled operations has remained below the England average since quarter one 2015/16.
- The cancer 62 day standard showed the hospital had met 92% of urgent GP referrals (79 treatments and seven breaches) as of June 2016. This was in line with the national standard. The current patient pathways over 104 day wait for treatment was nine (four either had dates or were being treated). A weekly patient list meeting was held with the CBU and support services such as diagnostics. The meeting discussed patients at risk of breaching or who had already passed their target date.
- Between April 2015 and March 2016, there had been 624 admissions to ICU. Admission to the ICU required consultant oversight. Of these admissions, 0.8% had a non-clinical transfer out of the unit: compared with other units this unit was within the expected range.
- ICU occupancy had been above the England average since January 2015. The percentage of bed days occupied by patients with discharge delayed more than eight hours was 12.2%, compared to the national average of 5.3%. The trust provided additional information from April to June 16 which showed that the percentage of bed days occupied by patients with discharge delayed more than eight hours was 7.7%, as compared to the national average of 4.8%.

- The hospital was monitoring their RTT performance as part of their improvement plan. Figures from October 2016, showed gynaecology was were performing below the national standard of patients being seen within 18 weeks. 76% of patients were being seen within 18 weeks, although below the national standard of 92%, the hospital was on track to achieve their trajectory target of 77% by the end of November 2016. This target was agreed with the local clinical commissioning groups as part of the overall recovery plan for RTT performance.
- Between October 2014 and March 2016, the bed occupancy levels for maternity generally higher than the England average between October 2014 and March 2016 with the hospital having 66% occupancy in March 2016 compared to the England average of 61%.
- There were 4,926 admissions to the paediatric ward from 1 April 2015 to 31 March 2016, of which 95% were emergency admissions, compared to the England average of 65%. This may indicate a lack of senior decision making because consultant cover is only provided eight hours per day Monday to Friday, compared to the recommended 12 hours a day, seven days a week.
- Patients were unable to access the majority of outpatient services in a timely way for initial assessments, diagnoses or treatment. There were long waiting lists with patients waiting up to 52 weeks for outpatient services. At the time of inspection in October 2016, the service had 18,816 patients on the waiting list for new appointments in outpatient services. Trust data showed 413 patients had been waiting over 52 weeks; however their data was not validated so we could not be assured of how many patients were waiting for long periods of time.
- The NHS Constitution states that patients should wait no longer than 18 weeks from GP referral to treatment. All NHS acute hospitals are required to submit performance data to NHS England which then publically report how hospitals perform against this standard. The maximum waiting time for non-urgent consultant-led treatments is 18 weeks from the day a patient's appointment is booked through the NHS e-Referral Service,or when the hospital or service receives the referral letter.
- The hospital was not reporting RTT performance for incomplete pathways at the time of inspection due to historical problems with their data that occurred after an IT system upgrade in August 2015. The issues had compromised the validity of recorded waiting times on their patient tracking list which monitored how long patients waited for their first outpatient appointment. This meant the trust could not be assured that

they were monitoring the patient waiting times accurately or that patients were being seen within the 18 week national standard. They had not reported RTT performance nationally since November 2015 but planned to begin again by December 2016

- When the issues were identified in November 2015, there were eight patients identified as having waited over 52 weeks for an outpatient appointment. However, after validating the data, it was found that 25,000 patients were waiting over 52 weeks. The hospital was in the process of validating over 150,000 data entries on the patient-tracking list to ensure they were accurately recording and managing waiting times. At the time of inspection, they had 413 patients waiting over 52 weeks for their first outpatient appointment. This data had not been validated so we could not be assured of how many patients waited over 52 weeks.
- The service was monitoring its own RTT performance for incomplete pathways as part of their improvement plan. Figures from October 2016 showed that 69% of patients were seen within 18 weeks. This remained below the national standard of 92%, although performance had improved since March 2016 when only 30% of patients were seen within 18 weeks. The hospital was on track to achieve their target of 77% by the end of November 2016, which had been agreed with local clinical commissioning groups.
- Data provided by the hospital showed that the majority of medical specialities were performing below the national standard of patients seen within 18 weeks of a referral for outpatient services. Performance at the time of inspection was:
  - Medical oncology: 47%
  - Ophthalmology: 59%
  - ENT: 72%
  - Cardiology: 69%
  - General medicine: 84%
  - Clinical haematology: 76%
  - Dermatology: 82%
  - Rheumatology: 75%
  - Gynaecology: 76%
- The RTT performance for medical oncology had remained between 40% and 50% since April 2016. The hospital had an action plan to address this which included a data validation exercise that was completed in November 2016; performance had increased to 63% as a result. However, this was still below the national standard of 92% of patients seen within 18 weeks.

The hospital planned to meet the national standard by December 2016 by funding patients to receive treatment at external providers, such as local NHS and independent hospitals, from November 2016.

- Specialities that were performing in line with or better than the 92% national standard of patients seen within 18 weeks were gastroenterology and endocrinology, which were performing at 95% and 97% respectively.
- At the time of inspection in October 2016, the service had 18,816 patients on the waiting list for new appointment in outpatient services. This had remained relatively unchanged since July 2016. The hospital stated that this was due to their focus on validating their data during that period. Minutes from board meetings confirmed that their data validation programme occurred at this time and was completed at the end of September 2016. Ophthalmology and urology had the most patients waiting, with 1298 and 637 patients waiting for new appointments respectively.
- At the time of inspection, 9% of patients on the waiting list had been waiting over 31 weeks, 4% had been waiting over 40 weeks, and 2% had been waiting over 52 weeks for treatment. Data on their patient tracking list showed that there were 413 patients waiting over 52 weeks; this number had reduced from 25,000 and was better than the hospital's planned reduction trajectory that had been agreed with commissioners. The remaining 413 patients were being prioritised and risk assessed for clinical harm. The data was being validated to ensure accurate waiting times were captured.
- Referrals were prioritised by clinical urgency; suspected cancer referrals first, then urgent referrals and then routine referrals on a 'next in turn' basis. Suspected cancer and urgent referrals did not experience delays in accessing appointments.
- The maximum waiting time for suspected cancer referrals is two weeks from the day a patient's appointment is booked through the NHS e-Referral Service,or when the hospital or service receives the referral letter. The hospital had met the national standards for cancer waiting times since October 2015, apart from in August 2016, when the percentage of patients receiving treatment within 62 days of referral was at 79%. The national standards were:
  - 93% of patients should be seen by a specialist within two weeks of referral.
  - 96% of patients should receive their first treatment within 31 days of diagnosis.
  - 85% of patients should receive their first treatment within 62 days of referral.

Summary of findings

- Patients did not experience delays in receiving appointments for radiology and diagnostic tests. Since October 2015, the radiology department regularly achieved 100% of patients receiving an appointment for imaging within six weeks of the request.
- Image reporting delays has remained on the clinical business unit's risk register since November 2012, due to the risk of care being compromised due to potential pathologies not being identified in a timely manner. In order to mitigate this risk, some images have been outsourced to external companies, and additional work has been offered to hospital staff. The department monitors the backlog and we have seen evidence of increasing outsourcing been carried out when the backlog of reports have grown.
- In October 2015, the radiology service manager advised the hospital board of approximately 22,000 unreported examinations. Between February and April 2016, the imaging department undertook an exercise to reduce this backlog by outsourcing the reporting of images for CT, MRI and GP patients that were waiting for over 10 days. This was seen to bring down the backlog significantly by April. As of 23 February 2016 in CT, 145 patients and in MRI 184 patients were waiting up to three weeks for a report. This figure had dropped to zero patients waiting over 10 days by the 14 April 2016.
- In June 2016, the hospital joined a radiology consortium with six other NHS hospitals in the East Midlands to replace the existing picture archiving and communications system (PACS) and radiology information system (RIS). This was to enable images and reports to be shared across the hospitals for timely radiology reporting. However, there were issues with the reliability of the IT systems, which had a negative effect on productivity and turnaround. This meant patients were experiencing delays in receiving their scan results. The hospital had a backlog of approximately 4,700 patients when they commenced the PACS and RIS upgrade. This increased to 15,612 in September 2016 and affected the majority of specialities.
- All urgent referrals for imaging, including cancer imaging, were prioritised within two weeks. However, patients waiting for non-urgent imaging results were waiting up to ten weeks for CT scan results and up to 12 weeks for MRI scan results. Plain film images also experienced a delay, but posed the least risk due to the images being initially reviewed by the referring team. Patients waiting times for plain film image results were up to:
  - A&E limbs: 10 weeks
  - A&E chests: 14 weeks

  - Paediatric: 10 weeks
  - General outpatient plain film imaging: 16 weeks
- The backlog peaked on 22 September 2016 at 15,612 images awaiting a radiology report. At the time of the inspection in October 2016, the backlog had reduced to 11,733 images following measures taken by the hospital to reduce the backlog
- The trust had taken action to minimise this backlog by outsourcing their radiology reporting. At the time of inspection, there were 11,733 images awaiting a radiology report. There was a backlog of 337 images outstanding for plain film appendicular skeletal A&E films. The most outstanding image was ten days old. This had reduced in the month prior to inspection when there were 2,995 patients waiting up to a maximum of ten weeks.
- Since October 2015, the radiology department regularly achieved 100% of patients receiving an appointment for imaging within six weeks of the request. This was with the exception of November 2015, which was still significantly better than the England average.
- A CQUIN (national framework for quality and performance) was in place for end of life care to identify the reasons patients receiving end of life care did not die in their preferred place of death. Ten sets of notes from patients at the end of life were sampled between January and April 2016. Data for the first reported period, April to June 2016, identified 10% of patients had died in their preferred place of death. The notes review identified, two patients had died in hospital as were unable to return to their residential care home, as they required additional end of life care, and a third patient died awaiting continuing care funding which was an emerging theme from the two NHS trusts involved in the CQUIN for Northamptonshire.
- The end of life care discharge service had received 117 referrals in the reporting period April 2016 to July 2016. Of the patients, who had participated in the discharge service, 79% had died in their preferred place of death. There were eight inappropriate referrals to the service, due to patients either being outside the geographical area or referrals being too close to end of life and patients had died suddenly. 21 patients had died at the hospital, of which four had chosen the hospital as their preferred place of death. 13 patients had unexpectedly died and four patients had died awaiting packages of care.

Learning from complaints and concerns

- There was a complaints policy in place ratified in June 2016. It made appropriate reference to the duty of candour policy. The

chief executive was ultimately responsible for complaints in the trust supported by the director of nursing and quality who was the operational director lead. The trust had a head of patient experience responsible for the day to day management of complaints.

- Reporting of complaints to the board was via the quarterly report of the patients experience steering group, which reported to the integrated governance committee and onto the board. The integrated governance report to the board included a single indicator which was the percentage of complaints responded to within the agreed timescale. For April, May and June 2016, the trust had exceeded their target of 85%, achieving 90% or above for each of these three months. However performance had declined for July and August at 83% and 63% respectively. A restructure of responsibilities in the complaints team had been undertaken aiming to achieve an improvement on this performance. At the time of the inspection, senior managers told us that 89% of complaints were responded to within timescales.
- No annual complaints report was produced for 2015/16.
- We reviewed five completed complaints files chosen at random. All the complaints reviewed met the target for response of either 25 or 30 days. The acknowledgment letter clearly outlined the key questions being investigated and a date for the expected response back to the complainant. These letters also include the named individual in the complaint team for any queries. The complaint responses included a section" To summarise the learning from your experience I can advise …" it went on to list the key points of action for the trust.
- The trust sought feedback from complainants. For the period April to June 2016, 18 responses had been received:
  - 53% stated the timescale was not met
  - 28% stated the response did not answer their complaint
  - 61% rated process as poor
- There were 19 complaints received by the Parliamentary Health Service Ombudsman in the last three months of 2015/16. Three were accepted, 13 did not proceed two were not upheld and one was discontinued.
- The ED had not met the trust's timescales for responding to complaints in the period August 2015 to July 2016, but following the introduction of a revised complaints' policy in July 2016, with longer timescales for a response, improvements had been made in responding to complaints with an average response timescale of 29 days (in the period April to September 2016). At the time of our inspection, the department had six on-going complaints which were being investigated.

- The medical care service had not met the trust's timescales for responding to complaints in the period August 2015 to July 2016, but following the introduction of a revised complaints' policy in July 2016, with longer timescales for a response, improvements had been made in responding to complaints with an average response timescale of 31 days (in the period April to September 2016). The complaints policy was updated in quarter 1 of 2016/17, together with supporting publicity materials, such as a leaflet, an easy read leaflet and a poster. All public materials would be reviewed by the Patient Experience Steering Group before publication.
- The hospital received 125 complaints about surgery from August 2015 to July 2016 about surgical care services. The service took an average of 69 days to investigate and close complaints; this was not in line with the complaints policy in place (from July 2014 to July 2016), which stated complaints should be responded to within 25 working days. In July 2016, the hospital implemented a revised complaints' policy which stated that timescales for response letters to be sent were 25 working days for simple complaints, 30 working days for complex complaints or within the timescale agreed with the complainant depending on the nature and complexity of the complaint. From information provided by the hospital for the period April 2016 to September 2016, it took an average of 33 days to investigate and close and that 81% of complaints had been responded to in line with requirements of the revised policy. This represented an improvement in the way the service managed complaints in accordance with the new timescales detailed in the revised policy.
- The maternity service had not met the trust's timescales for responding to complaints in the period August 2015 to July 2016, but following the introduction of a revised complaints' policy in July 2016, with longer timescales for a response, improvements had been made in responding to complaints with an average response timescale of 27 days (in the period April to September 2016). This was now in accordance with the trust's policy. There had been 22 complaints made about maternity services between August 2015 and July 2016. Six of the 22 complaints related to problems with communication, four to the attitude and behaviour of nursing staff, and four to treatment by medical staff.
- In the children and young people's service, there were six complaints made from April 2016 to September 2016. We were provided with a summary of these complaints, which included details of immediate action taken, as well as lessons learned. The lessons learned lacked detail about how things would be

Summary of findings

improved, for example, the lesson learned for one complaint about medication and observations on the paediatric ward was, 'Identified need for medical and nursing staff to communicate effectively'. There was no further detail about how this would be actioned, when or by whom. Lessons learned did not feed into the local governance meetings. Complaints were not responded to on a timely basis or in line with policy. Each of the six complaints took between 37 and 62 days for the complainant to receive a response, which exceeded the target set out in the hospital's complaints policy of 25 days. As only a brief summary of the complaint was provided, it was not possible to determine whether the complaint was complex and required longer than the 25 days as per policy. The main theme was care and treatment on the paediatric ward.

- The outpatients' service had not met the trust's timescales for responding to complaints in the period August 2015 to July 2016, but following the introduction of a revised complaints' policy in July 2016, with longer timescales for a response, improvements had been made in responding to complaints with an average response timescale of 26 days (in the period April to September 2016). The most common themes of complaints were delays to treatment, communication and cancellations. This was not on the service risk register.

Are services at this trust well-led?

We rated well-led as inadequate because

Inadequate

- The board was still relatively new but had seen more stability since the last inspection. There was a lack of capacity to recognise and respond proactively to emerging risks given the focus on urgent priorities.
- The delivery of high quality care was not assured by the leadership or governance in place.
- There was a failure to make improvements following the last inspection. Risks identified at the last inspection had not been addressed.
- The trust governors had not recognised there was a lack of effective challenge by the non -executive directors to the board. The reporting structure for the board was based upon discussion and challenge to performance information and business plans at the trust management committee, with a lack of clearly defined and reported challenge at the public board meetings.

Summary of findings

- Although there was a trust vision and strategy, this was not fully underpinned by detailed, realistic objectives and plans that all staff understood and were able to describe. Understanding of the trust's vision and strategy was variable amongst the staff we spoke with.
- The trust had recently introduced new CARE values known as CARE but most staff had to yet really understand how these impacted their work and embed them into ways of working.
- There were not effective systems in place to report and learn from risk with a lack of a robust effective system for identifying, capturing and managing risks at team, directorate and organisation level.
- Significant issues that threatened the delivery of safe and effective care were not always identified, and where risks were identified, adequate management of the risks, including assessment, mitigating action, and review, was not always demonstrated. There was not a clear understanding between the risks and issues within the services and teams.
- The areas for improvement identified by the nurse sensitive indicators and ward dashboards had no direct correlation to the services risk registers. Ward dashboards referred to some local risks but these were not systematically escalated to the service risk register.
- We found that the clinical business unit risk registers that were in place at the time of the inspection did not accurately reflect the risks to patient safety and the quality of care and treatment. The corporate risk register similarly did not reflect all known risk and appropriate mitigations.
- There was not a holistic approach to the monitoring of safety and performance data, supported and informed by robust, ongoing clinical audits in all services underpinned by robust action plans to drive improvements. We were therefore not assured staff at every level in the service had a robust understanding of all the risks to patient safety and were able to assess, mitigate and monitor all known risks.
- Whilst the trust had a quality improvement team, who maintained an overarching quality improvement plan: we found this plan did not directly link to the Health and Social care Act (2008) regulatory breaches that we identified on the last inspection, or to all risks on local risk registers.
- Not all staff were fully aware of the hospital's plans to remodel the beds in the hospital, which was designed to improve patient flow. A minority staff expressed low levels of satisfaction, high levels of stress and work overload.

- Effective fit and proper person checks were not in place. There was not an understanding of the requirements of the fit and proper and person's regulation at board level.
- Many initiatives that the trust were now introducing had been used in similar trusts for some time. Historically, there had been a lack of innovation within the trust coupled with a lack of effective peer benchmarking to help inform improvement plans.

However:

- The majority of staff did feel respected, valued, supported and appreciated. Some members of the board were visible and well known to staff.
- The trust had placed equality, diversity and inclusion at the centre of everything that it did.
- The vision was for the trust to progress from being an acute hospital to being an integrated provider of health services. By 2020, the trust aimed to have revitalised the current site and to become a health and wellbeing campus.
- The trust was participating in a wide-ranging extended clinical collaboration with another local acute NHS trust and other partners in the local health economy, stretching across all clinical specialties.
- The trust was also developing a new Faculty of Health Improvement and Innovation with the focus optimising elective care, urgent and emergency care, outpatients' performance and agency usage (nurses and doctors).
- The trust had implemented a range of health and wellbeing initiatives for staff including yoga, weight management and the hospital had now become a smoke free site. Staff feedback on these initiatives was positive.
- The Patient Experience Steering Group had launched new initiatives to engage with patients and the public.
- The trust was implementing a new dementia strategy to ensure patients with dementia had a better patient experience.

Leadership of the trust

- Other than the medical director who had been in post six years, the remaining executive directors had been in post three years or less, with the chief operating officer starting in early 2016. The board was therefore still relatively new but had seen more stability since the last inspection. The director of strategy and governance was acting as the chief executive officer at the time of the inspection.
- The trust chair had been in post for three years with three non-executives joining in the last three years. The chair had taken

the opportunity when the posts became available to review the mix of skills and experience and secure a non-executive team that had skills in clinical issues, commercial and strategy, finance, operational issues and quality.

- The council of governors consisted of 25 members, 13 of which were publically elected members; eight were nominated stakeholder representatives and four staff elected members. Public and staff governors were elected for a three year term with no governor being allowed to stand for more than two terms.
- The leadership team were clear about the strategic direction of the trust but lacked capacity to drive improvements in a timely fashion. They had not appropriately recognised some key risks and given their focus on urgent priorities such as the emergency department performance and the data validation programme for referral to treatment times (RTT) reporting: there was a lack of capacity to recognise and respond proactively to new and emerging risks.
- Key stakeholders expressed the view that, for a long time, the trust was inward looking and had only relatively recently began to fully engage with relevant partners and peers outside the trust to develop appropriate initiatives to drive improvements. The chief operating officer was newly appointed and had started to lead a more effective approach to understanding and addressing the RTT performance issues for the trust. The director of estates had been in post a year and had taken action as a priority to review the infrastructure of buildings and premises and to develop plans to address longstanding issues of concern, such as the limited car parking on site.
- The trust told us that the trust had led and had been influential in a number of countywide initiatives, some of which commenced before the previous inspection with others being launched over the past two years. Examples were:
  - The CEO has been the senior office for the clinical collaboration work with partner organisations in Northamptonshire bringing together services to provide joined up services and care for patients in the county. This had led to the development of a formal Federation between the two acute trusts, which was an innovative and new way of working.
  - The trust had been influential in creating a shared clinical oncology centre for south east midlands (SEMOC) with partner NHS trusts. The trust also chaired the new SEMOC steering group driving the improvements to care of patients receiving chemotherapy.

- The trust deputy CEO had chaired the regional Patient Safety Collaborative on behalf of the Academic Health Service Network (AHSN) and had been influential in establishing good partnership working and key work stream priorities for patient safety across east midlands. The trust had therefore been very much engaged in this work and a project to map organisational safety culture.
- The Director of Nursing and Quality had been an active member of the East Midlands Leadership Academy board for some time.
- The Director of Strategy and Medical Director developed and established the clinical collaboration work since 2014 which has brought clinicians together to create patient care pathways for dermatology and rheumatology which were to be launched in April 2017.
- The trust CEO was a member of the national NICE guidance forums.
- The trust Head of Compliance chaired the 'allocate healthassure' regional forum to create systems to enhance monitoring and support continuous improvement. This had enabled the trust to create innovative data capture systems to support continuous quality improvement which have been award winning for the past three years.

- The trust governors had not recognised there was a lack of effective challenge by the non -executive directors to the board. The reporting structure for the board was based upon discussion and challenge to performance information and business plans at the trust management committee, with a lack of clearly defined and reported challenge at the public board meetings. The trust told us that the governors were present at the board and subcommittee meetings and gave feedback at the end of each meeting. The trust said that their feedback had reflected an appropriate level of challenge. In addition, Healthwatch was present at the board and also provided feedback at the end of the meeting.
- The director of nursing and quality and the medical director were visible in some areas of the service.
- The leaders of the emergency department understood the challenges that they faced and were proud of the improvements that had been made since they joined the trust and took on their roles. However, they also recognised that they still had work to do to achieve their vision and objectives, which was to ultimately deliver safe quality care through

improvement and continued development of staff and processes. There was a lack of capacity in the leadership team to consistently embed learning from incidents and audits throughout the ED to drive improvements.

- Staff reported that leadership within medicine and surgery was very strong, with visible, supportive, and approachable managers. All staff felt that there was a positive working culture and a good sense of teamwork, which was open, honest, and transparent.
- In the intensive care unit (ICU), there had been some changes in leadership individuals over the previous six months. Staff told us that all new leaders were very welcomed, and felt that they bought new ideas and determination to improving the ICU. Lines of accountability and responsibility in ICU were clear and staff understood their roles and how to escalate problems. There were three nursing teams with a Band 7 critical care nurse led each nursing team. Nurses told us that the matron was visible and aware of all incidents. Senior staff fed back results of incidents to staff through the morning brief safety huddles and safety bulletins. The leadership team in ICU had acted upon the areas of concern identified by the last inspection
- There was a clear management and accountability structure in place for midwives and nurses, which included community midwifery. The department had a documented accountability structure. Gynaecology nursing and midwifery leads reported into the head of midwifery, who was also the Clinical Business Unit (CBU) lead for women's and children services. They provided operational leadership. Medical staff reported to the clinical director. Medical staff reported to the clinical director via the consultant obstetrician who was the medical clinical lead. Senior midwifery management had direct access to the trust board. However, there was limited evidence to demonstrate information about how midwifery issues were taken to the board. We did not see evidence of midwifery issues discussed in board minutes so we were not confident the board had oversight and understanding of all the issues affecting maternity service. During our last inspection, we found a lack of medical leadership and scrutiny regarding performance indicators. The trust told us they had set of expected standards and behaviours for its operational leaders however, staff we spoke with were not aware of this. We did not see any evidence that the leadership had changed or that this had been addressed on the current inspection.
- The director of nursing and quality had a responsibility to the board for maternity services. The trust told us they had a

nominated non-executive director with responsibility for maternity services however they did not identify who this was and staff we spoke with were unaware of the non-executive director with responsibility for maternity services was.

- The medical director and director of nursing and quality were the board representatives for end of life care. There was also a non-executive director lead that provided representation and accountability for end of life care at board level. There had been a change in local leadership in the past year and there was a positive focus on driving improvements in the service and concerns found at the last inspection had been mainly addressed.

Vision and strategy

- The trust had a five year strategy (2015-2020). This detailed the strategic objectives as:
  - To provide high quality care to individuals, communities and the population served.
  - To be a clinically and financially stable organisation.
  - To maintain a fulfilling and developmental environment for our staff.
  - To be a strong and effective partner in the wider health and social care community.
- The vision was for the trust to progress from being an acute hospital to being an integrated provider of health services. By 2020, the trust aimed to have revitalised the current site and to become a health and wellbeing campus.
- The trust had implemented a new Faculty of Health Improvement and Innovation with the focus on optimising elective care, urgent and emergency care, outpatients' performance and agency usage (nurses and doctors). The faculty was designed to link the recovery programmes to CBU performance and productivity. The trust had recruited to some posts including a new director of transformation. The improvement programmes under the campaign 'we will care together' were also established by the time of the inspection and was being monitored at an established weekly briefing.
- The trust was participating in a wide-ranging extended clinical collaboration with another local acute NHS trust and other partners in the local health economy, stretching across all clinical specialties. The transformation project was planned to take place from 2016/2017 to 2020/2021 and would deliver better health services to patients at lower cost to the taxpayer.

Summary of findings

- Not all staff were fully aware of the hospital's plans to remodel the beds in the service, which was designed to improve patient flow. Some staff described it as a 'stop, start' process with delays in the reconfiguration of beds and wards. Staff were not generally aware of the timescales for this reconfiguration.
- To support the delivery of the strategy the trust had developed the 'We will care together recovery and transformation programme'. In the current year the focus was on improving patient experience of urgent and emergency care and of elective care and treatment.
- Although there was a trust vision and strategy, this was not underpinned by detailed, realistic objectives and plans that all staff understood and were able to describe. Understanding of the trust's vision and strategy was variable amongst the staff we spoke with.
- The trust's quality strategy had the focus on four work streams: patient safety, clinical effectiveness, patient experience and leadership and culture.
- The trust had recently introduced new values known as CARE, this stood for: compassionate, accountable, respectful and engaging. There were posters displaying around the trust and most staff could recite them but they had to yet really understand how these impacted their work and embed them into ways of working. A minority of staff had been involved in workshops to develop the new CARE values that were launched in the weeks prior to our inspection.
- Staff were however familiar with the trust's 'I will' campaign. This was introduced in response to a death and a campaign known as 'Victoria's Legacy': it meant that staff made a pledge to patients of 'I will':
  - Keep you safe.
  - Keep you comfortable.
  - Keep your environment tidy.
  - Treat you with compassion.
  - Abide by the core values and behaviours of the organisation.
- The "I Will" campaign was an amalgamation of these five practice development campaigns and sets an expectation was that individual staff would sign a pledge promising patients that they would, keep them safe, keep them comfortable, keep their environment tidy, treat them with compassion and abide by the core values and behaviours of the organisation. We saw posters on display outlining the campaign and staff stated they used this to ensure the provided patients with the best care available.
- The ED departmental strategy had been implemented in July 2015 and focused on 'Improving the quality of the patient

journey by improving' and included the introduction of the ambulance streaming process, a frailty service through the ED therapy team, review and increase in staffing levels and increasing urgent care provision for minor injuries and illnesses. The strategy was on display in the staff communal area so that staff at all levels were aware and could comment on the plans.

- The trust was implementing a new dementia strategy to ensure patients with dementia had a better patient experience.
- The trust had launched the nursing and midwifery strategy 2016 to 2020 called 'Delivering safe high quality care to our communities' in October 2016. The strategic plan was written following recommendations from the Francis Report (2013), the Government's response 'Putting Patients First" and the findings of the Kirkup report (2013). Most of the staff knew of the new strategy, which had been launched but were unable to tell us in detail about it.
- At the time of the last inspection in September 2014, there was no clear vision and strategy for end of life care at the trust. There was no medical lead for end of life care in post and there was a lack of direction and co-ordination with no documented end of life care priorities documented for 2014/15. Since the last inspection in September 2014, a medical lead for end of life care had been appointed at the trust. The transformation lead nurse and medical lead for end of life care and the SPCT, told us their work was now a high priority for the trust. At this inspection, we saw end of life care had executive and non-executive board representation and we saw evidence of issues around end of life care raised at board meetings. The trust board, non-executive directors and the integrated governance committee had attended presentations on the progress of the implementation of the end of life care strategy. The trust had introduced the nationally recognised 'Five priorities for care of the dying person' and developed documentation to support these being applied in practice.

Governance, risk management and quality measurement

- The trust had an integrated governance committee which was a subcommittee of the trust board; its purpose was to monitor the strategic direction for governance and the management of risk within the trust. It had been due for review in January 2016. We did not find evidence that the function and purpose of committee had been reviewed as had been planned.
- We reviewed the board assurance framework and the corporate risk register. There was a lack of clear links between the two documents. In addition, the flow of information on risk from ward to board was limited with a lack of consistency in the

rating of risks. There was a lack of updating or closing of risks on the current management system. Risks in the clinical business units went through their governance meetings and were added to the corporate risk register on the basis of their risk rating. The trust had undertaken a review of the corporate risk register and Board Assurance Framework at the end of 2015/16 with a paper to the board. The trust told us that both documents had therefore been refreshed as a result of the review process.

- The trust had recognised a review of all risk registers was required and had engaged some specialist advice to support them with this just prior to the inspection. We found that the clinical business unit risk registers that were in place at the time of the inspection did not accurately reflect the risks in services.
- After the inspection we were provided with copies of the new and updated draft risk registers, however, these did not accurately identify all risk in services. For example, those relating to the mental health assessment room in emergency department, black breaches', failure to monitor, assess and mitigate the risks to patients due to delayed time to initial clinical assessment, lack of compliance with level 3 safeguarding children's training, lack of nurses in the paediatric emergency department when patients were present. We were therefore not assured that the risk management processes in place were sufficient to recognise, assess, monitor, and review and therefore reduce risks. This demonstrated a lack of action by the trust as another regulator had also expressed concerns earlier in the year about the overall governance and risk management process in the trust. The trust had only recently commending action to address this substantial concern with the appointment of a new risk manager.
- There was not a holistic approach to the monitoring of safety and performance data, supported and informed by robust, ongoing clinical audits in all services. Actions plans had not always been developed to address areas of risk or poor performance and those that were in place were not always effectively monitored. The trust was reliant on those areas of quality and safety that required improvement as identified by the nurse sensitive indicators. The trust told us that the nurse sensitive indicators system was planned to be developed into a system for ward accreditation. However, the ward dashboards had no direct correlation to the services risk register and the quality and performance governance systems in place had not recognised substantial risks in some services.
- There was not clear process in place to monitor improvements and changes made as the result of identified risks or service

improvements, which was integral to achieving the strategy. For example, the ED had developed an appropriate comprehensive paediatric competency framework to support adult nurses working in the children's ED; however, this was not Identified risks were managed by individual members of staff and discussed at departmental clinical governance meetings. However, we were not assured that the risk management process was robust. For example, the risk register had a risk related to access and security for the children's area. It had been previously identified that the access into the children's ED was not secure and the touch pad to leave the area was too low and a child could leave unsupervised. We saw that appropriate actions had been taken to prevent unauthorised access into the children's area. A swipe card access and a CCTV camera had been fitted outside the children's ED; however, the mitigation for children being able to leave had not been achieved. Health and safety colleagues had advised the ED that they could not raise the touch pad to leave the department due to access in an emergency. The mitigation for this was to increase paediatric cover to ensure that the area was not left unstaffed; however, at the time of our inspection there were still insufficient staffing levels to ensure that the department was not left unstaffed and the risk was due to be removed after being noted at the governance meeting.

- There were number of risks identified during the inspection which were not highlighted on the register to allow effective monitoring at all levels. For example, the lack of an adequate mental health room, the inaccurate recording of initial clinical assessment time, lack of mental capacity awareness, lack of staff training for safeguarding level three, inconsistent equipment checking and lack of space and privacy in the reception area.
- After our inspection, the trust carried out a number of actions in regards to the urgent concerns we raised. This included reviewing their streaming model, reviewing the staffing arrangements in children's ED and updating their processes to allow better oversight in the waiting area. All actions taken were added to the urgent care improvement plan to allow monitoring at all levels.
- The medical care service risk register was not comprehensive and some risks had been on the registers for up to two years. There were 29 risks on the register and there was not a timescale in place for the resolution of any of the risks. Whilst

control factors (mitigations) were evident for all risks, the registers only contained positive assurance (how the progress in managing the risk was being monitored) in 13 cases. Risks did not have a unique reference number.

- For example, one risk was recorded was that patient monitoring not available on Oakley Ward (cardiac ward) as the portable telemetry monitors only fed into the screens on CCU making detection of issues difficult and ongoing monitoring problematic. The risk was entered on the register on 1/4/2015 and the mitigation of the risk was 'Approval of business case to purchase equipment' but this was not dated. Many of the risks did not have sufficient assurance that mitigating actions were being monitored.
- The areas for improvement identified by the nurse sensitive indicators and ward dashboards had no direct correlation to the service risk register. Ward dashboards referred to some local risks but these were not systematically escalated to the service risk register. Poor completion of NEWS charts, poor compliance with mandatory training, poor compliance with dementia training on some wards, variable outcomes from stroke audits (SSNAP) and poor completion of MUST assessments on some wards within 24 hours were examples of risks to patient safety and the quality of care and treatment that had not been reflected in the service risk register. Risks identified by the service were not being assessed, monitored and mitigated via a robust, comprehensive risk register. Risks we identified on inspection were not recognised by the service, including the failure to escalate deteriorating patients, poor junior doctor cover for medical wards, and the poor completion and storage of patients' records. We were therefore not assured staff at every level in the service had a robust understanding of all the risks to patient safety and were able to assess, mitigate and monitor all known risks.
- The surgical division held its own risk register and clinical leads we spoke with were able to identify the top risks. Examples included; inadequate staffing levels, the impact of the ventilation works in the main theatres thus reducing the service's ability to meet their RTT and cancer targets. The risk registers seen had been reviewed and had updated actions.
- All managerial staff in critical care we spoke with were aware of their service risks and what actions were in place to mitigate them. However, they did feel it required updating as it was not fully current. We saw the risk register was discussed during CBU meetings.
- The maternity and gynaecology risk register at the time of the inspection contained eight risks. One of the risks relating to

gynaecology had been closed in September 2016. It identified information governance at risk due to exposed nature of the nurses' station, which included for example; the risk of patient information on display to hospital staff, patients and visitors who had no rights or needs for the information. The risk had been closed as Maple ward had moved. However, we saw similar risks on Rowan ward that had not been recorded on the risk register. We saw patient records were stored in an open trolley behind the nurses' station on the ward. The nurses' station was often unmanned. This meant that patient records were not stored securely and patient's information was not always protected.

- The maternity dashboard data did not meet RCOG good practice No.7 Maternity dashboard, clinical performance and governance scorecard. We saw evidence the management team were aware of this risk and an action plan had been developed. However, the concerns about the limited scope of the dashboard were not on the service's risk register.
- Significant risks identified on inspection, including the safety and security of Skylark ward, had failed to be considered and added to the risk register. The audit planning process lacked focus and most audits listed on the plan were not completed. Leaders were aware of the main risks, which had been identified and recorded on the risk register. However, leaders failed to recognise the significance and seriousness of some of the incidents which had occurred and the possibility of them reoccurring and the need to ensure that these had been escalated and added to the CBU risk register. For example, the risk of a patient climbing over and falling from the landing outside the paediatric ward as well as the deteriorating patient. Leaders failed to tell us about some of the serious incidents which had occurred shortly prior to our inspection.
- There was a lack of an effective governance framework to support the delivery of quality patient care. For example, radiologists were not up-to-date on basic life support mandatory training and there was no robust system in place to ensure staff were compliant with training,
- A new risk manager had recently been appointed at the hospital. One of their early roles was to review the reporting backlog delay and monitor the department's response and improvement plans and performance. The clinical director of radiology told us there were known problems with the lack of reporting capacity monitoring due to the old IT systems not having the capability of recording that information. It was

recognised that this was an area to action once the service had recovered from its reporting backlog issue. Senior staff told us there had been difficulties in recruitment that had affected image reporting capacity.

- Diagnostic imaging risks fed into the clinical business unit's risk register. This was regularly reviewed at the business unit's governance meetings. Risks identified included the Inability to recruit qualified staff in the imaging department. Various staffing groups had been identified as a particular risk such as cardiac catheter lab and CT and MRI specialist radiographers.
- Image reporting delays were also included on the risk register since November 2012. The department had attempted to mitigate this risk by outsourcing imaging to external companies and offering overtime to staff in the department. In 2012, we saw evidence that the department had risk assessed an agreement to not make formal reports on some examinations which would be viewed and reported by other clinicians in the hospital. Even with these actions in place, we saw evidence of two further peaks in imaging backlog (in October 2015 and summer 2016). The second peak in 2016 was largely beyond the trust's control due to problems in the transition to the new RIS and PACS systems. The trust took actions to further mitigate risks and to reduce the backlog.
- The risk register did not reflect all risks found on inspection. For example there was no specific mention or actions in place relating to the inpatient waiting area for x-ray that was not fit for purpose, poor compliance with mandatory training for radiologists. This meant that we were not assured that appropriate monitoring or interim measures were in place to reduce these risks. Risk found on inspection in outpatients clinics had not been recognised by the service or assessed, and included on the risk register. Effective mitigations were not in place. Some other risks identified on the register appeared to have no obvious actions relating to them such as the aging imaging equipment. At the time of the inspection we saw evidence of actions relating to this, but this was not reflected on the risk register.
- There was an active audit plan in place. Audits were identified from national, local and specialist sources as well as clinician based interest. All were logged centrally. A small percentage were behind their completion target date, the longest of which was over 500 day, however most were completed on time. Responsibility for implementing audit outcomes sat with the

senior clinical lead for the area. Actions plans had not always been developed to address areas of risk or poor performance and those that were in place were not always effectively monitored.

- The clinical governance indicators, including the nurse sensitive indicators, were compiled each month into a comprehensive Integrated Governance Report, which was presented to the monthly Integrated Governance Committee. Ward dashboards were in place so that areas for improvements could be identified, including compliance with training, infection control, pressure area are care and risk of falls. Whilst the trust has a quality improvement team, who maintained an overarching quality improvement plan: we found this plan did not directly link to the Health and Social care Act (2008) regulatory breaches that we identified at the last inspection, or to all risks on local risk registers.

Culture within the trust

- The current dignity at work policy was out of date. It was ratified in 2010 and was for review in November 2015.
- The emergency department had undergone significant changes in leadership since 2015 and the local leadership team had been working together for less than 18 months. Staff told us that their local leaders were visible and approachable and we saw good interactions between leaders and staff. Most staff told us that they felt confident to voice concerns openly and they would be listened to; however, the perception was that there would be minimal actions as a result.
- Some staff told us that they sometimes felt that there was not a whole trust approach to maintaining access and flow through the ED and if targets were not achieved it was an 'ED' problem. For example, they felt that there was not emphasis on ensuring that bed availability was up to date and there were effective communication systems in place to convey this information.
- There was an emphasis on 'breach avoidance' to meet targets and some staff felt that they were often required to move patients to an inappropriate area to meet a performance target or avoid a 12 hour breach in ED. We spoke to senior staff about this and they told us that the trust had significant issues with bed capacity and sometimes patients were moved to temporary areas; however, this was about patient care and keeping the ED open for patients arriving.

Summary of findings

- Staff at all levels in medical care were enthusiastic about their work and team working was evident during our visit. Almost all staff were proud of their wards and teams and spoke positively of the 'friendly' working environment at the trust, despite the ongoing work pressures most staff reported.
- Staff within the surgical services said they felt supported by their managers who looked after their welfare. They felt able to raise concerns and that their concerns would be acknowledged.
- In the children and young people's service, there was positive teamwork between medical, nursing and support staff and staff were patient focussed. However, some staff did not feel supported by senior management when things went wrong. The staff we spoke told us that local leadership worked well and staff felt listened to. Staff had mixed perceptions about how supportive senior management was and whether concerns escalated were always acted on. It was the perception of some staff that they did not feel supported when things went wrong and this affected staff morale. When we asked staff about serious incidents which had occurred within the unit, most of the more junior members of staff were unable to recall serious incidents.
- Senior nurses in Nene Park outpatients' clinic and the fracture clinic told us that staff morale was affected by the pressure and demand on services. In the other outpatient areas we visited, staff morale was good and staff told us they were well supported, despite the demands and challenges. Managers were said to be available to support staff and to provide advice where needed.
- The trust had implemented a range of health and wellbeing initiatives for staff including yoga, weight management and the hospital had now become a smoke free site. Staff feedback on these initiatives was positive.
- The trust had appointed a Freedom to Speak Up guardian and also a Guardian of Safe Working hours for junior doctors. Non-executive directors also carried out monthly walkabouts around the hospital to speak with all grades of staff.
- The trust had implemented a leadership development programme to support effective workforce development strategy with 81 staff completing the programme in 2015/16 and another 96 scheduled to attend in 2016/17. Staff spoke positively about this programme.

Equalities and Diversity – including Workforce Race Equality Standard

Summary of findings

- In July 2014 the Equality and Diversity Council agreed new work to ensure employees from black, minority and ethnic (BME) backgrounds had equal access to career opportunities and received fair treatment in the workforce. There were two measures in place the equality and diversity system 2 (EDS2) and the workforce race equality standard (WRES) to help local NHS organisations, in discussion with local partners including local populations, review and improve their performance for people with characteristics protected by the Equality Act 2010.
- NHS Employers had selected the trust as one of its 2016/2017 diversity and Inclusion Partners. In fact, it was the trust with the highest score. This indicated that the trust had placed equality, diversity and inclusion at the centre of everything that they did.
- The trust had provided a 'meet and greet' service at the main reception to help patients and visitors.
- A practice and professional development forum had been organised to ensure staff from all backgrounds received an assessment of training and development needs and were given opportunities to meet those needs. Job applications had been produced in an easy read format to support people with learning difficulties in applying for posts. The percentage of staff receiving equality and diversity training was one of the highest in the country.
- There was good support for a diverse community by providing extensive interpreter and translation service, including for sign language. Information had been provided in easy read and picture-based formats for patients with learning disabilities.
- Patient satisfaction levels had been monitored by equality groups, such as cancer services.
- The trust had been proactive in celebrating and raising awareness of social and religious occasions.
- In the 2015 staff survey, the trust performed better than the England average for the percentage of staff from black, minority and ethnic (BME) backgrounds experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months, at 25% compared to 28%, and for the percentage of BME staff experiencing harassment, bullying or abuse from staff in last 12 months at 26% compared to 28%. However although it performed better than the England average for the percentage of BME staff believing that the organisation provides equal opportunities for career progression or promotion at 78% compared to 75%, this was much less than for white staff at 90%. It performed in line with the national average for BME staff

who in the 12 last months had personally experienced discrimination at work from manager/team leader or other colleagues' but at 14% this was significantly higher than for white staff at 4%.

Fit and Proper Persons

- A paper had been presented to the trust board meeting in April 2015 to approve the amendment to the foundation trust constitution and an amendment to the board of directors' nomination and remuneration committee terms of reference. This paper referenced that the board had received development sessions in February and April 2015 on the fit and proper person regulation but no specific policy had been developed for the trust.
- At our inspection, there was not a policy in place giving clear guidance for all appointments to the board, executive team and which staff the trust may consider as associate directors of boards who are members of the board, irrespective of their voting rights.
- No audit programme was in place to review the evidence within staff personnel files on a cyclical basis. On a review of these staff files, we found gaps in essential documents, including written references and Disclosure and Barring Service checks having been carried out, which demonstrated that a robust recruitment and selection process had not always been followed. There was not an understanding of the requirements of the fit and proper and person's regulation at board level.

Public engagement

- Patients were encouraged to be involved and had attended trust board meetings. Patients had attended board meetings to present their patient stories.
- The Patient Experience Steering Group (PESG) met regularly, was well attended and reviewed themes arising from complaints to consider changes in services to improve the patient experience. The PESG had wide ranging membership including volunteers, members of the public, governors, commissioners and Healthwatch. The PESG had developed a Patient Experience and Improvement Strategy with an associated work programme. Priority areas for action had been identified as the trust's telephone response service, clinic letters and availability of car parking,
- The trust had also implemented mobile listening booths where patients and visitors could provide feedback, which was then reviewed by the PESG.

- Medical wards had also set up informal fortnightly 'surgery' meetings where patients and carers could meet with staff and provide feedback.
- There were a large number of volunteers from the local community working in various departments in the hospital. They included 21 meet and greet volunteers and 29 volunteers providing individual support to patients.
- The hospital had launched a "Joint School" education session for approximately 400 patients who required hip or knee replacements in July 2016. The aim was to give patients a clear indication of what to expect from their operation and what was expected form them by the hospital. The aim of the joint school was to explain why joint needed replacing, what anaesthetic they could choose to have and what to expect afterwards in terms of their wound care and rehabilitation. Feedback from patients included; "you learn about the exercises you can do in advance of your operation and how you will use them afterwards to help you recover" and staff "painted a very clear picture of what to expect during your operation and what happens afterwards".
- There was a Maternity Services Liaison Committee (MSLC), which had changed its' name to the Maternity Northants. A meeting was held every quarter, the meeting was for women and partners who had used maternity services to meet and discuss feedback and developments within the service. Meetings were also attended by members of the Kettering Hospital maternity senior management team.

Staff engagement

- Following poor staff survey results in 2014, a new workforce development strategy had been developed which was approved in August 2015. In the 2015 NHS staff survey four key findings were better than the national average, two about the same and the remaining 25 worse than the national average. The number of staff responding had decreased from 39% to 27%. Whilst the overall results remained concerning there had been improvement in ten of the key findings from the previous survey, with two deteriorating. An action plan was presented to the board in May 2016.
- An annual staff survey took place each year to gauge staff perception on a range of matters. We were provided with a copy of the action plan for the 2015 survey results for the Women and Children's CBU. The action plan stated that 132 responses

had been received, with five responses reporting they were unlikely to recommend, one response was extremely unlikely to recommend. An action plan was developed to address the six negative responses.

- The issues identified in the survey highlighted that some staff had reported that there was a lack of flexible working, that they felt overworked, unsupported and unappreciated and that managers were not visible. Actions to address the issues raised lacked detail and were unclear how they linked to feedback. For example one action was, 'improved communication of back to basics on mandatory day' and another, 'clinical commitment on call rota'.
- Senior managers told us that in response to the negative findings in the staff survey, they had launched the CARE values with joint working with staff, made more healthy food options available, had amended the appraisal process with clear focus on values and objectives, continued to carry out safer staffing reviews and had commissioning a new e-roster system staff planning staff rotas.
- All trust staff had received a leaflet about the five priorities of care for the dying patient.
- Staff who had attended end of life care training told us the communication skills training had been particularly helpful, as it had enabled them to communicate more confidently with patients and those close to them in the last days and weeks of life.

Innovation, improvement and sustainability

- The new Faculty for Health Improvement and Innovation was being developed to drive the trust's recovery programme for surgery and outpatients. This recovery programme included plans to increase throughput in theatres and outpatients, to introduce a text message service for outpatients' appointments and a new calling system for DNAs, implement a schedule tool for theatre use and implement a live theatre dashboard. Plans were in being developed with focus on improving patients' experience and outcomes, together with increased effectiveness of services. However, many initiatives that the trust were now introducing had been used in similar trusts for some time. Historically, there had been a lack of innovation within the trust coupled with a lack of effective peer benchmarking to help inform improvement plans.
- The trust told us that the trust had led and had been influential in a number of countywide initiatives and innovation. Examples were:

- The trust had been influential in creating a shared clinical oncology centre for south east midlands (SEMOC) with partner NHS trusts. The trust also chaired the new SEMOC steering group driving the improvements to care of patients receiving chemotherapy.
- Recent creative and effective infection prevention campaigns had been had been shared nationally as these were considered to be new and innovative.
- A practice development nurse initiative to introduce the 'Overseas Nurses Programme'. The staff member who developed this programme had a Florence Nightingale scholarship in recognition of this innovative approach to developing staff.
- The introduction of the trust 'Dragons Den' initiative to find creative ways to improve patient care and safety.
- The introduction of the Federation Model with another local acute trust to support clinical collaboration improving patient pathways to services. The trust said this was a new model of organisational integration.
- The development of a shared integrated governance framework to support collaborative working.
- The trust introduced a Health and Housing programme of which there were less than five nationally. This was a joint partnership between the trust, the local community NHS trust and the local borough council and sought to support patients jointly in providing the most appropriate housing for their well-being.
- The trust had a formal partnership agreement with a local charity to introduce a food parcel for vulnerable patients on discharge.
- The achievement of UKAS (the national body for the accreditation of testing and calibration laboratories) accreditation of the laboratories through a governance process which demonstrated best practice standards.

- The ED had plans to increase their urgent care provision through working with local commissioners and other external providers. At this inspection, there had been some improvements noted since our inspection in February 2016. These included the introduction of the frailty unit, ambulance streaming bay, emergency decisions unit and an increase in majors' capacity. There were areas highlighted where there had not been any changes since our inspection in February 2016. These included, inadequate staffing to meet the needs of

adults and children attending ED, a lack of effective systems to ensure that ambulance handovers occurred in a timely manner and a lack of sufficient detail in patients' records to ensure all aspects of their care was clear.

- The clinical collaboration programme involved Kettering General Hospital, another local acute NHS trust and other partners in the local health economy working together to a massively increased extent to provide a better service to patients and lower cost to the taxpayer. This programme was a key element of Northamptonshire's Sustainability and Transformation Plan (STP), which set out to implement a five-year plan for a sustainable service for health and social services in the county.
- The collaboration focused initially on 10 specialties, but others would be added later. Patients would be referred or triaged by a county service and then treated close to home.
- A number of engagement events were held to find out if each specialty could modify the service provided to better meet patients' needs.
- The trust had developed new treatment pathways to make better use of available staff, not just consultants but also specialist nurses and GPs with specialist skills.
- At this inspection, there had been the following improvements noted since our inspection in October 2014:
  - Nurse staffing levels had improved greatly to ensure patients were provided with safe care. Additional funding was provided to allow successful recruitment of nurses into the intensive care unit (ICU).
  - There was a vision and strategy in place for anaesthetic services and managers had a good knowledge of these.
  - New nursing leadership within the ICU meant that concerns were being addressed in a timely way and quality oversight of the ICU was improving.
- The ICU was running an 'Intensive Voices Appeal' to fundraise for the purchase and use of new assistive communication technology. This assistive communicative technology allowed patients to communicate using their eyes as a virtual computer mouse to type messages. The feedback from the use of this technology in the ward had been exceptionally positive.
- The trust received the UNICEF Baby Friendly Initiative accreditation for its maternity department and neonatal unit in August 2015. Baby Friendly Initiative accredits organisations that have established and implemented very high standards of care for all pregnant women and new mothers. It means the

organisation has shown it is committed to supporting mothers to initiate breast-feeding and encourages them to exclusively breastfeed for the first six months while at the same time also supporting parents who choose to bottle feed.

- The service told us the delivery suite had launched the “Listen to me" campaign to ensure women felt listened to during their stay on the delivery suite. Women were allocated a midwife; women could raise any concerns in relation about their care during their stay. The delivery suite also had a listen to me campaigner who could be contacted if anyone felt they needed to speak to someone else. Leaflets had been developed to provide information on the campaign and we saw these were available on the delivery suite. Women we spoke with on the delivery suite were aware of the campaign.
- There were two paediatric hot clinics each week which were held on the paediatric outpatient unit. Referrals could be made by the patient’s GP into the hot clinics, which were used for rapid access including one emergency slot at each clinic. The lead paediatrician utilised the clinics for both clinical and teaching purposes.
- Nurses, physiotherapists, dieticians, occupational therapists and support workers became end of life care champions in 2016. Champions acted as a resource for information related to end of life care. They also contributed to the development and implementation of the end of life care strategy across the trust.
- The imaging department had avoided junior radiographer anticipated vacancies through offering student jobs early on in their third year of training (on the condition of qualification) for when they had completed their degree. These radiographers were initially been employed as assistant practitioners while their professional registration was processed and once registration had been achieved they were appointed as radiographers. Radiology management told us that this process had worked well.

Overview of ratings

Our ratings for Kettering General Hospital

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

Our ratings for Kettering General Hospital NHS Foundation Trust

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

Outstanding practice and areas for improvement

Outstanding practice

- The hospital had launched a "Joint School" education session for hip and knee replacement patients. The aim was to give patients a clear indication of what to expect from their operation and what was expected form them by the hospital.
- The hospital had launched a new laser operation to support patients who required treatment for benign enlargement of the prostate by using a light laser to reduce the size of the prostate. This process had reduced the surgical time and the length of stay was no more than one day.
- The trust had direct access to electronic information held by community services, including GPs. This meant that hospital staff could access up-to-date information about patients, for example, details of their current medicine.
- Sixty volunteers supported the chaplaincy service through a programme of daily and weekly visits to wards and clinical departments. Volunteers attended a 10 week training programme, which included awareness sessions on end of life care, dementia, and hearing and visual impairment.
- There was a well-embedded play worker team, funding was sourced through donations from local businesses as well as fund raising activities. This was used to pay for new equipment as well as weekly visits from a music therapist, pet therapist and magician. The unit had modern toys and facilities for the children including a new projector, which projected moving images onto the floor, which entertained children under the supervision of a play worker.

Areas for improvement

Action the trust MUST take to improve

- Ensure that there are sufficient numbers of nursing and medical staff in adults and children's ED to meet the demands of the population and ensure safe care is delivered. To ensure that staff working in children's emergency department (ED) have the correct skills, competence and support to care for children.
- Ensure there are a sufficient number of medical registrars and junior doctors to cover out of hours and weekend shifts at all times across medical care wards. To ensure there is the required level of consultant obstetrician presence on the delivery suite.
- To ensure care and treatment are provided in a safe way for service users by following the British Cardiovascular Society guidance on nurse staffing numbers in the Coronary Care Unit. Ensure there is a sufficient number of nurses working in the Coronary Care Unit at all times.
- To ensure a qualified children's nurse works in the outpatient department in accordance with Royal College of Nursing guidance, 'Defining staffing levels for children and young people's services' which states that, 'a minimum of one registered children's nurse must be available at all times to assist, supervise, support and chaperone children'.
- To ensure that suitably qualified staff in accordance with the agreed numbers set by the hospital and taking into account national policy are employed to cover each shift. In the children's and young people service. There must be suitable numbers of staff trained in Advanced Paediatric Life Support and / or European Paediatric Life Support.
- Ensure that there are effective systems in place to prioritise, assess and treat all patients attending the ED. Ensure that there are effective processes in place to measure time to initial clinical assessment for ambulance handovers and self-presenting patients.
- To review the streaming competency framework and ensure that staff in this position have the necessary skills to identify a deteriorating or seriously ill patient in adult and children's ED. To ensure that all staff in outpatients who have direct contact and assess and treat children have the appropriate level of paediatric competencies to provide safe care and treatment.

Outstanding practice and areas for improvement

- To ensure the security of the paediatric ward and Rowan ward at all times and review security system on the postnatal ward to minimise the risk of visitors accessing the ward without being challenged.
- Ensure staff in medical care follow the hospital's medication policy in the safe prescribing, cancelling, handling, storage, recording and administration of medicines. Ensure staff follow the hospital's medication procedure for obtaining medicines for patients out of hours. The disposal of controlled drug ampules which have only been partially administered to patients must be recorded in the controlled drug register in the children's and young people service. To ensure that all medications are stored in outpatients areas in line with hospital policy and national guidelines.
- Ensure that the safeguarding children and vulnerable adult policies include all relevant information, specifically, details about female genital mutilation, child sexual exploitation as well as the referrals process for vulnerable adults. Ensure that all staff are trained to the required level of safeguarding children's training and adhere to hospital safeguarding policies.
- To ensure all staff have the required statutory and mandatory training and effective systems are in place to monitor this. To ensure that staff in the radiology department are up-to-date on basic life support training. To ensure that radiation dose awareness in plain film by the radiographers is in line with national standards.
- To ensure staff in ED and medical care have had sufficient training in the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).
- To ensure there are processes and procedures for staff in surgery to adhere to the Food Safety Act 1990 and the Food Hygiene (England) Regulations 2006 (Temperature Control Schedule 4 EU Regulation No.852/2004).
- To ensure that theatre staff comply with the Standards and Recommendations for Safe Perioperative Practice 2011 by the Association of Perioperative Practice or the hospital's operating theatre policy and the theatre standard operating procedure regarding the wearing of cover gowns and footwear when leaving and entering the theatre area.
- To ensure staff are aware of the escalation policy including triggers for escalation in ED and medical care and that these process and reviewed and monitored. Ensure National Early Warning Score (NEWS) charts are filled in clearly, accurately and legibly.
- Ensure that patients' records are completed with appropriate information to understand their care plans. Ensure all patients have person-centred care plans that are well maintained and reflect appropriately patients' changing needs and treatment.
- Ensure all confidential patient information in medical care, surgery and gynaecology and outpatients and diagnostics are stored in accordance with the Data Protection Act 1998.
- To ensure complaints are handled in line with hospital policy and effective systems are in place to monitor this.
- To monitor patients' referral to treatment times, and assess and monitor the risk to patients on the waiting list in surgery, children and young people's service and outpatients and diagnostic services.
- To develop an effective programme of cyclical audits to measure performance with evidence-based protocols and guidance in the ED. To establish a system for continuous monitoring of action plans developed in response to local and national audits. To ensure all clinical guidelines are up to date and reviewed in a timely manner in the maternity and gynaecology service. To ensure the local maternity dashboard meets RCOG good practice No.7 Maternity dashboard, clinical performance and governance scorecard standards.
- To ensure all staff are supported to recognise and escalate potential risks to the safety and quality of care and treatment for all patients and to ensure effective systems are in place to assess, mitigate and monitor these risks. The hospital should ensure that the risk registers are accurate and reflective of risks in series.
- To review the incident reporting processes in children's and young people service to ensure all incidents are reported and investigated and that actions agreed correlate to the concerns identified, are acted on and lessons learned are shared accordingly. Ensure ligature audits are undertaken and acted upon in the children's and young people's service.

Please refer to the location report for details of areas where the trust SHOULD make improvements.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: • There was no effective process in place to care for adult and paediatric patients that were experiencing mental health illnesses. • There were minimal processes in place to ensure that all patients with 'red flag' symptoms, children and those at risk of deterioration received an initial clinical assessment in a timely manner. • There was a lack of effective processes in place to ensure that all equipment, including resuscitation equipment, was checked and maintained for use. • Patients' records were not always completed in a manner that described their care and treatment in the emergency department and in medical care. • Not all patients had person-centred care plans that were well maintained and reflect appropriately patients' changing needs and treatment in medical care. • Staff were not always following the hospital medication policy in the safe prescribing, cancelling, handling, storage, recording and administration of medicines in medical care. Staff were not always following the hospital medication procedure for obtaining medicines for patients out of hours. • Staff were not always following the escalation process and promptly call for medical assistance in response to a patient's deteriorating condition and in accordance with the directions stipulated on the NEWS charts in medical care.

This section is primarily information for the provider

Requirement notices

- In children and young people's service, risk assessments were not undertaken for patients with mental health needs and 1:1 care from a suitably trained professional was not provided.
- The paediatric outpatient department was not supported by a trained registered children's nurse.
- Staff had not received training in supporting children and young people with mental health needs.
- Staff in had not been competency assessed in tracheostomy care.
- Sufficient numbers of staff had not been trained in Advanced Paediatric Life Support or European Paediatric Life Support.
- There were 413 patients waiting over 52 weeks for non-urgent outpatient appointments.
- Medication was not stored in line with hospital policy and national guidelines in some outpatient areas.
- Radiation dose awareness in plain film by the radiographers was not in line with national standards.

Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Diagnostic and screening procedures

Maternity and midwifery services

Surgical procedures

Treatment of disease, disorder or injury

Regulation

Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

How the regulation was not being met:

- There were insufficient numbers of medical and nursing staff within the service who had safeguarding children level 3 training, a requirement for all staff caring for 0-18 year olds in line with the Royal College of Paediatrics and Child Health Intercollegiate document 2014.
- Systems and processes to prevent abuse of service users were not established and operating effectively to minimise the risk.
- Not all staff in children and young people's service were trained to the required level of safeguarding.

This section is primarily information for the provider

Requirement notices

- In medical care and the ED, staff had not had sufficient training in the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and patients who lacked capacity to consent did not always have decisions made in line with legislation.
- Safeguarding children and vulnerable adult policies did not include all relevant information, specifically, details about female genital mutilation, child sexual exploitation as well as the referrals process for vulnerable adults.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: • The risk management systems did not provide sufficient oversight to mitigate the risks related to the carrying out of the regulated activities. • There was no effective process in place to manage and record the ambulance handover times and a lack of systems to monitor, collate and review this information to improve performance and patient experience. • There was no effective cyclical audit process in place to monitor compliance, identify best practice and areas for improvement. • There was a lack of effective policies and governance system to support service delivery. • Confidential patient information was not always stored in accordance with the Data Protection Act 1998. • National Early Warning Score (NEWS) charts were not all filled in clearly, accurately and legibly in medical care. • In the children and young people's service, adequate arrangements were not in place for the recording, reporting, investigation and taking appropriate action in relation to incidents which may occur during the carrying on of the regulated activity.

This section is primarily information for the provider

Requirement notices

- The departmental risk registers failed to identify all risks faced by directorates and had not all been updated and reviewed regularly.
- The clinical audit plan did not include sufficient numbers of audits to adequately assess quality of patient care and ensure outcomes are improved for patients. The audit plan was not monitored for progress and agreed audits were not consistently completed in the children and young people's service.
- In the children and young people's service, policies and guidance had not been developed for all aspects of patients care and treatment and some policies did not reflect the most recent guidance.
- In outpatients, there was no clear oversight of the waiting list and follow up of DNAs.
- There was a lack of effective and holistic understanding of risks throughout the service in outpatients and lack of effective risk management regarding delayed imaging and waiting lists for appointments.
- There was a lack of embedded standard operating procedures for managing outpatient clinics cancelled within six weeks.
- Patient medical notes were not always stored securely in outpatient areas.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: • There were insufficient numbers of registered nurses (children's branch) to ensure that the children's ED had one such nurse on at all times. Adult nurses working in the area had not received sufficient training to ensure that they were competent to care for children. • The hospital were not following the British Cardiovascular Society guidance on nurse staffing numbers in the Coronary Care Unit.

This section is primarily information for the provider

Requirement notices

- There was insufficient number of medical registrars and junior doctors to cover out of hours and weekend shifts at all times.
- There were inadequate medical and nurse staff numbers in accordance with its own minimum staffing levels in the children and young people's service.
- Staffing levels for both medical and nursing staff did not meet levels as recommended in national guidance in the children and young people's service.
- Only 57% of staff in the radiology department were up-to-date on the mandatory basic life support training.
- There was a lack of paediatric competencies for staff who had direct contact with children in outpatients.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints How the regulation was not being met: • Complaints were not investigated on time in many cases. • Effective complaints management systems were not in place.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed How the regulation was not being met: • Effective oversight and application of the requirements of this regulation were not in place. • Staff files did not contain the required employment and suitability to work checks

This section is primarily information for the provider

Enforcement actions (s.29A Warning notice)

Action we have told the provider to take

The table below shows why there is a need for significant improvements in the quality of healthcare. The provider must send CQC a report that says what action they are going to take to make the significant improvements.

Why there is a need for significant improvements	Where these improvements need to happen
This warning notice served to notify the trust that the Care Quality Commission formed the view that the quality of health care provided by Kettering General Hospital NHS Foundation Trust for the regulated activities detailed required significant improvement. How the regulation was not being met: • The systems to assess, monitor and mitigate risks relating to the health, safety and welfare of patients receiving care and treatment were not operating effectively so as to protect patients from the risks of avoidable abuse and harm. • Significant risks remained that the hospital had not recognised, assessed, monitored and mitigated. This represented significant failings in the overall hospital governance processes as the hospital was not aware of the level of risk regarding multiple concerns until we raised these as urgent concerns. • The governance systems in place were not sufficient to allow full oversight at board level of the potential risk to patients.	31 December 2016.