

North West Anglia NHS Foundation Trust

Hinchingbrooke Hospital

Inspection report

Hinchingbrooke Park
Huntingdon
PE29 6NT
Tel: 01480416416
www.hinchingbrooke.nhs.uk

Date of inspection visit: 28 February 2022 and 1
March 2022
Date of publication: 24/06/2022

Ratings

Overall rating for this service

Inspected but not rated ●

Are services safe?

Inspected but not rated ●

Are services effective?

Inspected but not rated ●

Are services caring?

Inspected but not rated ●

Are services responsive to people's needs?

Inspected but not rated ●

Are services well-led?

Inspected but not rated ●

Our findings

Overall summary of services at Hinchingsbrooke Hospital

Inspected but not rated



North West Anglia NHS Foundation Trust provides acute hospital services across three sites. At the time of our inspection, urgent and emergency care services were being provided across two sites from Peterborough City Hospital and Hinchingsbrooke Hospital. The trust employs approximately 7,073 members of staff and is supported by approximately 452 volunteers.

We undertook an unannounced focused inspection of Hinchingsbrooke Hospital urgent and emergency care services and medical care services (including older people's care) on 28 February and 1 March 2022. We also had an additional focus on the urgent and emergency care pathways across Cambridgeshire and Peterborough and carried out a number of inspections of services across a few weeks. This was to assess how patient risks were being managed across the health and care services during increased and extreme capacity pressures.

As this was a focused inspection at North West Anglia NHS Foundation Trust, we only inspected parts of our five key questions. For both core services, we inspected parts of safe, responsive, caring and well led. We included parts of effective in medical care. We did not inspect effective in urgent and emergency care at this inspection but would have reported any areas of concern.

The emergency department at Hinchingsbrooke Hospital was previously rated as requires improvement overall with safe, effective, responsive and well led being rated as requires improvement and caring being rated as good. Medical care was previously rated as good overall with safe being rated as requires improvement and effective, caring, responsive and well led being rated as good.

For this inspection, we considered information and data about performance for the emergency department and medical care. This inspection was partly undertaken due to the concerns this raised over how the trust was responding to patient need and risk in the emergency department and the wider trust in times of high demand and pressure on capacity. We were concerned with waiting times for patients, delays in their onward care, treatment and delayed discharges, as well as delayed and lengthy turnaround times for ambulance crews.

We looked at the experience of patients using urgent and emergency care and medical care services in Hinchingsbrooke Hospital. This included the emergency department, medical wards and areas where patients in that pathway were cared for while waiting for treatment or admission. We visited services and departments that patients may encounter or use during their stay. We also went to medical wards where patients from the emergency department were admitted for further care. This was to determine how the flow of patients who started their care and treatment in the emergency department and those cared for on medical wards, was managed by the wider hospital.

System wide summary

A summary of CQC findings on urgent and emergency care services in Cambridgeshire and Peterborough.

Urgent and emergency care services across England have been and continue to be under sustained pressure. In response, CQC is undertaking a series of coordinated inspections, monitoring calls and analysis of data to identify how services in a local area work together to ensure patients receive safe, effective and timely care. We have summarised our findings for Cambridgeshire and Peterborough below:

Our findings

Cambridgeshire and Peterborough

Provision of urgent and emergency care in Cambridgeshire and Peterborough was supported by services, stakeholders, commissioners and the local authority.

We spoke with staff in services across primary care, urgent care, acute, mental health, ambulance services and in care homes and domiciliary care agencies (social care). Staff had worked very hard under sustained pressure across health and social care services. Staff reported feeling tired and frustrated due to the sustained pressure and the impact this had on their wellbeing and on the delivery of training.

We identified a need for more capacity in primary care to meet people's needs in Cambridgeshire and Peterborough. We found some concerns in relation to access for patients trying to see or speak to a GP; however, other services proactively reviewed patients' attendance at emergency departments and took action to reduce avoidable attendances and improve access to appointments.

We visited a primary care unit run by an acute trust; whilst this was working well, we were told it was addressing an issue in access to primary care and was a short-term solution. We were told of a GP liaison service which enabled GPs and Consultants to work together to discuss individual patient needs. This service had successfully supported a significant number of people to stay at home or to access an alternative pathway and avoid going to an Emergency Department.

Access to NHS111 services for people in Cambridgeshire and Peterborough was generally in line with or better than elsewhere in England. Performance was closely monitored and there were plans in place to address staff shortages, particularly for health advisors, and there was a successful on-going recruitment campaign.

System partners in Cambridgeshire and Peterborough had been part of a collaborative project to launch a Virtual Waiting Room within the Cambridge and Peterborough region. The initiative aimed to help patients who call NHS 111 receive the care they need while alleviating the pressure on Emergency Departments (EDs).

Staff working in ambulance services reported a significant volume of calls which were inappropriate for a 999 response and could have been dealt with in primary care or urgent care services. Staff also reported a high number of elderly people seeking support through emergency services because they felt their care packages were insufficient and did not meet their needs.

Ambulance crews also highlighted their frustrations with the variation in pathways at different hospitals across Cambridgeshire and Peterborough and that ambulance crews were not prioritised for accessing alternative pathways. By streamlining pathways and handover arrangements, ambulance crews felt they could be more efficient.

For many complex reasons, including ambulance handover delays and staffing shortages, there were not enough crewed ambulances to respond to 999 calls within national targets. This posed a risk to people in the community waiting for a 999 response.

Staffing shortages in some Emergency Departments impacted on the delivery of safe and effective care. Staff were not all up to date with mandatory training and did not always assess risks appropriately.

Our findings

We visited a mental health service and found it met the needs of people who presented in the Emergency Department or transferred between acute and mental health services. However, staff within Emergency Departments reported problems in accessing mental health services and were not able to make referrals 24 hours, seven days a week. This impacted on the ability to provide appropriate care and treatment and moving patients to the appropriate service.

Whilst we found some examples of collaborative working focused on developing system wide resilience, we found Emergency Departments remained under significant pressure. Patients experienced significant waiting times in these departments and staff reported the challenges of caring for patients within the department for such long periods of time. Some staff felt too much risk was accepted and held within emergency departments and didn't always feel supported by system leaders.

Same Day Emergency Care pathways aimed to relieve the pressure from Emergency departments. However, these services also experienced staff shortages, and some were only available during set times. Opportunities were lost to use admission avoidance pathways for the frail and elderly and increasing the risk of patient harm such as falls and skin pressure damage'

Delays in discharge for patients in hospital were significant and impacted on their health and wellbeing. Staffing issues were also impacting on the social care provision in Cambridgeshire and Peterborough; although there were beds available in care homes, there was not always enough staff to enable admissions. The staffing issues were also present in domiciliary care agencies which reduced the availability of care at home.

Staff working across health and social care reported poor discharge processes. Staff working in care homes and domiciliary care services reported that patients were often discharged late at night and with insufficient information to ensure a safe transfer of care.

Staff working in these services also reported significant delays in ambulance responses, however they gave very positive feedback in relation to welfare calls received by GPs or 111 and 999 call handlers.

We found a lack of knowledge across social care services in relation to managing deteriorating patients. By increasing staff awareness, services may be able to meet people's needs without needing to request emergency services.

We observed some local and system escalation meetings and found there was limited, if any action taken in response to issues and risks escalated.

Summary of North West Anglia NHS Foundation NHS Trust – Hinchingbrooke Hospital`

- In the emergency department there was not always enough staff to care for patients and keep them safe. Training in key skills was available however not all staff had completed it. Staff had not completed training in advanced paediatric life support. It was unclear what level of training for safeguarding adults and children medical staff had received. Risks to patients were generally assessed, however risks were not always identified and acted on.
- In the emergency department, people could not always access the service when they needed it.
- In the emergency department, risks were monitored and reviewed; however, the risk register did not include all risks that were deemed to be high risk by the divisional leadership team.

Our findings

- In medical care, staff did not always complete risk assessments to minimise risks to patients. Shortages of staff trained in nursing care meant the service did not always have enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix and efforts were made to increase staffing levels for each shift. However, this did not always provide established levels of staffing.
- In medical care, people could access the service when they needed it but did not always receive care promptly due to pressures on bed capacity. There were high numbers of patients unable to leave the hospital as they were waiting for onward packages of care. Patients were being moved, sometimes at night, in order to admit them to the right place once a bed became available. Some patients were needing longer stays while they awaited treatment.

However:

- Staff understood how to protect patients from abuse, and managed safety well.
- In the emergency department, staff felt respected, supported and valued. They were focused on the needs of patients receiving care.
- In medical care, the service managed infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean. The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.
- In medical care, doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care. Key services were available seven days a week to support timely patient care.
- In medical care, staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs. Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.
- In medical care, the service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers. Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced.
- In medical care, leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. Staff contributed to decision-making to help avoid compromising the quality of care.

How we carried out the inspection

During the inspection we observed care, spoke with 44 members of staff and carried off site interviews with the senior leadership team. We spoke with nine patients and/or their carers. We observed care provided; attended site meetings, reviewed relevant policies and documents and reviewed 27 sets of patient records.

You can find further information about how we carry out our inspections on our website: www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection

Medical care (including older people's care)

Inspected but not rated



Is the service safe?

Inspected but not rated



We inspected but did not rate this service.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Ward areas were clean and had suitable furnishings which were clean and well-maintained. Furnishings including chairs, couches, mattresses and flooring were wipeable and easy to clean. Curtains were disposable and staff recorded the date they were put up and all were visibly clean. Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned.

The service performed well for cleanliness. There were effective systems to ensure standards of hygiene and cleanliness were maintained. Standards of cleanliness were regularly monitored, and results were used to improve infection prevention control (IPC) practices where needed. There was a regular programme of IPC audits to ensure good practice was embedded in all areas. Staff displayed cleaning and environmental audit compliance data on a white board visible to staff and patients and their families.

Monthly IPC audits were completed within the service. The audits included, but were not limited to, hand hygiene compliance, environmental and waste handling. Data from January and February 2022 showed that most medical wards scored 100% in the monthly hand hygiene audit.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Cleaning was carried out against schedules and cleaning records were up to date and demonstrated that all areas were cleaned regularly.

Staff followed infection control principles including the use of personal protective equipment (PPE) such as disposable gloves and aprons. PPE was readily available in all clinical areas. Staff adhered to 'bare below the elbows' principles to enable effective hand washing and reduce the risk of spreading infections. Hand sanitising units and handwashing facilities were available in all areas and handwashing prompts were visible for staff, patients and the public.

Patients with infections were nursed in side rooms with appropriate signage displayed to reduce the risk of spreading infection. Deep cleans were arranged following the discharge of patients with an infection. There were apron and glove stations near to all side rooms to ensure that patients, relatives and staff were protected.

There were designated wards for patients with COVID-19 symptoms and those who were known to be COVID-19 positive. Staff knew which wards were designated for these patients and were able to describe how they would provide care to patients with symptoms or newly diagnosed with COVID-19 in accordance with trust policy. There was clear signage related to social distancing in waiting areas such as ambulatory care.

Medical care (including older people's care)

There was rapid testing available for COVID-19. Staff screened patients for COVID-19 throughout their admission on set days and if they presented with signs and symptoms.

There were processes in place for clinical waste management. Clinical waste bins were foot operated and once bags were full, they were removed to a secured waste area. Waste was separated into different coloured bags to signify the different categories of waste. This was in accordance with the health technical memorandum (HTM) 07-01, control of substance hazardous to health (COSHH), health, and safety at work regulations. All sharp boxes we observed were correctly assembled, labelled, and dated. None of the bins were more than half-full, which reduced the risk of needle-stick injury. This is in accordance with HTM 07-01: safe management of healthcare waste. All sharp bins had temporary closures in place. Temporary closures are recommended to prevent accidental spillage of sharps if the bin was knocked over and to minimise the risk of needle-stick injuries.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

Patients could reach call bells and staff responded quickly when called. We observed staff ensuring patients had call bells within reach, as well as other equipment, for example walking aids. Patients we spoke with told us staff responded to them quickly.

The design of the environment followed national guidance. The environment was designed and managed to ensure the safety of patients using them. All wards were easily accessed and signposted from the main entrance. All wards we inspected were arranged to ensure separate male and female bays, with separate toilet and washing facilities allocated to each bay.

Security arrangements were adequate to prevent vulnerable patients leaving the building. Staff gained access to wards and clinical areas with electronic swipe cards. Visitors gained access using a call bell, which enabled staff to monitor visitors and patients entering the wards.

Staff carried out daily safety checks of specialist equipment. All wards and departments we visited had emergency resuscitation trolleys available. These were locked and secure with tamper seals. Daily and weekly checks had all been completed.

The service had enough suitable equipment to help them to safely care for patients and staff we spoke with did not report any shortages of equipment.

The maintenance and use of equipment kept patients safe. Electrical appliances and equipment had been tested and serviced to ensure they were safe to use and had stickers with appropriate dates to show this had taken place. We checked 26 pieces of equipment and all were in date.

Staff disposed of clinical waste safely. Waste management was handled appropriately with separate colour coded arrangements for general waste and clinical waste. Sharps, such as needles, were disposed of correctly in line with national guidance. Arrangements for control of substances hazardous to health (COSHH) were adhered to. Cleaning equipment was stored securely in locked cupboards.

Assessing and responding to patient risk

Medical care (including older people's care)

Staff generally completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

Appropriate systems were in place to assess risk, recognise and respond to deteriorating patients within the service. Systems were in place to appropriately assess and manage patients with mental health concerns.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. The service used an electronic national early warning score 2 (NEWS2) system. NEWS2 is a point system tool used to standardise the approach to detecting deterioration in a patient's clinical condition. The use of an electronic system meant senior nursing and medical staff had oversight of the clinical risk of patients that were unwell.

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and generally reviewed this regularly, including after any incident. Medical staff completed an initial admission assessment for patients, that included their presenting condition, past medical history and physical assessment. Further risk assessments were undertaken for venous thromboembolism (VTE), falls, malnutrition and pressure ulcers. These were documented in patient records and included actions to mitigate any identified risks. We reviewed 14 sets of patient records and saw risk assessments were generally completed on admission, reviewed regularly and when a change occurred. However, in two of the 14 cases we reviewed, not all risk assessments had been completed. One patient was admitted due to a fall; however, a falls risk assessment had not been completed. This meant the service did not always minimise and mitigate risk to patients.

Data provided by the service following our inspection showed compliance with completing VTE risk assessments within medicine as at January 2022 was 95%. All the records we reviewed during our inspection had the relevant VTE risk assessments completed.

Ward staff carried out intentional care rounding checks at least every two hours on all patients to document that comfort and care needs were met. Records we reviewed showed that these checks had been completed and recorded.

Staff knew about and dealt with any specific risk issues. There was a clear pathway for the management of sepsis. Sepsis is a potentially life-threatening condition when the body's response to infection injures its own tissues and organs. Early recognition and prompt treatment have been shown to significantly improve patient outcomes. Nursing and medical staff confidently described the signs of and what treatment should be initiated in line with national and local guidance. This included completing the 'Sepsis Six' pathway and immediate escalation to medical staff. Sepsis six is the name given to a bundle of medical therapies designed to reduce the mortality of patients with sepsis. All staff we spoke with knew how to escalate deteriorating patients and understood the importance of doing this in a timely manner.

The trust had an acute oncology service in line with the recommendations of the National Chemotherapy Advisory Group report. A 24-hour telephone line was available to patients to access.

The service had 24-hour access to mental health liaison and specialist mental health support (if staff were concerned about a patient's mental health). Staff knew how to contact the mental health team when required and were aware this was a 24-hour service.

Staff completed or arranged psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. Staff described how they would access the mental health team should they have any concerns, and there was a timely response to assess patients.

Medical care (including older people's care)

Staff shared key information to keep patients safe when handing over their care to others. Safety briefings included discussion around staffing and skill mix. Appropriate actions were taken following the safety briefing and concerns escalated to senior staff.

Staff participated in ward and board handovers where key information was shared at regular intervals throughout the day. This information included discharge planning, the patient's current wellbeing, any safeguarding issues, ongoing clinical needs and additional key information appropriate to the patients care.

Shift changes and handovers included all necessary key information to keep patients safe. Nursing staff on wards held a handover when staffing changed. This included all relevant information on each patients' needs.

Nurse staffing

The service did not always have enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and efforts were made to increase staffing levels for each shift. However, this did not always provide established levels of staffing.

Due to national shortages of nursing and support staff and staff absence the service did not always have enough nursing and support staff to keep patients safe. Staffing pressures were exacerbated by the pressures of the COVID-19 pandemic. The wards we visited displayed daily the staffing requirement for registered nurses and healthcare assistants for both day and night shifts. However, the number of nurses and healthcare assistants did not always match the planned numbers.

Data provided by the service following our inspection showed a total of 510 unfilled shifts (average of 18 unfilled early and late shifts per day) across all medical wards for the month of February 2022. Staffing was not always at planned levels for areas where patients received high dependency care outside of critical care, such as non-invasive ventilation. However, it was recognised nationally there was an increase in absence across the health and care sector, particularly due to short term sickness. Local leaders reviewed the staffing on each ward regularly with escalation and mitigation processes in place such as agency staff, bank staff and re-deployment of staff to other wards. No patients had come to harm as a result of insufficient staffing numbers.

Managers accurately calculated and reviewed the number and grade of nurses, and healthcare assistants needed for each shift in accordance with national guidance. Daily meetings enabled the staff team to identify any areas where staffing shortfalls occurred, and managers delegated staff accordingly.

Ward managers could adjust staffing levels daily according to the needs of patients. There was an established escalation and mitigation procedure in place for ward managers to raise staffing issues and concerns. Additional staffing requirements were discussed with the wider management team throughout the day at site meetings.

The service used bank and agency staff to meet planned staffing numbers. Internal bank and agency staff were offered unfilled shifts to ensure staffing establishment was met. Staff told us the bank staff used were generally the same staff and were known to the service. Managers made sure all bank and agency staff had a full induction and understood the service.

Medical staffing

Medical care (including older people's care)

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave locum staff a full induction.

The service had enough medical staff to keep patients safe. Medical staffing was appropriate with effective out of hours and weekend cover. Rotas were planned to ensure adequate numbers, and medical staff we spoke with told us there were sufficient staffing levels and a willingness for staff to cover each other at times of absence or due to holidays and training.

Most wards had dedicated consultants who were responsible for patients' treatment. The number of specialty consultants varied according to the specialty and ward size. Each consultant team had a registrar and junior doctors. Junior doctors were easily contacted and responded in a timely manner. All patients were seen by medical staff on a daily basis.

The service always had a consultant on call during evenings and weekends. Out of hours, on call consultants were contactable and a defined rota was in place. Medical cover overnight consisted of a team of registrars and junior doctors' who were responsible for inpatient areas.

Managers could access locums when they needed additional medical staff. Locum staff were given a full induction prior to before commencing duties.

Is the service effective?

Inspected but not rated



We inspected but did not rate this service.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

Information about the outcomes of patients care and treatment was routinely collected and monitored. Ward managers displayed quality and safety information including patient safety results, complaints and friends and family test results to inform patients and visitors of their performance at the ward entrance.

The service maintained a dashboard which reported on items such as, compliance with infection, prevention and control, compliance with risk assessments, sepsis screening/treatment, falls, pressure ulcers and complaints. The dashboard tracked monthly performance against locally agreed thresholds and national targets, where available.

The service participated in relevant national clinical audits. Examples included, but were not limited to, national audit of dementia, national heart failure audit, national lung cancer audit and the national asthma and chronic obstructive pulmonary disease (COPD) audit. Appropriate action was taken to monitor and review the quality of the service and to effectively plan for the implementation of changes and improvements required.

Medical care (including older people's care)

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. The division had a planned approach to clinical audit. A forward programme of audits for the current year was in place and progress against the plan was monitored.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Observation of practice, review of records and discussion with staff confirmed that all necessary clinicians were involved in assessing, planning and delivering patient care and treatment. Doctors, nurses and other healthcare professionals supported each other to provide good care.

Staff in all areas of the service told us they worked closely together to make sure patients received person-centred and effective care. Staff reported good relations and communications with other professionals and/or agencies.

There was evidence of multidisciplinary team working, for example, nurses working alongside specialist nurses, medical staff, healthcare assistants, pharmacy, and allied healthcare professionals. Patient notes we reviewed supported this.

The acute assessment unit had dedicated therapists, pharmacists and social workers and we saw effective multidisciplinary team working between the different staff groups.

Staff held regular and effective multidisciplinary team meetings to discuss patients and improve their care. Board rounds were completed at least twice daily and were attended by consultants, junior doctors, ward managers, nurses and allied health professionals. Discussions included patient milestones, discharge journey, plans for each patient, and whether the patient required a speciality review or escalation.

Pathways were in place for both referral between specialities in the hospital and between other trusts.

Staff referred patients for mental health assessments when they showed signs of mental ill health and or depression. Staff we spoke with during our inspection were aware of the mental health liaison teams and provided examples of cases where they referred patients to the service.

Care pathways were multidisciplinary, and staff of all disciplines developed and supported each other in the planning and delivery of patient care. Each professional group recorded their assessments in each patient's medical notes, and it was therefore easy to access information about the outcome of the evaluation and the ongoing care of patients from each professional's perspective. It was also clear who was the leading clinician and who had overall responsibility for each patient's care.

Throughout our inspection, we observed good interactions between medical, nursing, allied health professionals and support staff in all the areas we inspected. Staff we spoke with confirmed there was good multidisciplinary team working within the service and with external organisations.

Seven-day services

Key services were available seven days a week to support timely patient care.

Medical care (including older people's care)

Consultants led daily ward rounds on all wards. Patients were reviewed by consultants depending on their care pathway. Consultants on the acute assessment unit were available seven days a week and all new patients were seen on a daily basis. We reviewed the notes of 14 patients and found they all had a clinical assessment undertaken by a consultant as required within 12 hours of admission.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week. Consultant cover was provided seven days per week, with on-call arrangements out of hours. Key diagnostic tests could be undertaken seven days a week with urgent cases seen out of hours and at weekends.

In some areas, such as the acute assessment unit, staff told us there was access to therapies (such as physiotherapy and occupational therapy) seven days a week. However, this was not the case in all areas and there was a reduced service at the weekend that focused on patients who needed help the most.

Pharmacy was available seven days a week with an on-call service outside of usual working hours.

Access to social services (including discharge teams) was available Monday to Friday 9am till 5pm. However, some areas such as the acute assessment unit had a dedicated team based on the ward with access to social services seven days a week.

Is the service caring?

Inspected but not rated



We inspected but did not rate this service.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We observed staff engaging with patients in a positive and personalised way. Staff attitude was positive, and the atmosphere was warm and welcoming. Patients said staff treated them well and with kindness. We spoke with six patients during our inspection and they all had positive comments about the hospital and staff. Patients told us all staff were wonderful, caring and thoughtful.

Staff followed policy to keep patient care and treatment confidential. Staff closed curtains around patient bed spaces when delivering care to protect privacy and dignity. We observed staff knocking on doors, politely asking before opening curtains and waiting to be invited into rooms and cubicles.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Staff understood and appreciated the varying social and religious needs of their patients.

Understanding and involvement of patients and those close to them

Medical care (including older people's care)

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. Patients we spoke with told us staff communicated with them in a way, which they could understand, explaining their care, treatment and condition. All patients we spoke with told us staff fully involved them in their care.

We observed staff asking patients what they would like to be called and introduced themselves and their role. We observed staff involving patients during assessments and when taking observations on the ward.

Staff talked with patients in a way they could understand, using communication aids where necessary. We observed staff using language that patients understood and gave patients time to ask questions if they were unsure about anything. Staff interacting with confused patients showed genuine empathy, gave patients extra time and reassurance.

Staff recognised when patients needed additional support to help them understand and be involved in their care and treatment and enable them to access this. We saw, and staff told us how they could access language interpreters, sign language interpreters, specialist advice and advocates. There were special arrangements made for people living with dementia on medical wards.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Patients and their relatives provided feedback by completing patient surveys, and through the complaints and compliments procedure. We also saw thank you cards displayed in wards. Data provided by the service showed from April 2021 to January 2022, patients level of satisfaction and average recommendation was 96%.

Staff supported patients to make advanced decisions about their care. Staff told us patients and families about the importance of making advanced decisions so that they could make decisions about what happened to them.

Staff supported patients to make informed decisions about their care. Staff spoke openly with patients about the risks and benefits of procedures and treatment plans, so they could make informed decisions about their care. We noted where patients lacked capacity, family members had been involved in decision making and staff had a good understanding of the need to involve families and those close to the patient in their care.

Is the service responsive?

Inspected but not rated



We inspected but did not rate this service.

Service planning and delivery to meet the needs of the local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Medical care (including older people's care)

Managers planned and organised services, so they met the changing needs of the local population. The service understood the different requirements of the local people it served by ensuring that it actioned the needs of local people through the planning, design and delivery of services. The service worked collaboratively with external agencies to improve services provided by the trust. This included working with the clinical commissioners, general practices and neighbouring NHS trusts to identify the needs for the local community.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. Staff were familiar with the importance of same gender accommodation. We saw evidence of single gender bays, toilets and shower facilities on all wards. Data provided by the service following our inspection showed there were no mixed gender breaches between December 2021 and February 2022.

Facilities and premises were appropriate for the services being delivered. As a result of the COVID-19 pandemic, the service had reviewed the wards which enabled the service to continue to provide care for non COVID-19 patients. However, staff told us that bariatric patients could only be cared for on the acute assessment unit due to fire exits and structural implications. This sometimes led to pressure on other services within the hospital. A person is classified as having obesity and may be referred to as a bariatric patient when they have a body mass index (BMI) that is equal to or greater than 30.

Staff could access emergency mental health support 24 hours a day seven days a week for patients with mental health conditions, learning disabilities and dementia. The service worked well with local teams embedding a pathway to care for patients living with a mental health condition or a learning disability.

The service had systems to help care for patients in need of additional support or specialist intervention. Specialist nurses were available and assisted staff with the management of patients admitted to the hospital with various medical conditions.

The service had the Reminiscence Interactive Therapy Activities (RITA) system in place which offered digital reminiscence therapy. It was a relatively new tool in the fields of nursing and healthcare which encompassed the use of user-friendly interactive screens and tablets to blend entertainment with therapy and to assist patients (particularly with memory impairments) in recalling and sharing events from their past through listening to music, watching news reports of significant historical events, listening to war-time speeches, playing games and karaoke and watching films.

The service relieved pressure on other departments when they could treat patients in a day. Patients referred to the ambulatory care unit had been assessed as needing short-term care which should be possible to provide in the same day. Staff in the unit saw patients the same day and told us they were able to ask them to return for follow-up appointments if needed.

Access and flow

People could access the service when they needed it but did not always receive care promptly due to pressures on bed capacity. There was a high number of patients unable to leave the hospital as they were waiting for onward packages of care. Patients were being moved, sometimes at night, in order to admit them to the right place once a bed became available. Some patients were needing longer stays while they awaited treatment.

General and acute bed occupancy at Hinchingsbrooke Hospital was consistently lower than or similar to the East of England and England averages from 17 October 2021 until the end of December 2021. However, from the start of

Medical care (including older people's care)

January 2022 onwards, the proportion increased and became higher than the East of England and England averages. Managers recognised the service had capacity issues with available beds due to the high number of patients who were medically fit to go home, but were delayed due to a number of reasons, such as patients waiting to return to their care home or for a rehabilitation bed.

Staff were required to monitor the number of delayed discharges and look at how to manage these effectively. Data received from the service following our inspection showed a total of 44 patients under medical care at Hinchingbrooke Hospital were medically fit for discharge awaiting discharge as at 1 March 2022. Of these, four patients were waiting to return to their care home or restart care, 24 patients were waiting for home-based care, six patients were waiting for rehabilitation/interim beds, and 10 patients were waiting for care home based care.

Managers and clinical leaders participated in site meetings held three times a day. During these meetings managers discussed the number of patients waiting for an inpatient bed within the service, the number of discharges planned for patients, and plans on how to manage shortfalls.

Managers recognised the impact that delayed discharges had on flow throughout the service and were aware of the poor flow through the wider Cambridgeshire and Peterborough health and care system. They told us there was a high level of system working required towards resolving these issues.

Managers worked to minimise the number of patients requiring medical care being cared for on non-medical wards. They were discussed at the site meetings. While managers attempted to reduce the number of patients requiring medical care being nursed on alternative wards, this was made more challenging by the bed capacity pressures within the service. At the time of our inspection, there were 45 patients requiring medical care being nursed on alternative wards. In order to minimise risk, the service had arrangements for dedicated medical staff to review any medical patients on non-medical wards on a daily basis and there was a dedicated medical team responsible for the care of these patients.

Managers monitored waiting times and aimed to make sure patients could access services when needed to ensure they received treatment within agreed timeframes and national targets. However, given the significant strain on capacity in the services it was not always possible to do this.

The service had systems in place to improve access to timely treatment. Patients were generally admitted to the medical wards from the emergency department (ED), or the acute assessment unit (AAU). The acute assessment unit had dedicated multidisciplinary staff, including therapists, pharmacists and social services, based on the unit which allowed for timely assessments and onward treatment. However, due to bed capacity issues throughout the service, staff told us the length of stay in short stay wards and assessment areas had sometimes increased beyond what was clinically expected. This was as a result of demand on beds elsewhere in the hospital and patients being found a bed in areas which were not those planned for their care and treatment. The average length of stay on the AAU in the four weeks before our inspection was 24 hours, which was the expected length of stay within the unit. The average length of stay on the medical short stay unit (MSSU) for the same period was 132 hours. The expected length of stay on MSSU was less than 72 hours.

General Practitioners (GPs), paramedics and community teams had direct telephone access to AAU to relieve pressure on the ED. AAU had established admission avoidance pathways in place, such as providing elective infusions and access to a hospital at home service.

Medical care (including older people's care)

Staff tried not to move patients between wards at night. However, staff told us this was not always possible due to the high demand on beds and sometimes patients were moved between wards at night. Data provided by the service following our inspection showed between 31 January 2022 and 27 February 2022, there were a total of 633 moves at night in medical care.

Managers and staff worked to make sure patients did not stay longer than they needed to and started discharge planning for patients as early as possible. Most staff said discharge planning started from when the patient arrived. Staff planned discharge carefully, particularly for those with complex mental health and social care needs. The hospital had specific teams to support with discharge planning and finding onward care.

Is the service well-led?

Inspected but not rated



We inspected but did not rate this service.

Leadership

Leaders had the skills and abilities to run the service. They understood the priorities and issues the service faced and recognised further actions were required to address challenges within the service. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

There was an established leadership structure within the emergency and medical division. This included a divisional director, divisional operations director, and a divisional nursing director. They were supported by associate divisional directors, operational managers, clinical leads, matrons and ward managers. Staff we spoke with told us the management team were supportive and visible throughout the wards.

We met with the divisional leadership team (DLT) who spoke with pride about the work and care their staff delivered on a daily basis. The team demonstrated an awareness of the service's performance and the challenges they faced. However, the team recognised further actions were needed to address the challenges, including more cohesive working with system partners and more streamlined patient pathways.

The leadership team were committed to nurturing and developing a more coordinated approach to enable quality improvement to be embedded across the service. Senior leaders were involved on a day to day basis, to support a safe and effective approach to clinical staffing and patient flow. However, this was challenging given the pressure the service was facing. Leaders were aware of issues associated with delayed discharges impacting flow and had developed a plan to address them. This included working collaboratively with a number of partners, both internal and external, to lead on a programme of work designed to provide improvements in flow across the hospital. Other initiatives to improve the flow through the hospital included the relaunch of long length of stay meetings, collaborative approach to MDT teaching to ensure patients are referred for discharge support, three patient flow coordinators to work alongside the discharge planners, and targeted ward based teaching in patient flow initiatives. Managers were developing key performance indicators to measure success and highlight areas for improvement.

Medical care (including older people's care)

At a local level, matrons oversaw multiple wards and assisted ward managers. We observed that matrons were visible on the wards. Ward managers told us they were supported by the matrons and senior leads.

Ward managers were organised and demonstrated strong and supportive leadership. They were knowledgeable about the ward's performance against the trust priorities and the areas for improvement.

Leaders were supportive of staff development and staff we spoke to told us there were a number of internal and external leadership programmes available to them.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid compromising the quality of care.

There were clear assurance systems in place, and performance issues were escalated appropriately through established structures and processes. There were processes to manage current and future performance, which were regularly reviewed at specialty and divisional meetings. There was a systematic programme of clinical and internal audit to monitor quality, and systems were in place to identify where action should be taken.

The service had arrangements in place for identifying, recording and managing risks. The emergency and medical division had a risk register which included a description of each risk, an assessment of the likelihood of the risk materialising, its possible impact and the lead person responsible for review and monitoring. We observed the risk register was monitored within the governance framework and regularly reviewed.

Key quality performance indicators were measured and reported monthly to the trust board. They covered a wide range of quality indicators, including number of pressure ulcers and falls, infection control indicators, incidents, response to treatment times, complaints, and friends and family test results.

All the medical wards had a display board visible to visitors and staff, with details of their performance in relation to some of the ward quality indicators and also their planned and actual staffing levels.

Managers from the service took part in daily site meetings which had a focus on improving flow through the hospital where possible. These meetings were attended by colleagues from across both hospital sites meaning risk could be considered as an overall trust and shared.

There were regular staff meetings to share learning from incidents and complaints. Where specific actions were required, they were fed back at daily handovers and safety briefings.

The trust had a policy and plans in place for emergencies and other unexpected or expected events, such as adverse weather, flu outbreak or a disruption to business continuity.

Medical care (including older people's care)

Areas for improvement

Action the trust **MUST** take is necessary to comply with its legal obligations. Action a trust **SHOULD** take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust SHOULD take to improve

- The service should ensure risk assessments are completed in a timely manner. Regulation 12
- The service should continue to regularly review the nursing staffing levels in order to increase these to meet establishment levels.
- The service should continue to review and improve patient flow.

Urgent and emergency services

Inspected but not rated



Is the service safe?

Inspected but not rated



Our rating of safe stayed the same. We rated it as requires improvement.

Mandatory training

Mandatory training in key skills was available although not all staff had received it, and plans were in place to make sure everyone completed it. Not all staff received the relevant level of life support training.

Staff received mandatory training. Staff informed us most training continued throughout the COVID-19 pandemic, although it was held by line conferencing facilities. At the time of our inspection, mandatory training had reverted back to face-to-face training. The trust target for completion of mandatory training was 90%. Training rates varied with most falling below the trust target. For example, 72% of healthcare assistants and 73% of nursing staff had completed equality, diversity and human rights training, although 91% of administrative staff, 91% of medical staff and 100% of additional clinical services staff and estates staff had completed it. All staff groups were below the target for adult basic life support (65% healthcare assistants, 60% medical staff and 68% nursing staff) and paediatric basic life support (31% nursing staff).

Life support training was available, however staff confirmed they did not receive advanced paediatric life support training. Immediate life support training had been completed by 60% of nursing staff. Advanced life support was completed by 20% of medical staff and 73% of nursing staff. The department ensured there was always someone on shift with advanced adult life support training. Paediatric immediate life support had been completed by 60% of nursing staff. Due to no staff having advanced paediatric life support training, the department was not operating in line with standards for children in emergency care settings.

Various sepsis training modules were provided to staff. An annual training programme available to nursing staff had a 70% completion rate and a training programme for renewal every three years was available to medical staff, which had a completion rate of 29%. Additional practical competency training was available specific to adults, which had a completion rate of 65%, paediatrics with a 76% completion rate and maternity with a 76% completion rate.

The mandatory training was comprehensive and met the needs of patients and staff. Mandatory training included those topics listed within the core skills training framework including, but not limited to, fire safety, conflict resolution, manual handling and life support training relevant to the individuals role, for example paediatric immediate life support.

Training on recognising and responding to patients living with dementia was available through e-learning. However, training figures showed 37 out of 107 eligible staff had completed the dementia e-learning. Therefore, we were not assured staff had received suitable training to be able to adapt care and treatment for patients living with dementia.

Managers monitored mandatory training and alerted staff when they needed to update their training. Completion of training was monitored by administrative support and staff were reminded when training was due. The local leaders were aware various training modules were not in line with the trust target and had actions in place to improve this.

Urgent and emergency services

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Most staff had training on how to recognise and report abuse and they knew how to apply it.

Nursing staff received training specific for their role on how to recognise and report abuse, however it was not clear whether medical staff received training to the appropriate level. For safeguarding adults training, 89% medical staff had received level 1 training, 88% of nursing staff had received level 2 and 63% had received level 3. Data we received following our inspection indicated medical staff had not received training to the appropriate level, which was not in line with the intercollegiate document: adults safeguarding: roles and competencies for health care staff. However, we also received an email which confirmed 89% of medical staff had received level 3 training therefore we were unsure if medical staff had received the appropriate level of training or if this was a documentation issue.

For safeguarding children's training, 95% of medical staff had received level 1 training and 30% had received level 2 training. For nursing staff, 100% had received level 1, 80% had received level 2 and 77% had received level 3 training. Data we received following our inspection indicated medical staff had not received training to the appropriate level which was not in line with the intercollegiate document: safeguarding children and young people: roles and competencies for health care staff. However, we also received an email which confirmed 18% of medical staff had received level 3 training, therefore we were unsure if medical staff had received the appropriate training or if this was a documentation issue.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Records we reviewed demonstrated staff had considered potential safeguarding concerns during patient attendances within the emergency department.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. This was also evidenced in patient records we reviewed whereby the relevant authorities had been contacted.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They generally kept equipment and the premises visibly clean.

Areas we visited were visibly clean and had suitable furnishings which were clean and well-maintained. Although we noted in the fit to sit area, one chair had visible tears which would have prevented adequate cleaning and one drip stand was visibly dirty. We observed domestic staff carrying out cleaning responsibilities throughout our inspection.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Cleaning schedules were detailed including who was responsible for cleaning a specific area or piece of equipment, as well as the frequency. Schedules also documented when the next deep clean was due, as well as scheduled curtain changes. Weekly audits were carried out against the cleaning schedule, for the month of February 2022, the department achieved 98%.

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff were observed using PPE during patient contact, including washing hands before and after. There were sufficient supplies of PPE throughout the emergency department and adjoining areas. We also observed staff adhering to the practice of bare below the elbow. However, we noted dispensers for alcohol gel were not always filled.

Urgent and emergency services

Hand hygiene was audited on a monthly basis which demonstrated 100% compliance for January and February 2022.

Staff cleaned equipment after patient contact, although we did not see equipment labelled to show when it was last cleaned. We observed staff routinely cleaning equipment between patient use, including patient trolleys. However, equipment was not labelled to identify when it had been last cleaned which meant staff could not be assured they were using equipment which was clean and free from potential infection risks.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment generally kept people safe. Although, action had not been taken to reduce all risks around specific equipment. Staff were trained to use them. Staff managed clinical waste well.

Patients could reach call bells and staff responded quickly when called. Patients were able to access call bells and we observed staff responding to these quickly.

The design of the environment generally followed national guidance. Since our last inspection, improvements had been made to the physical environment of the service, including an expansion for a dedicated paediatric waiting area and paediatric consultation rooms. Staff told us this had improved the ability to see paediatric patients in a timelier manner as well as having oversight of them in the waiting area. While improvements had been made to the environment, paediatric patients were triaged within the waiting area if no cubicles were available which meant triage was carried out at times with other patients in the same room. There was also no dedicated toilet facilities which meant children would have to walk through the adult waiting room to access toilet facilities. This was on the departments' risk register.

There were two mental health rooms, one in the adult emergency department and one in the paediatric emergency department. Staff referred to these as quiet rooms. Both were safe and fit for their designated purpose.

In one of the two resuscitation rooms, an airflow outlet was in place close to an oxygen outlet. In June 2021, a National Patient Safety Alert (NPSA) was published regarding the 'elimination of risk of inadvertent connection to medical air via a flowmeter' which all trusts were required to be compliant with by 16 November 2021. We reviewed a copy of the trusts' action plan in relation to the alert and noted actions were still ongoing regarding the requisition of nebulisers, before being able to remove and discard all medical airflow meters except those tethered to equipment for niche use.

Cubicles were available in the major and minors area to isolate patients as required. However, there was not a separate isolation area with adequate resuscitation facilities. The clinical lead recognised this as a problem, although stated the need for a separate isolation area had not occurred. While this inability to segregate potential COVID-19 patients in the emergency department was on the departments' risk register as a low risk, there was no additional detail to determine whether the lack of a separate isolation area for resuscitation had been assessed. Following our inspection, the trust confirmed an assessment had been carried out, however no evidence had been provided to demonstrate this.

The emergency department was also reconfigured in response to the COVID-19 pandemic, which had changed in line with changing demands throughout the pandemic. Part of the waiting area had been sectioned off for those patients with COVID-19. Patients were triaged in this area. Patients were then walked through the ambulance area to an isolation cubicle to reduce the risk of exposure to the rest of the patients.

Staff carried out daily safety checks of specialist equipment. This included resuscitation equipment, which was available, stored safely and fit for purpose. Safety checks were carried out on a daily basis by staff.

Urgent and emergency services

The service generally had enough suitable equipment to help them to safely care for patients. However, junior doctors told us when the department was busy, majors patients were cared for in the minor area cubicles which did not have the relevant observation facilities. They were concerned about the potential risk to patient safety. This was not documented on the departments' risk register. At the time of our inspection, no incidents of harm to patients as a result of a lack of equipment in the minors area had occurred.

Staff disposed of clinical waste safely. Clinical and domestic waste bins were segregated appropriately, and sharps bins were signed, dated and stored appropriately.

Assessing and responding to patient risk

Staff generally completed risk assessments for each patient. They removed or minimised risks and updated the assessments. However, sepsis audit records demonstrated staff did not always identify and act upon patients at risk of deterioration.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Nationally recognised tools were used to identify deteriorating patients. We saw national early warning scores 2 (NEWS2) documented in patient records. Staff told us the actions they would take if a patient deteriorated.

The department completed spot check audits of the early warning scores to ensure staff completed the records accurately and escalated as appropriate. The trust had set a compliance target of 95%. In the period April 2021 to January 2022, the department did not achieve the target in May 2021 (65.5%), June 2021 (71%), September 2021 (77.8%) and October 2021 (90%). Compliance with NEWS2 from November 2021 to January 2022 had improved with compliance scores of 95%, 95.6% and 96.7%. Where areas for improvement was identified, action was taken.

Paediatric early warning scores were also monitored with a compliance target of 95%. In the period April 2021 to January 2022, the department did not achieve the target in June 2021 (88.6%), July 2021 (94%), October 2021 (92.8%) and January 2022 (90%). Where areas for improvement was identified, action was taken.

Walk-in patients were able to use a self-service check-in which was clarified by reception staff. Following check-in, patients were triaged using the Manchester Triage system. Half of the nurses (53%) had now received training in the Manchester triage system. Triage comprised of history of events, allergy status, vital signs observations and pain relief. We heard and observed the triage nurse assessing those waiting to see if patients needed a quicker assessment. We heard how two nurses would carry out triage if demand required it, however often due to staffing capacity, this was not possible. This meant as the department became busier, triage times became longer.

Patients arriving by ambulance would be triaged in the rapid assessment and treatment (RAT) area which was in use on the day of our inspection. However due to understaffing, this area was not always in use. If the RAT area was full or there was no cubicle for a patient arriving by ambulance, a handover of clinical information from the paramedics was taken by a clinician and documented as the triage without a clinician seeing the patient. This was escalated to the executive team at the end of our inspection. Ambulance crews monitored patients and carried out observations on the ambulance if patients could not be admitted to the emergency department straight away.

Children were triaged in a separate waiting area specifically for paediatrics.

Urgent and emergency services

During our inspection, we reviewed 13 sets of patient records and found five patients had been triaged within 15 minutes of arrival. Of the eight not triaged within 15 minutes, the times ranged from 17 minutes to two hours and 31 minutes. At 11.45am, we saw there were 38 patients in the emergency department, 10 patients were waiting for triage with the longest wait of 33 minutes.

Staff completed risk assessments for each patient and knew about and dealt with any specific risk issues. Completed risk assessments for falls, venous thromboembolism (VTE), sepsis and pressure areas were documented in patient records. Staff we spoke with were knowledgeable regarding specific risk issues.

Audits were carried out to monitor compliance with the sepsis six bundle. Audit results from December 2021 to February 2022 showed an improving picture, however, did not meet the trust target of 90%. In February 2022, 80% of the 20 patient records sampled were screened for sepsis, 56% of these had screening tools completed to trust standard. Forty-five percent were reviewed by a clinician within an hour, 85% had their oxygen requirements assessed within an hour and 40% had intravenous (IV) antibiotics administered within an hour. With the exception of three delays, the rest were due to delays in ambulance handovers. Fifty percent had IV fluid administration within an hour, 50% had blood cultures taken within an hour and 75% had a fluid chart commenced, although 45% of the total had a fluid chart commenced within an hour. Action plans were in place to work with the clinical teams to provide additional training.

The service had access to mental health liaison and specialist mental health support if staff were concerned about a patient's mental health. Access to this support was available 8am to 6pm, seven days a week. Records we reviewed demonstrated referrals were made to the psychiatric liaison team as appropriate. However, we observed a patient arriving by ambulance in crisis who waited at least two hours on the ambulance, had not been seen by clinical staff and no referral to the mental health teams had been made. The mental health team did not accept referrals after 3.30pm and the patient was still on the ambulance at 4pm. Staff confirmed patients would be admitted if support was required from the mental health team and they presented out of hours.

During our inspection we did not see staff complete, or arrange, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. We reviewed two sets of records for patients who may have been at risk of self-harm, which did not contain psychosocial assessments or risk assessments, although one had been referred to the psychiatric liaison team. This meant there was a potential that patients at risk of self-harm or suicide would not receive the relevant care and treatment or in a timely manner.

Staff shared key information to keep patients safe when handing over their care to others. We observed key information being handed over, for example when patients arrived by ambulance and information was given to emergency department staff, however ED staff did not have sight of the patients. One patient arrived by ambulance with chest pain, ambulance staff monitored the patient for more than an hour on the ambulance. Ambulance staff handed over patient information including from an electrocardiogram (ECG), which was documented as the triage. However, emergency department staff had not reviewed or seen the patient or the ECG. We alerted staff who then liaised with the ambulance staff.

Shift changes and handovers included all necessary key information to keep patients safe. Safety huddles and handovers were held at the beginning and end of each shift. Patient needs were discussed as well as specific risks and additional resources due to gaps in the staffing rotas.

Staffing

Nurse staffing

Urgent and emergency services

The service did not always have enough nursing staff and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers reviewed staffing levels and skill mix, and gave bank and agency staff a full induction.

The service did not always have enough nursing staff to keep patients safe. The emergency department had a planned establishment of 58 whole time equivalent (WTE) nursing staff, with an actual WTE of 44. There were ongoing recruitment programmes in place to fill the vacancies.

Staff confirmed each shift required 11 registered staff, five healthcare assistants and two emergency nurse practitioners; two of the 11 registered staff were registered sick children's nurses. However, despite an increase in the number of patient attendances, staff told us there were often gaps in the rota which were not always covered by agency staff. We reviewed the rota for February 2022 against the hours filled by agency and bank staff and noted any gaps in the rota were filled. However, this did not identify where staff were moved to help on wards, which we were told was often, and staff confirmed they did not report these as incidents. However, no patients had come to harm as a result of insufficient staffing numbers.

The department manager adjusted staffing levels daily according to the needs of patients. Staffing reviews were carried out and demonstrated an increase of 28.14 WTE for 2021/22 for Hinchingsbrooke Hospital emergency department. Staff told us when there were not enough staff on shift, the rapid assessment and treatment (RAT) area would not be in use and they felt additional staffing was not in place to meet the additional numbers of attendances the department was seeing.

The service had high vacancy rates. Nursing staff had a vacancy rate of 24% against the trust target of 5%. Although the service had low turnover rates against a trust target of 10% which was 5% for nursing staff.

Sickness rate for nursing staff were above the trust target. Nursing staff had a sickness rate of 6% in December 2021 which was at the trust target of 6%.

The service had high rates of bank and agency nurses. Throughout the month of February 2022, we noted bank and agency staff were used on a daily basis. Twenty-one point six percent of the worked hours were provided by agency staff and 17.31% by bank staff.

Managers limited their use of bank and agency staff and requested staff familiar with the service. This helped provide continuity with staff familiar to the service.

Managers made sure all bank and agency staff had a full induction and understood the service. This was recorded and filed for reference.

Medical staffing

The service did not always have enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix, and gave locum staff a full induction.

Urgent and emergency services

The service did not always have enough medical staff to keep patients safe. The emergency department had a planned establishment of 35.5 whole time equivalent (WTE) medical staff, with an actual WTE of 23. Consultant cover was in line with the Royal College of Emergency Medicine guidelines from 8am to midnight and a paediatric emergency medicine (PEM) consultant was also in post. The service had ongoing recruitment programmes in place to fill the vacancies.

The service had high vacancy rates. Medical staff had a vacancy rate of 35% against the trust target of 5%. Although the service had low turnover rates against a trust target of 10 which was 0% for medical staff.

Sickness rates for medical staff were low. Medical staff had a sickness rate of 3% against the trust target of 4%.

The service had low rates of locum staff and high rates of bank staff. Throughout the month of February 2022, 2.62% of the worked hours for medical staff was provided by agency staff and 41.93% by bank staff.

Managers could access locums when they needed additional medical staff. During our inspection, we spoke with three long-term locum doctors who also told us they received a full induction to the service before they started work.

The service had a good skill mix of medical staff on each shift and reviewed this regularly. However, junior doctors reported overnight shifts were not always filled, particularly within the middle grade rota. We reviewed the rota for February 2022 and noted gaps were filled with locum and bank staff.

The service always had a consultant on call during evenings and weekends. This was confirmed by the clinical lead and through review of the medical staffing rotas.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff stored and managed all medicines safely. The service now ensured fridge temperatures and the temperatures of the room where medicines were stored were routinely monitored. There were clear instructions of what action was required if temperatures were outside of the ideal range and staff were aware of what action to take.

Is the service responsive?

Inspected but not rated



Our rating of responsive stayed the same. We rated it as requires improvement.

Access and flow

People could not always access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not always in line with national standards.

Waiting times were monitored, however patients could not always access emergency services when needed and did not receive treatment within agreed timeframes and national targets.

Urgent and emergency services

During our inspection, we reviewed 13 sets of patient records and found five patients had been triaged within 15 minutes of arrival. Of the eight not triaged within 15 minutes, the times ranged from 17 minutes to two hours and 31 minutes. We also observed ambulance conveyed patients did not always have a face-to-face triage. For example, ambulance staff handed over patient information which was documented in patient records as the triage. However, clinical staff members from the emergency department had not seen or reviewed the patient themselves. This was escalated to the executive team at the end of the inspection.

Between October 2021 and December 2021, 19.8% of handovers took place more than 60 minutes from arrival. This was similar to the East of England average. Hinchingsbrooke emergency department reported the sixth highest proportion of handover delays for all hospitals covered by the ambulance service. During our inspection, staff told us ambulances could wait between one and two hours when the department was at its busiest.

The Royal College of Emergency Medicine (RCEM) recommends patients wait no more than one hour from time of arrival to receiving treatment. Between 17 October 2021 and 6 February 2022, 25.2% of patients received treatment within one hour of arrival. This was the fourth lowest site level in the East of England. Staff told us the number of attendances had increased, including an increase in the number of patients arriving by ambulance. This was to reduce some of the pressures from Peterborough City Hospital. Of the 13 records we reviewed, seven waited more than one hour to see a doctor, of those they ranged from two hours and nine minutes to four hours and 44 minutes.

Compliance with the RCEM guidance to see, treat, admit or discharge within four hours was not always met. While the trust overall was worse than the East of England and England average, Hinchingsbrooke emergency department fluctuated and throughout February 2022 was above the East of England and England averages to see, treat, admit or discharge patients within four hours. The clinical lead informed us the conversion rate to a ward admittance was between 10% and 12% of emergency department attendances. From October 2021 to February 2022, the percentage of patients admitted from the emergency department was consistently below the regional and England average.

Performance data showing the percentage of patients waiting longer than 12 hours from a decision to admit, was not broken down at site level. In November 2021, the trust reported 161 patients waiting more than 12 hours from the decision to admit, in December 2021 the trust reported 129. On the day of our inspection at 9.30am, the longest wait to be admitted was five hours and 46 minutes where the patient was waiting for a bed on a medical ward.

The clinical lead for the emergency department told us the use of a Hospital Ambulance Liaison Officer would assist with the flow of patients within the department. Although there were no current plans to introduce this role.

The teams worked to make sure patients did not stay longer than they needed to. There was an electronic information board at the nurses station which included how long patients had been in the department for, as well as NEWS2 scores. Records we reviewed confirmed that while patients sometimes had a delay in triage and to be seen by a doctor, they did not wait in the department an excessive amount of time before being discharged home or admitted to a ward.

The number of patients leaving the service before being seen for treatments was low. The trust stated no patients left the emergency department without being seen.

Is the service well-led?

Inspected but not rated



Urgent and emergency services

We inspected but did not rate this service.

Leadership

Leaders had the skills and abilities to run the service. They understood the issues the service faced but did not always manage the priorities well. They supported staff to develop their skills and take on more senior roles.

The divisional leadership team had the skills and abilities to run the service and understood the issues urgent and emergency care faced. Staff we spoke with told us the divisional leadership team were supportive, but not visible due to being based on the Peterborough City Hospital site and rarely attended site at Hinchingsbrooke Hospital. This had partly been recognised with the introduction of a new lead nurse specific to Hinchingsbrooke Hospital emergency department.

There was an emergency medicine divisional triumvirate for the trust which covered the emergency departments at Peterborough City Hospital and Hinchingsbrooke Hospital. A clinical lead, lead nurse and service manager for the emergency department reported to the triumvirate.

Staff told us they were supported to develop their skillsets and we noted some recent promotions within the department whereby staff had been supported to progress. For example, staff were supported by the clinical educators to develop leadership skills to develop to a band 7 role.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff told us they felt respected, supported and valued by their immediate line managers. Staff explained how they felt tired following the COVID-19 pandemic, however the trust had invested in ensuring the wellbeing of staff was maintained.

Staff were positive about working in the department and explained how the department felt like a family. Although some staff did feel exhausted from the increase of patient attendances within the emergency department without an increase in the number of staff. They remained focused on the needs of patients receiving care, with a passion to ensure patients remained safe with good quality care.

Staff explained how they were able to raise concerns with their immediate line managers and felt able to speak freely.

An open culture was promoted within the department to ensure staff, patients and their families could raise concerns, which were acted on.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact.

Urgent and emergency services

Assurance systems were in place to monitor risks, issues and performance, which were discussed at monthly clinical governance meetings. Themes from root cause analyses, clinical audits, mortality and morbidity reviews, complaints, risks and workforce were all discussed amongst other topics.

Risks were escalated to the executive team depending on the severity of the risk. The divisional leadership team spoke about the main risks within the service, including the capacity and capability of the division to affect the flow of patients throughout relevant pathways and the impact it had on urgent and emergency care performance.

The service' risk register mainly corresponded with concerns we had during our inspection. In total, there were 15 risks, of which eight related to both Peterborough City Hospital and Hinchingsbrooke Hospital and seven were specific to Hinchingsbrooke Hospital. The leadership team explained their top risks related to patients waiting on the back of ambulance, waiting to see a doctor and staffing. The inability to transfer patients from ambulances into the emergency department was the highest risk on the divisional risk register, the inability to recruit to consultant and middle grade positions was also a top risk. However, there was no risk recorded on the risk register relating to delays in seeing a doctor. The divisional team also spoke about the increase in diverted ambulances to Hinchingsbrooke and how this had impacted on staff morale, however there was no risk relating to this on the risk register.

Areas for improvement

Action the trust **MUST** take to improve

- The service must ensure appropriate staff receive advanced paediatric life support training and maintain mandatory training competencies. Regulation 18 (2) (a)
- The service must ensure medical staff have received the appropriate level of safeguarding adults and children training. Regulation 18 (2) (a)
- The service must ensure National Patient Safety Alerts are actioned, specific to airflow meters. Regulation 12 (1) (2) (a) (b) (d) (e)
- The service must ensure risks to patients are properly assessed and acted upon. Regulation 12 (2) (a) (b)
- The service must ensure patients are able to access treatment in a timely manner. Regulation 12 (2) (b)
- The service must ensure risk registers include the top risks of the division. Regulation 17 (2) (a)

Action the trust **SHOULD** take to improve

- The service should ensure equipment is clean and ripped fabrics are repaired or chairs are replaced. Regulation 12
- The service should ensure the environment is fit for purpose specific to the needs of paediatric patients. Regulation 15
- The service should continue the pace around nursing and medical staffing recruitment programmes.