The Princess Alexandra Hospital NHS Trust

The Princess Alexandra Hospital

Quality Report

Princess Alexandra Hospital
Hamstel Road
Harlow
Essex
CM20 1QX
Tel:01279 444455
Website: www.pah.nhs.uk

Date of inspection visit: 28 and 29 June 2016, 2 and 6 July 2016
Date of publication: 19/10/2016

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

Ratings

Overall rating for this hospital	Inadequate
Urgent and emergency services	Inadequate
Medical care (including older people's care)	Requires improvement
Surgery	Requires improvement
Critical care	Inadequate
Maternity and gynaecology	Outstanding
Services for children and young people	Requires improvement
End of life care	Inadequate
Outpatients and diagnostic imaging	Good

Summary of findings

Letter from the Chief Inspector of Hospitals

We carried out a comprehensive inspection on 28 and 29 June 2016 as part of our regular inspection programme. This inspection was carried out as a comprehensive follow up inspection to assess if improvements have been made in all core service since our last inspection in July 2015.

The Princess Alexandra Hospital NHS Trust is located in Harlow, Essex and is a 460 bedded district general hospital providing a comprehensive range of safe and reliable acute and specialist services to a local population of 350,000 people. The trust has five sites; The Princess Alexandra Hospital, St Margaret's Hospital, Herts and Essex Hospital, and Rectory Lane Clinic. At our inspection on 28 and 29 June 2016, we inspected The Princess Alexandra Hospital. On our unannounced inspection on 2 and 5 July 2016, we inspected The Princess Alexandra Hospital. We reviewed the service provided at the Rectory Lane Clinic and found that this location did not require registration, the trust would be applying to remove this location.

During this inspection, we found that there had been deterioration in the quality of some services provided since our previous inspection in 2015. During this inspection, we found that the trust had significant capacity issues and was having to reassess bed capacity at least three times a day. This pressure on beds meant that patients were allocated the next available bed rather than being treated on a ward specifically for their condition. We found that staff shortages meant that wards were struggling to cope with the numbers of patients and that staff were moved from one ward to cover staff shortages on others. The trust sees on average around 350 patients a day in its emergency department (ED).

We have rated The Princess Alexandra Hospital location as inadequate overall due to significant concerns in safety, responsiveness and leadership, with the apparent disconnect between the trust board leadership level and the ward level. It was evident that the trust leaders were not aware of many of the concerns we identified through this inspection. We found that the staff were very caring in all areas. We have rated the maternity and gynaecology service as outstanding overall.

Our key findings were as follows:

- Shortages of staff across disciplines coupled with increased capacity meant that services did not always protect patients from avoidable harm, impacted upon seven day provision of services and meant that patients were not always treated in wards that specialised in the care of health issues.
- The disconnect between ward staff and the matron level had improved. However, some cultural issues remained at this level which required further work.
- The relationship between staff and the site management team had improved, though this was still work in progress and the trust acknowledged further work was required here.
- Agency staff did not always receive appropriate orientation, or have their competency checks undertaken for intravenous (IV) care for patients on individual wards. This had improved by the time our unannounced inspection concluded.
- The storage, administration and safety of medication was not always monitored and effective.
- Information flows and how information was shared to trust staff were not robust. This meant that staff were not always communicated to in the most effective ways.
- The staff provided good care despite nursing shortages.
- There were poor cultural behaviours noted in some areas, with some wards not declaring how many staff or beds they had overnight to try and ease the workloads. This was a result of constant pressure on the service activities.
- The mortuary fridges had deteriorated since our last inspection and some were no longer fit for purpose. These were repaired and sealed during our unannounced inspection to ensure they provided an appropriate environment for patients.

Summary of findings

- Across surgery, there were notable delays in answering call bells on surgical wards including Kingsmoor and Saunders ward.
- Gynaecology inpatient care had not improved, but declined, since our previous inspection. The inpatient gynaecology service, which was operated through surgery, was not responsive to the needs of women.

We saw several areas of outstanding practice including:

- The ward manager for the Dolphin children's ward had significantly improved the ward and performance of children's services since our last inspection
- The tissue viability nurse in theatres produced models of pressure ulcers to support the education and prevention of pressure ulcer development in theatres. This also helped to increase reporting.
- The improvement and dedication to resolve the backlog and issues within outpatients was outstanding.
- The advanced nurse practitioner groups within the emergency department were an outstanding team, who worked to develop themselves to improve care for their patients.
- The gynaecology early pregnancy unit and termination services was outstanding and provided a very responsive service which met the needs of women.
- The outcomes for women in the maternity service were excellent and comparable with units in the top quartile of all England trusts.
- MSSA rates reported at the trust placed them in the top quartile of the country.
- The permanent staff who worked within women's services were passionate, dedicated and determined to deliver the best care possible for women and were outstanding individuals.
- The lead nurse for dementia was innovative in their strategy to improve the care for people living with dementia.

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

Importantly, the trust must:

- Ensure that safeguarding children's processes, reporting and investigations for the safeguarding of children are improved.
- Ensure that staff caring for children and young people have appropriate levels of life support training in line with the Royal College of Nursing 'Health care service standards in caring for neonates, children and young people'.
- Ensure that staff are provided with appraisals, that are valuable and benefit staff development.
- Improve mandatory training rates, particularly around (but not exclusive to) safeguarding children level three, moving and handling, and hospital life support.
- Ensure that there are safe and efficient staffing levels at all times.
- Ensure that resuscitation trolleys and difficult airway trolleys are routinely checked, stocked and kept in a safe condition for emergency use.
- Ensure that fridge temperatures are monitored, and acted upon when concerns are identified.
- Ensure that women undergoing elective gynaecology procedures, including but not exclusive to termination of pregnancy (TOP) procedures, are cared for by staff trained in the clinical, holistic and social needs of women.
- Ensure that rapid discharge of patients at the end of their life is monitored, targeted and managed appropriately.
- Ensure that trust staff are knowledgeable and provide care and treatment that follows the requirements of the Mental Capacity Act 2005.
- Ensure that governance arrangements, including the risk register and board assurance framework are embedded, robust, and actively reflect the risks within the organisation.
- Ensure that the quality of record keeping on critical care improves.
- Reduce the impact or likelihood of mixed sex accommodation breaches on the high dependency unit (HDU).
- Ensure that complaints are learnt from, and learning is shared throughout the trust.
- Ensure that patients arriving by ambulance into the ED are appropriately assessed and triaged in a timely manner in accordance with The Royal College of Emergency Medicine (RCEM) guidelines.

Summary of findings

As a result of the findings from this inspection I have recommended to NHS Improvement that the trust be placed into special measures. It is hoped that the trust will make significant improvements through receipt of support from the special measures regime prior to our next inspection.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	Inadequate 	Overall we rated the emergency department (ED) at The Princess Alexandra Hospital as inadequate. Safety and responsiveness of services was rated as inadequate, how effective and well-led the service was has been rated as requires improvement, and caring was rated as good. Patients arriving by ambulance were not routinely being initially assessed within 15 minutes as required. Many patients were in the ambulance waiting area for prolonged periods, with patients not being assessed or handed over to the trust teams. Levels of nurse staffing in the resuscitation room were unsafe. There was no clinical oversight or view of the waiting room. Regular checking of equipment, including resuscitation trolleys and defibrillators, was not taking place. Fridge temperatures were not routinely monitored to ensure safe storage of medicines. Mandatory training compliance for the department was low, especially on paediatric life support. The service was mostly following guidelines known to them from the Royal College of Emergency Medicine (RCEM) and National Institute for Health and Care Excellence (NICE). However, staff were not familiar with all recent guideline updates. Staff had not received regular appraisals. The unplanned patient re-attendance rate was consistently higher than the England average. Concerns were raised about how staff were trained, developed and progressed in their roles within the ED. There was a lack of clinical audit taking place. The service had not achieved the four hour performance standard since August 2014. The percentage of patients waiting four to 12 hours from the decision to admit until being admitted has been longer than the England average since May 2015. Ambulance delays over 30 minutes were some of the worst in England. Black breach rates were high. Calls bells went unanswered for prolonged periods of time when the emergency department was busy. Staff we spoke with were unaware of the trust's values. There was a business plan, vision and strategy for the service with some basic objectives

Summary of findings

for the ED to improve around four hour performance. However, it was limited to four hour performance and financial penalties, rather than linking it to patient safety and outcomes.
Caring was good because the trust had systems in place to offer multi-faith support and bereavement services. Care provided by staff to patients was seen as kind and compassionate.

Medical care (including older people's care)	**Requires improvement**		We have rated medical care at The Princess Alexandra Hospital as requires improvement overall, with safety and responsiveness rated as requires improvement and the other domains rated as good. Nurse staffing levels did not always meet the expected established staffing requirements on the wards. Agency nurses were administering intravenous medications without providing evidence of training competencies, which placed patients at risk. However, the trust took immediate action to resolve this. There were gaps in the checking of the resuscitation equipment and medicines fridges. There were gaps in the records for the controlled drugs register checks. Staff were not always aware of outcomes from local audits. Appraisal rates had reduced since our last inspection. There were high numbers of out of hours discharges reported. The trust acknowledged that there were issues with speciality input and bed availability as patients could not always be placed on the appropriate specialist ward. There was a clear leadership structure across the service. Staff showed a commitment to the service and demonstrated pockets of innovation in their area of work. However, we also identified risks to the service that had not been identified on the risk register. We were concerned about some of the poor cultural practices of the nursing staff in the medical care services. Staff demonstrated a kind, compassionate and caring approach to patients. However, we also found that there was a theme in complaints relating to staff communication issues with patients and their relatives.

Summary of findings

Surgery

Requires improvement

Surgery services required improvement overall. Safe was rated as inadequate, with effective, caring, responsive and well-led rated as requires improvement.

The reduction in nurse staffing had direct impact on patient safety on Kingsmoor and Saunders ward with delayed care. Establishment nursing numbers did not match patient acuity consistently. Management of incident reporting was not robust. Monitoring of staff competencies was poor. Mandatory training rates were low across surgery. Storage of intravenous (IV) fluids on Saunders ward was not secure. Medication prescription and administration was not time specific. The difficult intubation trolley in theatres was not appropriately stored or regularly checked. The quality of mortality and morbidity meetings was poor.

Not all guidelines were updated in line with national guidance. The trust results in the National Emergency Laparotomy Audit indicated four out of 11 measures reported were rated amber. Appraisal rates were poor. Consent on the day meant there was a very limited opportunity for patients to consider all the information prior to the procedure taking place.

Staff delivered care in a compassionate, supportive and considerate manner. Patients provided consistently positive feedback about their care and treatment. Friends and Family Test data (FFT) showed an average of 97.8% of patients on surgical wards said that they would recommend the service. Call bells were not answered in a timely manner. Patients were not always aware of which ward they would be admitted to after surgery. Referral to treatment times (RTT) standard of 92% was met in only four of 11 specialties. Theatre utilisation was impacting on service delivery. Discharge planning was not consistent. Out of hours transfers between 10pm and 7am were high. The number of patients being held in the post anaesthetic care unit (PACU) for more than 12 hours was high.

There was instability within the senior management team. Oversight to risk and quality management was limited. Staff at a local level were not

supported to ensure that risks were identified, reported and managed in a timely manner. Failure to retain and recruit staff was impacting on staff morale.

Critical care

Inadequate

Overall we rated critical care services at The Princess Alexandra Hospital as inadequate. Safe, responsive and well-led were rated as inadequate. Effective was rated as requires improvement, and caring was rated as good.

There was evidence of poor medicines management practices, which posed potential serious risks to safety. Concerns included unsafe practices with morphine, carelessness in the storage and transfer of potassium chloride, and access to controlled drugs by non-registered staff. There was poor and inconsistent documenting of patient records. There was little evidence of learning from incidents and sharing feedback among staff, meaning there was an increased potential risk of incidents reoccurring. The difficult airway trolley was disorganised, incomplete and had items on it that were not part of the trolley. We saw that the last check carried out on the trolley was five months prior to the inspection. Daily checks were not being carried out on resuscitation trolleys. We were concerned about the competencies and induction processes for agency staff as the unit was not conducting internal competency checks. The quality of mortality and morbidity meetings was poor.

There was a lack of effective multidisciplinary (MDT) working. Physiotherapists did not have sufficient input to maximise patient outcomes and physiotherapy staffing did not meet national standards, which could have an impact on patient rehabilitation needs. Documentation of MDT working in patient records and handovers was poor. Ward rounds did not routinely involve MDT input. Staff gave negative feedback about the training they received to maintain competencies. Appraisal rates were the lowest in the trust at 23%.

Bed occupancy was consistently at 100% or over. There were mixed-sex accommodation breaches on the unit owing to the lack of capacity, and no evidence of action taken to mitigate this. Critical care patients regularly had to be treated in the post

anaesthetic care unit (PACU) because of the lack of bed space. The longest length of stay in the PACU was over 72 hours. Delayed discharges were a significant risk owing to the problems with access and flow on the unit. There was a high rate of out of hours discharges at over twice the rate on average for similar units nationally. There was no clear formal system in place for learning from complaints and concerns in order to improve the service for patients.

There was a lack of information sharing between the service leads and the staff on the unit. The risk register did not include several of the risks to patient safety we observed during our inspection such as the poor culture surrounding medicines management and controlled drugs, and the inconsistent documentation of patient records. We were concerned about some aspects of the culture as some members of staff told us leadership was not visible or approachable, and felt unsupported.

Maternity and gynaecology

Outstanding ☆

Overall we rated maternity services as outstanding. With caring and well-led outstanding and safety, effective and responsiveness being rated as good. Incident reporting and learning from incidents was embedded within the service. The environment within the unit was secure. The service was consistently providing 60 hours, or more, of consultant time to the labour ward per week. Staffing levels were monitored and managed effectively.

Outcomes for women who used services were generally better than expected when compared with other similar sized services. However caesarean section rates were higher than the national average. Breastfeeding rates were better than the England average and natural vaginal delivery rates were the best in the East of England and comparable with the national average for England. The service had an outstanding process for auditing, learning from national reports and recommendations as well keeping up to date with current guidelines. The termination of pregnancy service was outstanding and followed all elements of national guidelines and legislation.

The maternity service was rated as outstanding for being caring because staff providing both maternity

and gynaecology care were dedicated, compassionate, caring and they consistently went beyond the call of duty to deliver the best experience possible for the women.
The services were delivered working in partnership with commission teams and community services within Essex and across the borders. However, we also found that the lack of a gynaecology in-patient ward meant that women did not always receive timely care whilst accommodated in various wards across the trust.
The governance and risk management systems within maternity and gynaecology services were robust and well established. The medical, midwifery and operational leadership team were respected and staff spoke highly of the clinical leads for the service and how involved and approachable they were, which created an open culture.

Services for children and young people

Requires improvement

Children and young people's services were rated as requires improvement overall, with the safe domain rated as inadequate, well-led rated as requires improvement, and the remaining domains rated as good.
The service was rated as requiring improvement for safety because root cause analysis investigations and three day investigation reports were not always completed to a good standard. Processes for safeguarding children were not robust, as reflected by five serious safeguarding incidents. This was a long standing issue from our previous inspection. Mandatory training levels were below the trust target across the service, and were at their lowest for medical staff.
Daily safety checks for emergency trolleys, controlled drugs and drug fridge temperatures were not consistently completed. This was reflective of a poor culture on Dolphin ward and the neonatal unit around daily checks. An audit into antibiotics usage on the neonatal unit showed that babies waited over double the time recommended to receive antibiotics when required.
The service was not in line with Royal College of Nursing guidelines relating to staff training levels for life support training. The transition service was disjointed for long term conditions and the service did not have a transition nurse, with provision in

place for diabetic children but not epileptic children. Staff were not trained in supporting children with mental health problems despite mentally unwell children regularly being admitted to the ward.
Response rates for the Friends and Family Test were very low and did not give any context to the results of the survey. Parents and carers on the neonatal unit felt that communication was lacking.
Arrangement of the environment in the day surgery unit and recovery areas meant that children had to walk past adult areas to get to the anaesthetic room, and adults in recovery would often directly face the children's bay.
We were concerned that there was a lack of grip from the leaders of this service in regards to management monitoring and actions regarding the safeguarding of children. There were significant risks for safeguarding children that were thematic and were similar to themes from the last inspection that had not been addressed.

End of life care

Inadequate

End of life care at The Princess Alexandra NHS Trust was rated inadequate overall. Safe and effective have been rated requires improvement, with caring rated as good. Well-led and responsive have been rated as inadequate.
The mortuary environment was not fit for purpose, with damage and inefficiencies in the workings of the fridges and freezers. Medical staffing was not in line with national guidance, with the equivalent of 0.4 whole time equivalent palliative care consultants. Medical staffing was being provided on a service level agreement from two local hospices.
Safeguarding was not included within the anticipated last days of life care plan. There was a risk nursing staff may not consider safeguarding when undertaking care planning. Medication was being prescribed and administered without documenting times on medication charts.
Patient outcomes were not routinely or robustly being monitored. The trust had a decrease in the number of clinical outcomes achieved within the End of Life Care Audit, published in March 2016.
There were no end of life care champions in clinical areas. Multidisciplinary team meetings were attended by palliative care nurses and a palliative

care consultant. However, no other professions attended, for example physiotherapy, occupational therapy or social workers. There was inconsistent knowledge amongst staff around the Mental Capacity Act.
No formal counselling or emotional support was available for patients at the end of life or their families. One patient stated they felt no member of staff was taking the lead on their care.
The trust did not routinely monitor patients preferred place of care or preferred place of death.
The fast track discharge process was not being monitored or audited for patients at the end of life. Patients were at risk of waiting extended periods of time to be discharged.
There was no vision or strategy in place for end of life care. A non-executive director had been appointed to lead end of life care. However, this was in May 2016 and they were not yet fully established in post. There was a disconnect between clinical staff and the executive lead for end of life care. The executive and non-executive leads showed limited oversight of the service. There was no risk register which collated risks for end of life care that could be monitored. The risks identified by the specialist palliative care team and the executive team did not match the risks that had been documented. There was a decline in compliance with 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR) form completion, despite executive oversight. The trust had limited improvement plans in place at the time of inspection.

Outpatients and diagnostic imaging

Good

Outpatient and diagnostic imaging services at The Princess Alexandra Hospital have been rated as good overall. Safe, caring and well-led have been rated as good with responsiveness requiring improvement. We do not rate effective in outpatient and diagnostic services due to there being an inconsistent data set for services of these types.
During this inspection we followed up on a number of areas which we found to be inadequate or requiring improvement during our last inspection in July 2015. The previous issues related mainly to

patients having to wait unsafe amounts of time before being offered an appointment. We found that the service had taken action and improvements were seen.

We rated this service as good because:

Staff were aware of how to report incidents and when this should be done. There was a clear escalation pathway for safeguarding concerns and medication was stored appropriately, in line with manufacturer's guidance. Mandatory training compliance was good and staff were competent in their roles. However, the main outpatient department was dated and in need of repair and refurbishment, and 10 out of the 11 patient records we reviewed did not contain up to date patient information.

Policies and procedures were developed using relevant national best practice guidance and patient outcomes were monitored via national audit arrangements. However, the local audit plan was limited in content meaning that there was limited opportunity to improve patient outcomes locally.

Staff provided compassionate and respectful care to patients. We observed that staff were understanding and maintained patient dignity. The majority of patient feedback that we received during our inspection was positive, and the latest Friends and Family Test (FFT) results demonstrated 96% of patients would recommend the service.

Outpatient and diagnostic imaging services were well-led. There was a cohesive leadership team and staff felt managers were approachable and that there was a strong open culture. Patients and staff were engaged in the running of the service and staff were enabled to be innovative. Since our previous inspection, governance systems had been reviewed and a clear structure had been put in place.

The Princess Alexandra Hospital

Detailed findings

Services we looked at

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

Detailed findings

Contents

Detailed findings from this inspection	Page
Background to The Princess Alexandra Hospital	15
Our inspection team	15
How we carried out this inspection	16
Facts and data about The Princess Alexandra Hospital	16
Our ratings for this hospital	17
Findings by main service	18

Background to The Princess Alexandra Hospital

Sites and Locations:

The trust has four sites. The main site is The Princess Alexandra Hospital. There are also smaller sites where services are provided including St Margaret's Hospital, Herts and Essex Hospital and the Rectory Lane Clinic.

Population served:

The Princess Alexandra Hospital NHS Trust is located in Harlow, Essex and is a 460 bedded district general hospital providing a comprehensive range of safe and reliable acute and specialist services to a local population of 350,000 people. Harlow is classed as an urban area, in which the largest age group is 16 to 44 (38.6%). The distribution of age groups is similar to the England Average. Black, Asian and minority ethnic (BAME) residents make up 11.1% of the population, within which the largest group are those identifying as Asian / Asian British (4.6%) of total population.

Deprivation:

The Princess Alexandra Hospital is situated in Harlow, Essex. Harlow Local Authority is in the second most deprived quintile nationally. The health of people in Harlow is varied compared with the England average, about 20% children live in poverty. Life expectancy is lower than the England average. 18.2% of children (year 6) and 27% of adults are classified as obese and the levels of teenage pregnancy are worse than the England average. The rate of smoking related deaths was worse than the average for England and rates of sexually transmitted infections and tuberculosis (TB) are worse than average.

Our inspection team

Our inspection team was led by:

Chair: Gill Hooper, retired Director of Nursing/Deputy Chief Executive

Head of Hospital Inspections: Fiona Allinson, Head of Hospital Inspections, Care Quality Commission

The team included 10 CQC inspectors and a variety of specialists including, a director, a director of nursing, head of clinical services and quality, a pharmacist, two medical consultants, a consultant in emergency medicine, a consultant obstetrician, an intensive care consultant, a consultant midwife, a consultant critical care nurse, a junior doctor and seven nurses at a variety of levels across the core service specialities.

Detailed findings

How we carried out this inspection

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

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

The announced inspection took place on 28 and 29 June 2016. The unannounced inspections took place on 2 and 5 July 2016.

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

We carried out an announced inspection visit on 28 and 29 June 2016. We spoke with a range of staff in the hospital, including nurses, junior doctors, consultants, administrative and clerical staff, radiologists, radiographers, pharmacy assistants, pharmacy technicians and pharmacists.

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

We would like to thank all staff, patients, carers and other stakeholders for sharing their balanced views and experiences of the quality of care and treatment at The Princess Alexandra Hospital NHS Trust.

Facts and data about The Princess Alexandra Hospital

Size and throughput

This organisation has four locations

There are 501 beds in the trust. With 388 for emergency and elective adult inpatients.

The main commissioning CCG at this trust is West Essex CCG and East and North Herts CCG.

The trust serves a population of approximately 350,000 people from Harlow, Essex and East Hertfordshire.

The trust employs 2817 staff (WTE).

The trust revenue is £196.1million and cost was £233.8million, leaving a 2015/16 deficit of £37.7million.

There were approximately 115,000 accident and emergency (A&E) attendances at this trust between 2015/16 and 72,120 inpatient admissions. During 2015/16 there were 2302,960 outpatient appointments.

Safety

There were two never events reported March 15 to March 16. Both were reported in surgery.

There have been zero counts of MRSA, 20 of Clostridium difficile (C.Diff) and three of MSSA reported between March 2015 and March 2016. MSSA rates reported at the trust placed them in the top quartile of the country.

Effective

There were two mortality outliers in this trust in skin and subcutaneous tissue infections and therapeutic endoscopic procedures on upper GI tract.

Caring

In the CQC inpatient survey 2015 the trust performed "about the same" as other trusts for all but one question.

Responsive

Between 2015/16, this trust received 292 complaints.

Detailed findings

Public funding was the most common reason for delayed transfer of care (38.2% for the trust where the England average is 4.5%).

Bed occupancy for been consistently higher than the England average since January to March (Q1) 2015/16.

Well-led

Since January 2014 staff sickness levels have decreased and have remained below the national average.

In the GMC National Training Scheme Survey, all answers except two were "within expectation"

In the NHS staff survey: the trust had 14 negative findings, and 10 positive findings.

Our ratings for this hospital

Our ratings for this hospital are:

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

Urgent and emergency services

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

Information about the service

The Princess Alexandra Hospital is located close to Harlow town centre and draws on a core population of approximately 350,000 people. Patients attend the emergency department from various areas including West Essex and East Hertfordshire. Harlow is classed as an urban area, in which the largest age group is 16-44 years of age, this is approximately 38.6% of the local population and similar to the England average. Harlow local authority is in the second most deprived quintile nationally.

The Princess Alexandra Hospital NHS Trust emergency department had 98,640 attendances between April 2015 and March 2016, 22,515 attendees were under 17 years of age. The number of patients attending urgent and emergency care services at The Princess Alexandra Hospital has decreased by approximately 927 patients in comparison to April 2014 to March 2015. The accident and emergency (A&E) department was originally built for approximately 60,000 attendances per year but is currently seeing in excess of 98,000 attendees.

The emergency department offers immediate emergency and urgent care to the patients of West Essex and East Hertfordshire. Emergency services are provided 24 hours a day, seven days a week. The department consists of 15 majors cubicles, three resuscitation beds, a majors ambulatory care unit and a separate paediatric emergency department. The paediatric emergency department consists of five cubicles and a high dependency bay and provides cover from 7.30am to 1am seven days a week. Outside of these hours, paediatrics are directed to the main adult emergency department. In addition, the department offers access to a general practitioner (GP), which is provided by a private company in the aim to reduce admissions to the emergency department.

We used a variety of methods to help us gather evidence during our two day inspection of the emergency department. We spoke with 11 patients and 28 members of staff employed in various roles including doctors, nurses, clerical and domestic staff. We reviewed 18 sets of patients notes for accuracy and completeness, paying particular attention to the correct following of specific pathways for conditions such as head injury and SEPSIS (also referred to as blood poisoning or septicaemia). In addition, we checked the environment for cleanliness and the maintenance of equipment within the department. We looked at a range of data provided by the trust prior to inspection and also checked documents and policies available to staff within the emergency department.

In addition, the director of operations, emergency department lead consultant, associate chief nurse and a senior nurse from the emergency department were interviewed.

Urgent and emergency services

Summary of findings

Overall we rated the emergency department (ED) at The Princess Alexandra Hospital as inadequate.

- Patients arriving by ambulance were not routinely being initially assessed within 15 minutes as required. Many patients were in the ambulance waiting area for prolonged periods of time, with patients not being assessed or handed over to the trust teams. The trust was of the view that the ambulance crew were responsible for the patients. However, this was not correct and not in line with the Royal College of Emergency Medicine (RCEM) guidelines.
- Patients in the corridor area waiting to be handed over to trust staff were clinically at risk of deterioration due to a lack of clinical oversight from trust staff. The staff working within the department were not able to tell us who was waiting, and who were the sickest patients to come into the department as a priority.
- Levels of nurse staffing in the resuscitation room were unsafe. We observed at times throughout the inspection that one nurse was caring for three acutely unwell patients in the resuscitation area.
- There was no clinical oversight or view of the waiting room.
- Regular checking of equipment including resuscitation trolleys and defibrillators was not taking place.
- Fridge temperatures were not routinely monitored to ensure safe storage of medicines. Medicines cupboards security was a concern due to the key safe with all keys in being left unlocked, the entrances to the main department were also not secure.
- At the time of the inspection, we noted that the agency staff employed were administering intravenous medicines (IV's) without the trust checking or assessing their competencies to undertake this work.
- Mandatory training compliance for the department was low, we were particularly concerned about the low levels of paediatric life support training.
- Staff were not aware of the changes or updates to the major incident plan, and staff had not received any recent practical training in major incident awareness.
- Despite frequently assisting patients with mental health conditions, security staff had no training in relation to mental health awareness.
- The emergency department was mostly following guidelines known to them from the RCEM and National Institute for Health and Care Excellence (NICE). However, staff were not familiar with all recent guideline updates.
- Staff had not received regular appraisals with 45% of nursing staff within the ED and 7.1% of paediatric nurses receiving an appraisal. The unplanned patient re-attendance rate was consistently higher than the England average.
- Concerns were raised by staff about how staff were trained, developed and progressed in their roles within the ED.
- The undertaking of local audits was limited, with minimal nursing audits being undertaken. There was a lack of clinical audit taking place. The trust participated in national RCEM audits. The trust audit results for the RCEM audits were below the required standard. Some of these audits were reported on in our last inspection because no new audits had been published nationally during the last 12 months.
- The service was not achieving the four hour performance standard since August 2014. The percentage of patients waiting four to 12 hours from the decision to admit until being admitted has been longer than the England average since May 2015.
- During winter 2015/16 the trust was in the 25% of trusts in England with the most ambulances delayed over 30 minutes. The rate of black breaches for ambulance handovers was high.
- Calls bells went unanswered for prolonged periods of time when the emergency department was busy.
- Staff were unaware of the trust's values.
- Key risks around not being up to date with RCEM guidelines in ED had not been identified through the governance process.

However:

Urgent and emergency services

- Staff were familiar with the incident reporting system.
- Patient records were well completed.
- The emergency department had seven whole time equivalent and one long-term locum consultants in place at the time of our inspection.
- Hydration and nutritional needs of patients were being met.
- Clear pathways were in place for patients with head injuries and fractured neck of femur. Pain relief was monitored and well managed.
- Care provided by staff to patients was seen as kind and compassionate. We spoke with 11 patients who reported that staff were kind and caring and that they felt informed them of their treatment plans and condition.
- The NHS friends and Family Test results revealed that from March 2015 to February 2016, 91% to 97% of patients would recommend the department to friends and family.
- The department had access to a dedicated nurse specialising in dementia and learning disabilities.
- The number of people leaving the emergency department before being seen was consistently better than the England average.
- Nursing staff had a good working relationship with consultant staff.
- The local risk register reflected many of the key risks for the service, with clear plans in pace to monitor these.
- There were processes in placed for patient and staff engagement.

Are urgent and emergency services safe?

Inadequate

We rated the safety of urgent and emergency care as inadequate because:

- Levels of nurse staffing in the resuscitation room were unsafe. We observed at times throughout the inspection that one nurse was caring for three acutely unwell patients. However, since the inspection the trust has taken action and increased staffing to cover the resuscitation area, but it would take time to ensure this staff level was stable.
- There was a 25% nursing staff vacancy rate with a 30% turnover rate.
- Patients arriving by ambulance were not routinely being initially assessed within 15 minutes as required. Many patients were in the ambulance waiting area for prolonged periods with patients not being assessed or handed over to the trust teams. The trust was of the view that ambulance crews were responsible for the patients. However, this was not correct and not in line with RCEM guidelines.
- Patients in the corridor area waiting to be handed over to trust were clinically at risk of deterioration due to a lack of clinical oversight from trust staff. The staff working within the department were not able to tell us who was waiting, and who were the sickest patients to come into the department as a priority. This placed patients at risk of harm. The trust took action to resolve this, though on our unannounced inspection the new process was not yet embedded.
- Regular checking of equipment including resuscitation trolleys and defibrillators was not taking place in the department leading to concerns that should this be required, it would be either missing or not working correctly.
- During our unannounced inspection, we noted that one resuscitation trolley adjacent to the majors ambulatory care unit was inaccessible due to being blocked by a variety of other equipment. The trolley had also not been checked for two days.

Urgent and emergency services

- On both days of our inspection, and during the unannounced inspection it was noted that the key safe, containing keys to access medications within the majors area was open therefore allowing access to drugs such as muscle relaxants, pain relief and antibiotics.
- There was no clinical oversight or view of the waiting room within the ED. During our inspection, a patient collapsed in the waiting room and other patients had to call for help. Trust staff swiftly responded but it was a known risk to the department. The trust was implementing changes to the area following our inspection.
- Agency staff were administering IVs without the trust checking or assessing their competencies to undertake this work. The trust took immediate action to stop this following our inspection. However, during the unannounced inspection we observed an agency staff member go to give intravenous (IV) medicines.
- Training figures revealed the trust had failed to meet its target of 95% in relation to the training of both medical and nursing staff for the safeguarding of children levels one, two and three.
- On both days of our inspection, access to the main emergency department from the waiting area was not secure.
- Emergency department staff were not aware of the changes or updates to the major incident plan. Staff had not received any recent practical training in major incident awareness.
- Within the ED 0% of medical staff had received paediatric intensive life support (PILS) training, 16% of adult nurses, 8% of ENP's, and 58% of paediatric ED staff had received training.

However, we also found that:

- Staff were familiar with the incident reporting system. We saw evidence that learning had taken place from investigations that had been carried out as a result of incidents.
- Reviews we carried out on patient notes revealed accurate completion with the appropriate following of pathways if applicable to patient care.
- The emergency department had seven whole time equivalent and one long term locum consultants in place at the time of our inspection. A business plan for 12 consultants had been accepted and recruitment was ongoing.

Incidents

- There have been no 'never events'. Never Events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. reported in the urgent and emergency care department between March 2015 and March 2016.
- The trust reported six serious incidents (SI's) within the emergency department between March 2015 and March 2016, of which one pertained to abuse/alleged abuse of an adult patient by staff, one was in relation to delayed diagnosis.
- Staff reported incidents using an electronic Datix system, staff we spoke with were all able to explain how to report an incident and if in doubt, they felt confident discussing their concerns with a member of senior staff.
- Staff attended daily 'safety huddle' meetings to discuss incidents and learning from these. We saw a board in the staff room named 'Know what you are doing' detailing incidents and learning from these with clear examples provided. Incident meetings took place once per week, the aim of which was to discuss complaints and incidents and then feedback pertinent information to staff.
- We saw evidence that mortality and morbidity meetings were taking place on a monthly basis. We viewed past programmes, agendas and examples of action plans that had been put in place with information cascaded to appropriate staff members.
- We were told by a senior nurse that the duty of candour policy had recently been updated, this policy had been discussed at 'safety huddle' meetings. When speaking with two middle grade medical staff we found a lack of knowledge and understanding around duty of candour.
- The root cause analysis of four incidents from the trust were reviewed to gain assurances that incidents were investigated correctly and lessons learnt. One incident revealed that there was a lack of knowledge surrounding the need to refer children to safeguarding if their parent/carer were admitted to the emergency department. The root cause analysis for this incident revealed clear recommendations to ensure that children were referred appropriately and in a timely manner. As a result of this investigation, plans were put in place to

amend the department's electronic patient information system to include a visual computer prompt for staff in relation to possible concerns for children in the care of the patient they are assessing.
- A senior member of nursing staff reported mortality and morbidity (M & M) meetings occurred on a monthly basis. Due to sickness within the trust we were told that recent meetings prior to our inspection had been cancelled.
- We spoke with one doctor in the emergency department who reported they tried to attend the monthly M & M meetings and described receiving an annual email summarising M & M issues.
- We saw past programmes for M & M meetings with clear agendas and examples of actions plans being raised and circulated within the emergency department. There was a named lead responsible for this circulation of information.

Cleanliness, infection control and hygiene

- There were no reported cases of MRSA between April 2015 to March 2016.
- There had been no reported cases of Clostridium difficile (C-diff) in the period April 2015 to March 2016 in the emergency department.
- Hand hygiene audit data provided by the trust for the emergency department revealed that for a 12 month period between April 2015 and March 2016, audit results were not available for five of these months. Results varied between 90% and 100%. The paediatric accident and emergency department achieved 96% to100% for all except one month where data was not provided.
- During our inspections we observed good episodes of hand hygiene from nursing staff. However, we noted on three occasions, doctors did not wash their hands in between patient care and when handling blood gasses/ samples and touching equipment.
- One doctor was not bare below the elbow as wearing a wristwatch, which they were asked to remove and immediately did.
- Monthly cleaning audits were carried out for both the adult and paediatric emergency department. This data revealed that from March 2015 to February 2016 the adult department achieved an average 91% compliance for this period. The paediatrics emergency department achieved, on average 94% compliance for the same period of time. The trust target for cleanliness audits was 98%.
- Hand hygiene audits completed between July 2015 and March 2016 showed that the ED did not submit data on four of the eight months (50% submission rate) during this period. The results ranged from 100% to 90% compliance. The trust's target for compliance is above 95%, which the service achieved on three months during this period.
- Domestic staff told us they replaced the disposable curtains in the department when visibly soiled and at least every six months. All curtains we saw were dated within six months of use and appeared visibly clean.
- There were numerous hand gel dispensers available to staff and patients within the emergency department. Dispensers were located in prominent locations on entrance to the reception area. Gloves and aprons were readily available for staff within the department.
- All areas were clean with active cleaning taking place during the two day inspection period.
- All clinical waste bins had the correct coloured bin liners. We noted that four sharps bins within the department were assembled and in use without the attached label being completed on the sticker for each bin. These containers were, however, within the recommended fill level, minimising the risk of needlestick injuries.

Environment and equipment

- All defibrillators, electrocardiogram (ECG) monitors and fire extinguishers were within the recommended service period and appeared visibly clean. They had labels clearly identifying when the next service was due.
- On inspection in the resuscitation area, we noted that a manual blood pressure machine and intravenous fluid warmer were not regularly serviced and out of date by six months and one month respectively.
- Access to the department was via a security code entrance for all ambulance personnel. Patients self-presenting to the department via the front door accessed the waiting area adjacent to reception through automatic doors. However, we noted that the main doors to the majors area of the department were not locked or key coded. This meant that the department was not secure and unauthorised personnel could have gained access to the majors emergency area.
- The majors area of the department had a mental health assessment room. This room was free from ligature

points and had suitably weighted chairs and installation of an alarm. There was a second door for emergency exit from this room in addition to the main door, to allow rapid escape for staff should the need arise.

- We checked equipment available in the resuscitation room. There were three bays in this area, each with its own resuscitation trolley containing emergency equipment and drugs. Each trolley had a check sheet which was required by staff to check and sign on a daily basis. On inspection of records it revealed significant periods of time when no checks had taken place. Records revealed periods of between nine and 13 days where no checks had been signed for and therefore stock and availability of equipment could not be guaranteed. We immediately highlighted our concerns to the staff in this area.
- During our unannounced inspection, we noted that one resuscitation trolley adjacent to the majors ambulatory care unit was inaccessible. It was blocked with a large oxygen cylinder on a trolley, an overflowing double bagged dirty linen trolley and waste packaging on the floor. We checked the trolley and identified that it had not been checked for two days and the defibrillator on it had not been tested. We immediately bought this to the attention of the nurse in charge to ensure that this was rectified.
- When asking a member of senior staff where the difficult airway tray was located within the resuscitation room, they were unable to tell us. We were told that the equipment layout within this area had recently been changed. Upon speaking with two other staff this equipment was found. However, delays in location of this equipment could have potentially led to a compromise in patient care, treatment and safety.
- We noted that the majority of the waiting area had no direct vision from reception staff or clinical staff thus leading to concerns for patients who may fall acutely unwell within this area. During day one of our inspection we heard a member of the public shouting for help due to a patient collapse in the waiting area. Clinical staff responded in a timely manner and moved the patient in to a cubicle within the emergency department. There was one emergency button within in the waiting area. However, due to its position it was not in view of the majority of patients. We spoke with reception staff who highlighted their concerns regarding the lack of direct sight to the waiting area, they reported they tried to locate patients that looked very unwell in the two chairs directly opposite the reception desk. However, this was difficult when the department is busy.
- The waiting area within the paediatrics emergency department was accessed via a secure intercom. The area was clean and provided children with a variety of age appropriate toys and a television to make their time within the department as comfortable as possible. Toys were plastic to enable effective cleaning. The trust provided cleaning check sheets for April 2016 to June 2016 detailing daily checking of toys to ensure they were in working order.

Medicines

- Regulations state that controlled drugs should be secured in a lockable wall mounted cupboard with only authorised staff having access to keys. The controlled drugs cupboard within the adult resuscitation area was locked securely and all stock levels were documented and accurate. The cupboard was locked when not in use and keys held by one authorised member of staff.
- The temperature checking and recording for the medicine fridge within the resuscitation room was inconsistent, missing numerous checks within the last five month period. Medicines within this fridge were placed on three shelves; storage was chaotic leading to the risk of difficulty locating a specific medicine when required.
- We requested to see the check list and stock levels of medicines contained within this fridge, a member of nursing staff told us they did not have a list of medicines within this area and stated 'experience tells us what is in there'.
- Out of the previous 28 days prior to our inspection, the medicines fridge in the resuscitation area had not been temperature checked on 16 days in this period. Checks of previous months also revealed large omissions in the checking of this equipment. Medicines within this fridge required a constant temperature and therefore the integrity of medications could not be ensured.
- Further medicines storage was located within the clean utility room in the majors area of the emergency department. Access to this room was by code. On both days of our inspection it was noted that the key safe, containing keys to access medications within this area was open therefore allowing access to medicines such as muscle relaxants, pain relief and antibiotics. We

escalated our concerns to the nurse in charge who promptly secured this area. During our subsequent unannounced inspection this key safe was found to be unlocked once again.
- The paediatric emergency department demonstrated secure storage of all controlled drugs with regular twice daily checks having taken place. We were assured that due to departmental closure at 1am the medicines keys were returned to the site office for secure storage overnight.
- All portable oxygen cylinders within the emergency department had acceptable levels of oxygen in and were within their use by date.
- We reviewed 18 sets of notes during our inspection and found all notes had allergies documented or 'no known allergies' if applicable.
- At the time of the inspection, we noted that the agency staff employed were administering IVs without the trust checking or assessing their competencies to undertake this work. The trust took immediate action to stop this following our inspection. However, during the unannounced we observed an agency staff member go to give IV medicines. We alerted this to the nurse in charge who ensured the procedure was followed. Whilst we were aware that the procedures had been updated and issued to all staff, we were not assured that staff in charge of the service were given sufficient time to familiarise themselves with the update prior to starting their shifts.

Records

- We reviewed 18 sets of patient notes for completeness. We found that the notes were accurately completed with documentation of appropriate risk assessments, pain relief and National Early Warning Scores (NEWS) correctly calculated. One set of notes with a high NEWS score had triggered escalation to a doctor in a timely manner. Other notes revealed that pathways for SEPSIS (also referred to as blood poisoning or septicaemia) and head injury had been accurately followed with subsequent CT imaging in relation to the head injury of one patient.
- Of the 18 records, 10 were reviewed for observations, pain scoring and other clinical indicators and pathways. One set of patient notes were found to contain a consultant letter not pertaining to the named patient on the care record. We informed the nurse in charge of this error who immediately removed this document.
- The trust told us that clinical records audits took place every week. Data provided by the trust prior to inspection showed these audits revealed poor completion of notes with instances of missing information on risk assessments including NEWS scoring, allergies, skin integrity and appropriate neurological examinations for those with a head injury.

Safeguarding

- The trust had a named lead for adult and children's safeguarding. Staff were encouraged to take responsibility in relation to raising safeguarding concerns. Further advice from senior staff was available should staff need guidance surrounding how to raise or deal with a safeguarding concern.
- We spoke with the children's safeguarding lead during our inspection who explained her visits to the emergency department took place on a daily basis to ensure that referrals were carried out and provide staff with further guidance should this be required.
- Nursing staff were achieving 96% compliance with adult safeguarding training within the adult emergency department and 100% within the paediatric emergency department. However, medical staff were non-compliant having achieved 74% completion rate.
- Training data provided by the trust revealed that all nursing and medical staff had not achieved the trust target of 95% in relation to the safeguarding of children, level one, two and three.
- Data provided by the trust revealed that nursing staff were not meeting the trust target of 95% compliance in relation to safeguarding children training level two and three falling short at 86% and 75% completion rate respectively.
- We spoke with the named safeguarding lead for paediatrics during our inspection. We were told that a serious case review found poor sharing of information to be identified as a particular risk. As a result of this review, sharing of information had improved, enabling information to be shared between various teams including GPs, health visitors and midwives. Safeguarding staff can now add 'alerts' on to patient records to ensure all clinicians are aware of any safeguarding concerns.
- Staff told us they felt confident when raising safeguarding concerns, the department had a named safeguarding lead for both adults and paediatrics. We spoke with four nursing staff from a variety of grades

who told us they were up to date with safeguarding training. We were given a recent example of a referral one staff member had made with subsequent involvement of the police in relation to an alleged assault. Staff had access to online adult and child safeguarding policies.

Mandatory training

- Data provided by the trust showed all medical and nursing staff had not met the 95% trust target for mandatory training in the following subjects; fire safety(71% medical staff, 70% nursing staff), infection control (65% medical staff, 61% nursing staff), moving and handling(59% medical staff, 87% nursing staff), values (56% medical staff, 70% nursing staff), equality and diversity (59% medical staff, 78% nursing staff), dementia (68% medical staff, 92% nursing staff), hospital life support (HLS) (47% medical staff, 65% nursing staff) and information governance (42% medical staff, 71% nursing staff).
- We were told that hospital life support training rates had declined over the previous six months due staff illness within the training department in the trust. Emergency department medical staff had achieved 47% and nursing staff 65% compliance in relation to hospital life support training. These both fell short of the trust target of 95%.
- Paediatric life support is required by all staff working in ED who may care for children. Within the ED 0% of medical staff have received training, 16% of adult nurses, 8% of ENP's, and 58% of Paediatric ED staff have received training.
- The trust were not providing face to face training in relation to duty of candour. We were told that that policy had training implications and 'Being Open' training sessions were being organised by the trust's patient safety & quality team and/or the trust's training and development department.
- Staff had access to an E-learning toolkit to use in the absence of the classroom sessions. When speaking with two middle grade doctors it was evident that they not aware of duty of candour. There was no specific training data available for duty of candour.
- Security staff were clearly visible during our inspection when assisting the emergency department staff with an agitated patient. We requested data for security staff in relation to training in mental health. This revealed that whilst a mental health issues course was recommended once every two years, data revealed that no staff had undertaken this training.
- Data provided by the trust revealed that 42% of medical staff and 66% of nursing staff within the emergency department had undertaken training in the Mental Capacity Act (MCA, 2005) and Deprivation of Liberty Safeguards (2007). This fell short of the trust's target of 95% compliance.

Assessing and responding to patient risk

- Patients self-presenting to the front door of the emergency department were required to book in at reception prior to being called by a nurse practitioner for an initial assessment. If receptionists were concerned regarding the condition of a patient they could electronically 'red dot' the record to alert staff to this patient as a priority. We saw this process in use during our inspection for a breathless patient. Reception staff also reported that they would escalate concerns regarding a patient to a senior clinician should the need arise.
- There was no clinical oversight or view of the waiting room within the ED. During our inspection a patient collapsed in the waiting room and other patients had to call for help. Trust staff swiftly responded but it was a known risk to the department. The trust was implementing changes to the area following our inspection.
- Patients arriving by ambulance were assessed within the ambulance bay, consisting of three trolley spaces. Planned staffing for this area consisted of one registered nurse and one healthcare support worker. On day one of our inspection this area was staffed as planned. However, on day two there was not a registered nurse with two healthcare support workers only. We saw this area in operation during the inspection. However, when the department was busy, ambulance crews were unable to hand over in a timely manner, leading to queues of patients down the adjacent corridor.
- The median time to initial assessment in March 2016 was 14 minutes; this was twice the England average of seven minutes.
- We requested data detailing the time to initial assessment for patients attending the emergency department through the self-presentation route and via

ambulance. The hospital did not hold data specifically for each and monitored the median time to assessment .This meant that the trust could not be sure as to where their shortfalls in initial times to assessment were.

- Staff told us that when the department was very busy the nurse in charge would monitor the queue of ambulances at regular intervals to prioritise patients whilst monitoring their condition for deterioration. On both days of our inspection we did not witness this practice in action, we found that this area was not clinically observed and that there was no assessment or triage process by medical staff taking place.
- One ambulance crew was actively treating a patient with central chest pain in the corridor. Despite escalating their concerns three times to a variety of staff in the department, the patient was not treated as a priority. We immediately escalated our concerns to the nurse in charge who went to the corridor area with a doctor. We observed the doctor start to see and treat patients at the front of the queue and work their way down. The medical or nursing staff did not know whom the sickest patients were or who to see as a priority.
- There were cubicles for assessment and triage (RAT). However, these did not happen outside of the three rooms available. At one point during our inspection there were 14 ambulances queued and crews were unable to handover patients. On speaking with the trust they were of the view that the ambulance crews were responsible for the patients until handover had taken place. This was not in accordance with the Royal College of Emergency Medicine's guideline 'ED crowding' issued in December 2015. Managers of all levels to executive level within the department were not aware of this guideline or that the hospital was responsible for the safety and welfare of patients in the ambulance queues on their premises.
- The department had no standard operating procedure (SOP) in place for the monitoring of patients awaiting handover in the corridor therefore leading to a lack of monitoring for patients within this area. We bought the lack of this document to the attention of a matron, who ensured us one would be compiled immediately. We observed this was in place during our unannounced inspection. However, the procedure was not being followed. The procedure was that a doctor was to have clinical oversight of patients in the queue for clinical priority. However, we observed that the doctor was not present during our inspection and three patients were waiting to be handed over or assessed for more than 30 minutes.
- During this inspection four ambulance crews were seen waiting over 60 minutes to handover and 16 crews were delayed in handing over for more than 30 minutes, thus presenting a potential negative impact on patient care. Crews reported they had booked their patients in to reception but no formal handover had taken place.
- The emergency department had a large number of instances of the time between ambulance arrival and formal patient handover exceeding 60 minutes; this is commonly referred to as a black breach. For the months of January, February and March 2016, per month black breaches figures were reported to be 68, 160 and 82 patients respectively for these months.
- During our meeting with management, there was a recognition at trust level that the emergency department became a "short stay ward" due to lack of flow in the hospital leading to gridlock within the emergency department.
- The department used the National Early Warning Score (NEWS) to monitor and detect deterioration of patients. In the 18 sets of notes we reviewed we saw this tool being used appropriately with correct scoring carried out. One set of notes revealed timely escalation of a patient with a high NEWS score to a senior clinician.
- We were told that when the department became full, the nurse in charge escalated this to the site team in order to put the escalation process in place. We saw a copy of this policy which was reviewed in December 2015. The policy outlined colour coded triggers and the appropriate course of action to take should demand increase within the emergency department.
- The adult emergency department had a GP in place to triage patients between the hours of 10am to 10pm, seven days a week. This service was provided by an independent organisation. The GP told us that they would scan the list of those booked in to the department and identify patients that were suitable for GP care. This service was triage only, with appropriate patients being referred back to their own GP or when out of hours they were signposted to the nearest Stellar Healthcare hub. This area had assistance from a healthcare assistant. We were shown data that

indicated on one particular day, 43 patients were seen by the triage GP, who successfully re-directed 22 patients to other healthcare organisations therefore avoiding admission to the emergency department.

- During the first day of our inspection, we noted a patient with mental health illness within a cubicle in the department. The following morning, upon our return this patient was still located within the emergency department. Upon speaking with staff it was revealed that an approved mental health practitioner (AMP) and psychiatrist had been requested the previous day. However, there had only been one team available overnight. This patient was in the department for 24.25 hours at this time due to a lack of response from the mental health crisis team therefore occupying a bed within the department resulting in a negative impact on flow.
- Staff voiced concerns that due to funding cuts in the Hertfordshire area, 42% of patients from this region were experiencing delays in the emergency department due to slow response from Hertfordshire mental health services. On occasions, this has led to patients being in the department for prolonged periods of time and sometimes overnight.

Nursing staffing

- During our inspection we looked at nurse staffing levels within the adult and paediatric emergency departments. In the adult emergency department, a senior nurse in charge was planned for each shift who was not supernumerary in role. Staffing did not reflect the requirement to ensure patient safety with three nurses in majors for 15 cubicles plus the mental health room, one nurse in resuscitation, two nurses in majors ambulatory care, one nurse in the ambulance assessment unit, one in the rapid assessment area and a nurse in charge.
- The paediatric department had three registered paediatric nurses on shift at all times in the paediatric emergency department. When the emergency department was closed between 1am and 7.30am paediatrics were seen within the adults emergency department.
- The department did not use a specific acuity tool in relation to staffing. However, we were told they worked to a nurse staffing template which is broadly similar to other emergency departments of a similar size. The department was not aware of or following the safer staffing guidelines detailed by the Royal College of Emergency Medicine.
- This was in contrast to the knowledge of the Chief Nurse who utilised an appropriate tool to calculate staffing levels for the ED. The tool identified that the service was significantly short on nurses and funding and recruitment was needed to fill these gaps. The trust was working on recruitment but this was a challenged process.
- The resuscitation room had only one trained nurse planned on both days of our inspection. This nurse was treating and caring for up to three acutely unwell patients at any one time. We saw a patient who began fitting and whilst extra staff happened to be in the area at this time, a swift response could not have been guaranteed had this not been the case. After this episode, the nurse in charge relocated a qualified nurse from the majors department to assist in the resuscitation area.
- The times that we observed patients being looked after by one nurse was not safe. There was also no easy mechanisms for this member of staff to call for assistance without leaving the area. Following the inspection the trust had increased the staffing around resuscitation and majors. During the unannounced inspection staff in resuscitation told us that they were grateful they were listened to and that the staffing levels had changed, and that they felt able to provide safer care.
- The whole time equivalent (WTE) establishment for nurses is 57.46 with 19.49 HCSW total 77.75. There are 11.82 WTE Emergency Nurse Practitioners. Vacancy at the time of inspection was 9.75 WTE band 5s, 2.59 WTE band 7s and 6.48 band 6 total of 18.82 registered nursing vacancies giving a 32% vacancy rate.
- The whole time equivalent establishment for nurses was 97.08 with 73.09 staff in post.
- The paediatric emergency department had no vacancies with all roles filled. All nurses within the paediatrics emergency department were trained in paediatrics. Two junior nurses we spoke with reported the opportunity to gain experience in the resuscitation area was restricted due to a lack of senior nursing staff and difficulties with skill mix.
- The adult emergency department were using agency staff to cover shifts and in most cases reported it was

their own permanent staff carrying out those extra shifts to ensure familiarity with the emergency department. The nurse in charge told us that all agency nurses had a background in emergency care and were subjected to drug calculations testing and IV competencies prior to working in the department.

- Sickness rates for nursing staff within both the paediatrics and adult emergency department was at or below the trust average of 3%. It is to be noted, however, that the average turnover rate for nursing staff within the emergency department was 30% and therefore above the trust target of 20%.
- Bank and agency use within the Medical health group where the ED is located, was 32% costing £940,321 in February compared to £1,000,000 in January 2016.

Medical staffing

- The adult emergency department had seven whole time equivalent and one long term locum consultants in place at the time of our inspection. We were told that a business plan for 12 consultants had been accepted and once appointment of these staff had taken place they would be employed as extra physicians. The trust had 21% of medical staff at consultant grade, below the England average of 23%.
- Data provided to us prior to inspection detailed that the trust had a greater proportion of junior doctors at 30% compared to the England average of 24%.
- There was consultant cover in the department between the hours of 9am to 5pm. Registrar staff were available on call from the hours of 5pm to 9am following morning. However, senior nursing staff reported consultant presence, although not on the staffing board, occurred until at least 9pm on the majority of days.
- Paediatric Consultant cover was available between the hours of 8.30am to 9.30pm Monday to Friday, 8.30am to 2.30pm and 7pm to 10pm at weekends , with a junior doctor cover for 24 hours a day, seven days per week.
- The medical staffing rota meant that the service was not able to demonstrate that the coverage of the service met the required 16 hour consultant presence by the Royal College of Emergency Medicine. The department had out of hours access to a middle grade doctor 24 hours a day. We noted that the rota only showed a coverage of between eight and 10 hours. However, consultants were regularly on site for 14 to 16 hours. The Chief Medical Officer informed us that this was in their job plans but the rotas needed revising to reflect hours actually worked and paid for.
- The department had 24 hour cover from a range of registrar and middle grade doctors. We were shown an example of this rota which demonstrated the presence of at least one member of staff from this grade in the department at any one time increasing to six to ten staff between the hours of 4pm to midnight.
- The paediatric emergency department had access to a registrar between the hours of 9 to 5pm. A junior doctor was in the department between the hours of 1pm to 9.30pm. From 5pm on call consultants provided consultant cover to the children and young people healthcare group, should this be requested via a bleep system.
- We saw a handover between consultants and doctors during their shift. All patients were discussed and reviewed in detail, with access to the computer for information on the patients concerned. All patient care plans were reviewed and specific vulnerabilities of patients discussed. The handover included a review of analgesia and antibiotics for patients undergoing treatment and care.
- The department used locum doctors who were inducted to the trust and had competency and CV checks carried out by a department consultant prior to their first shift within the department.

Major incident awareness and training

- An information folder was readily available to staff for dealing with a major incident, in addition further information was available on the intranet should staff require this. The hard copy of the major incident plan available in the department was due for review in January 2014. We highlighted this to the nurse in charge who reported that an up to date version was available online and staff had access to prompt cards in the event of a major incident occurring. An electronic copy of the policy provided by the trust prior to our inspection showed this policy was updated in December 2015. However, the staff were not aware of this.
- The major incident planning officer told us that the trust had a close working relationship with local sites for

which they had responsibility for. He reported that all areas of the hospital had red action prompt cards available to staff for guidance should a major incident occur.
- The major incident storage facilities were well stocked and stored in a user friendly and accessible way. All equipment was within its use by date.
- There has been no recent practice major incident exercise. We were told this had been difficult to achieve due to the current level of service demand on staff.
- Staff had an eLearning session as part of their induction in relation to major incidents.

Are urgent and emergency services effective?

(for example, treatment is effective)

Requires improvement

We rated the effectiveness of emergency and urgent care as requiring improvement because:

- The emergency department was mostly following guidelines known to them from the Royal College of Emergency Medicine and National Institute for Health and Care Excellence (NICE). However, staff were not familiar with all recent guideline updates, for example ED crowding and rapid assessment.
- Nursing staff had not received regular appraisals; 76% of nursing staff within the ED and 0% of paediatric nurses had received an appraisal between April 2015 and March 2016.
- The unplanned patient re-attendance rate between January 2015 and December 2015 was consistently higher than the England average of 5%, varying between 7.3% and 7.6%.
- Concerns were raised about how staff were trained, developed and progressed in their roles within the ED. Concerns were raised to us by several staff members about a culture of favouritism in the service when it came to development opportunities.
- The undertaking of local audits was limited, with minimal nursing audits being undertaken. There was a lack of clinical audit taking place.
- The trust participated in national Royal College of Emergency Medicine (RCEM) audits. The trust audit results for the Royal College of Emergency Medicine (RCEM) were below the required standard. Some of these audits were reported on in our last inspection because no new audits had been undertaken nationally during the last 12 months.

However, was also found that:

- We saw evidence that the hydration and nutritional needs of patients were being met.
- Clear pathways were in place for patients with head injuries and fractured neck of femur
- Pain relief was monitored and well managed for patients in the department, though we noted some delays in response times for pain relief.
- All nursing staff working in the paediatric emergency department were specifically trained and registered in paediatrics.

Evidence-based care and treatment

- The department used the Royal College of Emergency Medicine (RCEM) clinical standards for emergency departments within their policies. However, we were not assured that the department was up to date with all latest guidelines issued. We found that no one within the department was aware of the guidelines for ED crowding issued in 2015. This meant that the policies for the service did not reflect the latest requirements. We were not assured the department was ensuring that the service was demonstrating effectiveness by ensuring best practice guidelines were adhered to.
- During our inspection we saw that the emergency department was referring to guidelines, all of which were accessible via computer. Guidelines were in place for head injury, sepsis and venous thromboembolism (VTE) amongst other things. All policies we checked were in date and had a clear review date in place.
- One set of patient notes we checked revealed that trust cardiac guidelines were in use and appropriately referred to national guidelines including National Institute for Health and Care Excellence (NICE). Guidelines had subsequently been adjusted in line with previous lessons learnt from serious incidents.
- Clear pathways were in place for patients with head injuries. During the inspection, we observed one patient with a head injury receive treatment in line with best practice, receiving a CT scan where clinically suitable. In

addition, another set of notes we reviewed detailed a patient who was identified as having sepsis, receiving the correct treatment including antibiotics, monitoring and referral to the medical team.

- The trust organised an internal audit in relation to paracetamol overdose following poor outcomes from the RCEM audit. This audit took place between April 2015 to October 2015, with data obtained from 55 patient records. It revealed that 6% of patients had plasma levels taken and recorded prior to the recommended four-hour post ingestion time.
- In addition, it was noted that 12% of patients arriving less than eight hours after ingestion had not received treatment in line with the 2012 Medicines Healthcare Regulatory Agency (MHRA) guidelines. Target compliance with this RCEM guideline was set at 100%. This audit highlighted poor documentation of test results. The department undertook a few local audits to assess nursing practices. However, the range of audits undertaken was limited and we were not aware of any local audits which had been undertaken by medical staff in the service recently. We examined the urgent care audit plan for the service, which showed that the service was only partaking in the national audit set. This was linked to how busy the medical staff had been working clinically to cover shifts.
- Audits were locally undertaken weekly on 10 sets of patient records for completeness. However, there were no formal learnings, trends, outcomes, improvement monitoring recorded or shared for these audits. Of the three audits provided, undertaken during 2016, the listed actions taken included speaking with staff about their record keeping and omissions.
- Observation of practice on an invasive procedure audits from March 2016 were reviewed during this inspection. These identified practice learning for the staff members involved. However, there were no formal learnings, trends, outcomes, improvement monitoring recorded or shared for these audits.

Pain relief

- We reviewed the notes of five patients in relation to pain scoring. All notes demonstrated that pain relief had been offered and documented in a timely manner should it have been necessary. In addition, when observing a consultant handover, pain relief was discussed for each patient this was applicable to.
- Data from the CQC accident and emergency survey (2014) showed the emergency department to be performing 'about the same' as other trusts in relation to the provision of pain relief and control of pain.
- We saw staff actively offering pain relief to patients and frequently checking if patients were experiencing pain.
- Staff in the paediatric emergency department told us pain relief was offered to all children during initial triage on arrival at the department therefore demonstrating compliance with the Royal College of Emergency Medicine Management of Pain in Children guidance.

Nutrition and hydration

- We observed staff offering patients food and drink if clinically safe to do so.
- We spoke with 11 patients who reported they had been offered fluids at regular intervals.
- Housekeeping staff told us they had set times to offer hot drinks. However, additional beverages could be provided when requested. During our time in the department we saw domestic staff providing hot beverages for relatives who had been in the department for extended amounts of time.
- Out of hours sandwiches were available for patients who were subjected to extended lengths of stay within the department.
- Patients and relatives in the waiting area had access to vending machines providing hot and cold drinks and snacks.
- The CQC accident and emergency survey (2014) revealed that the trust were performing 'about the same' as other trusts in relation to the provision of food and drink for patients in the emergency department.

Patient outcomes

- The unplanned patient re-attendance rate in the accident and emergency department between January 2015 and December 2015 was consistently higher than the England average of 5%, varying between 7.3% and 7.6%. This was worse than the England average for the entire period.
- The trust participated in national Royal College of Emergency Medicine (RCEM) audits. Some of these audits were reported on in our last inspection because no new audits had been undertaken nationally during the last 12 months. Those that have been undertaken had not been published at the time of the inspection.

- The RCEM Severe Sepsis and Septic Shock (2013/2014) Audit showed only one out of 12 standards was being met, which was the recording of blood glucose measurement on patient arrival. For three standards, the trust was performing in the lower England quartile, these were the obtaining of blood cultures, administration of antibiotics and the institution of urine output measurement in the emergency department. For the remaining eight standards, the trust was either between the upper and lower England quartiles or in the upper England quartile.
- The RCEM Asthma in Children (2013/2014) audit showed the trust were failing to meet all but one out of 18 standards, which was the recording of pulse on patient arrival. Whilst the majority of results were within the middle 50% of all trusts, it is to be noted that the taking/recording of oxygen saturations and peak flow were both in the lower England quartile.
- The RCEM Initial Management of the Fitting Child (2014/2015) Audit showed the trust were achieving 100% compliance with three standards relating to management of seizure, blood glucose recording and the recording of presumed aetiology. The trust did not meet two developmental standards in relation to the recording of eye witness history and provision of written safety advice on discharge, with results in the lower England quartile.
- Data from the RCEM Assessment of Cognitive Impairment in Older People (2014/2015) Audit showed that the trust failed to meet the one fundamental when recording a National Early Warning Score (NEWS) on 95% of patients. The required RCEM standard for this measure was 100%. The remaining four developmental standards auditing the recording of cognitive impairment, use of a cognitive assessment tool and communication of assessment findings with other relevant services revealed the trust were performing between the upper and lower England quartiles.
- The trust participated in the RCEM Audit for Paracetamol Overdose (2013/2014). The audit revealed that the trust did not achieve any of the five standards in relation to this audit and that performance was in the worst 25% for two standards and in the middle 50% for the remaining three. Consultants we spoke with told us that as a result of these audit results, the emergency department had undertaken its own paracetamol audit to address the shortfall in care surrounding this.
- The trust took part in the RCEM standards for consultant sign off. This identifies three types of patient which should be reviewed by a consultant prior to discharge. These are: adults with non-traumatic chest pain, febrile children (less than one year old) and patients making an unscheduled return to the ED, with the same condition within 72 hours of discharge. Audit data (2013) revealed the trust was in the upper England quartile for one measure and between the upper and lower quartiles for two measures (Consultant discussing the patient and a senior doctor seeing and discussing the patient). Results revealed it was in the lower England quartile for a consultant seeing the patient.
- There were no active Care Quality Commission outliers relating to the emergency department at the time of our inspection.
- Between January 2015 and December 2015, the number of patients leaving the department without being seen ranged between 1% and 1.8%, this was better than the England average NHS trust performance indicator during the whole period.
- Guidelines and policies were clearly available within the paediatric emergency department in the high dependency bay. These were in date and clearly displayed to enable staff access to them in a timely manner.

Competent staff

- All nursing staff working in the paediatric emergency department were specifically trained and registered in paediatrics.
- Staff appraisal data showed that the trust were failing to meet their target of 95% appraisal completion rate for the majority of staff within the department. Of the nursing staff within the ED 76% of adult nurses and 0% of paediatric nurses had received an appraisal between April 2015 and March 2016'
- The trust provided overall appraisal data, but did not provide us with a breakdown of this data by core service. We were not able to get the exact appraisal rates for medical staff working in ED.
- The department had access to a dedicated nurse specialising in dementia and learning difficulties. These specialist staff were available Monday to Friday between the hours of 8am to 4pm. Outside of these hours all contact relating to patients with learning disabilities and dementia were referred to the site manager who would

then feedback information to the team. Close liaison between the emergency department and learning disabilities team took place during our inspection for a patient with learning disabilities.
- Nursing staff had access to a Nursing and Midwifery Council (NMC) revalidation policy. We saw this policy, which was in date. The policy laid out clear requirements for revalidation and offered staff aware sessions and eLearning for support with the revalidation process.
- Medical staff had access to a revalidation policy which incorporated General Medical Council (GMC) revalidation requirements. On review of this document, we found that the trust offered training for staff and that external quality assurance of the appraisal process was recommended.
- The medicine healthcare group patient safety and quality/compliance group meeting minutes from February 2016 discussed NMC revalidation in detail. Including how the service would ensure revalidation was achieved, who the reviewers would be, and how information would be disseminated to all staff.
- The service had implemented a clear process for accessing further education and development. Staff were required to apply for further education and follow a set criteria for consideration. The list of courses available included emergency care and advanced skills in clinical assessment.
- One staff member told us that they felt that "favouritism" was a factor when requesting progression and further training within the emergency department. A member of nursing staff reported that staff members with less experience in the department had been progressed and given the opportunity for development prior to them, which they felt was unfair.

Multidisciplinary working

- During our inspection we witnessed care of a patient with learning difficulties being referred appropriately to social services, this demonstrated effective communication between services such as GPs, follow up appointments on hospital wards. The learning disabilities team also had an input on the relation to planning of discharge.
- Monthly mental health liaison meetings took place which included the emergency department and mental health nurse.
- Staff had access to the community assessment and re-enablement team of nurses (CARS), with access to their services between 2pm to 9pm, seven days a week. The aim of these additional staff was to assess patients and help facilitate discharge back to the community, thus avoiding admission to hospital.
- The business plan for 2016/17 detailed a key area for improvement in the service was response times from specialty services in the hospital. At the plan was written on 29 January 2016, the average response time for specialty referral response was 83 minutes. This was significantly above the 30 minute standard recommended by RCEM.
- During our inspection we witnessed an alert call arrive via the ambulance service, bringing an acutely unwell patient in to the resuscitation area. The registrar within the emergency department swiftly escalated concerns surrounding the patient via a bleep system, requesting surgical consultant presence immediately. The consultant arrived swiftly who then began to asses and treat the patient.

Seven-day services

- The emergency department had consultant presence in the department between the hours of 9am to 5pm seven days per week. After this time, cover was provided by an on call service.
- Paediatric consultant cover was available between the hours of 8am to 6pm Monday to Friday, with senior house officer cover 24 hours a day, seven days per week. A mental health nurse was available between the hours of 8am to 10pm each day. Staff described difficulties when seeing and treating patients from the Hertfordshire area due to lack of funding. As a result, patients from this area would wait longer to be seen by mental health services.
- Radiographers within the department had access to two computerised tomography scanners (CT), one magnetic resonance imaging scanner (MRI) and x-ray equipment. Staffing of this area was 24 hours per day with radiographers. During this time if results required interpretation this was provided by an outside provider who would feed results back to the emergency department to enable swift decision making and treatment in a timely manner.
- The trust provided us with their inclusion criteria for scanning out of hours between 9pm and 8.30am. Clear protocols were in place for head trauma, seizure, head

pain, spinal trauma, multiple trauma, aneurism and abdominal pain. All results were interpreted by an outside provider who provided a radiological report within one hour.
- An alcohol liaison nurse was available Monday to Friday who worked with the emergency department to follow alcohol pathways.
- Mental health nurse cover was provided between the hours of 8am to 8pm each day.
- Staff had access to the community assessment and re-enablement team of nurses (CARS), with access to their services between 2am to 9pm, seven days a week.
- A physiotherapist was available 8am to 5pm, seven days a week.

Access to information

- The emergency department had a large flat screen monitor in the department detailing patient names, location within the department and length of stay. We were approached by a patient who was concerned that her name was incorrect on this board and did not tally with her cubicle. We bought this to the attention of a nurse who informed us it would update shortly. Concerns were noted around this screen due to a possible breach of patient confidentiality. Members of the public were seen to frequent this area leading to breach of confidential information.
- Patient records within the majors area of the emergency department were kept in a trolley adjacent to the nurses' station. During our inspection we saw that patient notes were left unattended and open on the desk therefore leading to a possible compromise in patient confidentiality. The trolley in which notes were stored did not have clearly labelled pockets as to which cubicle they pertained. This led to the risk of patients' notes being incorrectly placed within this area.
- Staff had access to systems throughout the trust including radiology, pathology and the cosmic system. Access to the systems was provided through the use of NHS smart cards to secure the systems. This meant that staff had access to the systems they required to provide patient care.
- Agency medical staff had access to the departmental IT systems via passwords provided on commencement of shift. We spoke with one junior grade doctor who reported they would explain the system to new locums. However, the majority of locums used within the department were regular members of staff and therefore familiar with the systems in place.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Two staff we spoke with had a good understanding of the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (2007).
- Staff had access to these policies via the intranet and we were told by a senior nurse that advice could be sought if required. We requested training data in relation to the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (2007) to ascertain levels of compliance. This data revealed that 42% of medical staff, 31% of emergency nurse practitioners (ENP's) and 66% of nursing staff within the emergency department had received training in the Mental Capacity Act (2005) and Deprivation of Liberty (2007).
- During our inspection, we saw staff asking patients for consent to perform simple procedures such as the taking of blood pressure and removal of clothing prior to recording of heart tracing (ECG) in the resuscitation room.
- The trust provided us with their policy on consent. However it was noted that this policy was due for review in January 2014. This policy detailed consent for both adults and paediatrics.
- Staff in the children's emergency department were familiar with the requirements of Gillick competence, and they were able to demonstrate when it would be appropriately used.

Are urgent and emergency services caring?

Good

We rated caring within urgent and emergency care as good because:

- We spoke with 11 patients who reported that staff were kind and caring and that they felt informed them of their treatment plans and condition. Care provided by staff to patients was seen as kind and compassionate.

Urgent and emergency services

- The NHS friends and Family Test results revealed that from March 2015 to February 2016, 91% to 97% of patients would recommend the department to friends and family.
- Patients understood what was happening with their care and treatment, and were kept informed about what they were expecting to happen regarding admission and discharge arrangements.
- Emotional support, bereavement and multi-faith services were available to support patients and their families.

However, we also found that:

- One member of staff we spoke with voiced concerns about the ability to provide basic level care when the department was busy. Our observations of staff and care witnessed during the inspection supported this statement as staff were very busy but trying their best.

Compassionate care

- The results for the NHS Friends and Family Test (FTT) in relation to the emergency department showed that during the period March 2015 to February 2016 91% to 97% of patients would recommend the emergency department to friends and family. The trust scores have been consistently good over this period and better than the England average of 88%.
- The CQC A&E survey results for 2014 revealed that the trust were performing significantly worse than other trusts for four out of the 24 questions. The poor results were in relation to how patients did not feel listened to, general communication and what to do if worried after leaving the department in relation to their treatment or condition. For the remaining 20 questions the trust scored 'about the same' as other trusts.
- One member of staff we spoke with voiced concerns about the ability to provide basic level care when the department is busy. This was observed throughout our inspection. Staff worked to try and provide the care. However, when the department was busy we noted that the staff, due to the numbers on duty, were not being able to meet the demand of the volume of patients attending, were not able to provide basic care, or answer requests in a timely way. For example, on one occasion we had to raise to staff that a patient had waited a lengthy period of time for a staff member to attend to them. Staff were trying hard to meet people's needs. However pressures were impacting on how compassionate care was provided.
- We witnessed one patient call bell ringing for approximately 5 minutes, which was answered by a domestic member of staff. In addition, a patient monitor alarm was noted to be ringing for 15 minutes before being silenced by a member of the nursing team.
- We observed care provided to a patient who was awaiting transfer to a mental health trust. The patient had been in the department for over 24 hours. The patient was agitated and looked after by trust staff and security staff. We observed that there were tensions between the patient and staff members at times, who did not always act in a compassionate way in their presence. For example, we observed staff discussing their weekend plans whilst the patient was exhibiting agitation.
- We witnessed kind and compassionate care from a healthcare assistant within the emergency department when assisting a patient with dementia. The staff member was seen to speak with the patient in a reassuring way, to which the patient response was positive.
- A patient in the resuscitation room said 'the nurses are all wonderful, especially the lady who has been looking after me today'. We saw this particular nurse speaking with this patient and explaining treatment and plans of care in plain English, in a supportive and kind manner.

Understanding and involvement of patients and those close to them

- All of the patients we spoke with described staff as kind and caring in the emergency department. One patient said 'I know what is going on, staff are kind. The nurse has offered me pain relief but I do not need it. I am waiting for a bed'. Another patient reported 'I have been looked after well and have had some antibiotics'. Further comments from a patient included 'they have told me what is going on and contacted my wife as soon as I arrived in the department, I have been offered pain relief and have had a drink of water'.
- We spoke with one patient who stated 'staff have told me what is going on, I am waiting for a bed and some more treatment for my heart'. Another patient reported that he had been informed of his condition and the treatment he was due to receive. We spoke with the

relatives of two patients who both reported that staff had informed them about the care and plans of treatment for their relatives. One of the relatives had been informed about the admission process but voiced concerns about the length of time it was taking to get to a hospital ward.

Emotional support

- The trust employed two full time members of staff in the bereavement office which were available Monday to Friday, 8.30am to 4.30pm.
- The hospital offered all patients, relatives and staff use of a chaplaincy service and spiritual care service. The chaplaincy service was available 24 hours a day via an emergency on-call basis.
- Bedside religious support was available for Holy Communion and prayer. Access to multi-faith support was also available via the switchboard.
- The trust provided support to staff including informal counselling, reflection on practice and assistance with work or personal related issues. Debriefing was also provided following episodes of emotionally traumatic care provision should staff require this.
- Relatives and patients had access at all times to the 'Hospital Sanctuary' for quiet prayer and reflection if required.

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

(for example, to feedback?)

Requires improvement

We rated urgent and emergency care as inadequate because:

- Between August 2014 and May 2016 the emergency department did not meet the NHS national target of 95% for seeing, treating, admitting or discharging patients within four hours. The figures steadily declined from 81% in November 2015 to 73% in May 2016.
- The percentage of emergency admissions via the emergency department waiting four to 12 hours from the decision to admit until being admitted has been longer than the England average since May 2015. This figure has substantially deteriorated between December 2015 and February 2016, rising from 20% to 42%.
- During winter 2015/2016 the trust was in the 25% of trusts in England with the most ambulances delayed over 30 minutes.
- Between August 2015 and March 2016 there were 563 black breaches reported. Between 1 April and 17 July 2016 there had been 520 black breaches reported.
- The ambulance service handover hours lost in the emergency department from 1 April to 17 July 2016 showed that there were 1383 ambulance hours lost at The Princess Alexandra Hospital. This was a 183% increase on the same period of 2015/16.
- Patient flow through the emergency department was recognised as a key issue by the trust. During our unannounced inspection we identified concerns that there were available beds on wards overnight, which had not been declared. This had a negative impact on the emergency department flow.
- Whilst bed capacity in the hospital was high during the inspection it was noted that patient records viewed in the ED revealed a delay in decision to admit (DTA) times, therefore negatively impacting on flow through the department and onward to a ward.
- There was no standard operating procedure in place for the ambulance queues and priorities of patients in the queue based on times. This meant that escalation of these areas was not timely and impacted upon the safety of patients.
- During our inspection we noted that calls bells went unanswered for prolonged periods of time when the emergency department was busy.

However, we also found that:

- Patients and relatives had access to information on how to make a complaint. Staff we spoke with were aware of the complaints procedure and we saw evidence of the dissemination of information in relation to complaints and concerns.
- The department had access to a dedicated nurse specialising in dementia and learning disabilities.
- The number of people leaving the emergency department before being seen was consistently better than the England average.

Urgent and emergency services

Service planning and delivery to meet the needs of local people

- The trust was working with local commissioners, NHS England, NHS improvement to try and plan how the service was placed through the community. The wider executive management team, stakeholders and commissioners were working together to try and determine the right plan for the service to reduce activity flowing through the hospital.
- The trust had implemented a GP based triage system provided by an outside organisation to reduce admissions to the emergency department, we saw this in use during our inspection.

Meeting people's individual needs

- The emergency department had access to a translation telephone line via the switchboard. Staff told us that if necessary they sought the assistance of multilingual staff to aid with translation when required to provide patients with assistance in a timely manner.
- A dedicated nurse specialising in dementia and learning difficulties was in place to provide care and support for patients and staff. These specialist staff were available Monday to Friday between the hours of 8am to 4pm. Outside of these hours all contact relating to patients with learning disabilities and dementia were referred to the site manager who would then feedback information to the team. We observed close liaison between the emergency department and learning disabilities team during our inspection.
- On five occasions during the inspection we witnessed that call bells went unanswered for more than five minutes. We were concerned that patients were not being tended to in a timely manner.
- During our inspection we saw the use of electronic alert statuses on patients records who had been identified as vulnerable or having additional needs. This enabled clinicians to treat patients according to their needs in a respectful and dignified way.
- Information leaflets were clearly available to relatives and patients within the waiting area. This information included advice on minor illness and injuries, along with posters on how to access GP care out of hours.
- We inspected the waiting area of the adult emergency department. The area consisted of approximately 40 chairs. Food and drinks were available via vending machines to patients and relatives. The department had a varied range of leaflets on minor injury and illness along with posters signposting patients to pharmacy and GP services.
- The emergency department had a specific relative's room for those attending with acutely unwell patients. The room had comfortable seating and was located near to the resuscitation room. This enabled sensitive discussions to take place away from other patients and relatives, providing relatives with privacy and quiet surroundings.

Access and flow

- Patient flow through the emergency department was recognised as a key issue by the trust executive team and staff within the emergency department. During our inspection we saw staff speaking with the site management team to try and create flow within the department. We were provided with policies in relation to patient flow escalation, which had recently been reviewed.
- Staff we spoke with were clear in their knowledge regarding the chain of command when flow became an issue within the department.
- We saw the nurse in charge escalate concerns regarding flow to the site team and matrons during our inspection.
- Between August 2014 and May 2016, the emergency department did not meet the NHS national target of 95% for seeing, treating, admitting or discharging patients within four hours. The figures steadily declined from 81% in November 2015 to 73% in May 2016. Performance for February was 74%, March was 76%, April was 75%, and May was 73%.
- Whilst bed capacity in the hospital was high during the inspection it was noted that patient records viewed in the ED revealed a delay in decision to admit (DTA) times, therefore negatively impacting on flow through the department and onward to a ward.
- The percentage of emergency admissions via the emergency department waiting four to 12 hours from the decision to admit until being admitted has been longer than the England average since May 2015. This figure has substantially deteriorated between December 2015 and February 2016, rising from 20% to 42% during this period.
- Between January 2015 and December 2015, the number of people leaving the emergency department before

being seen was consistently better than the England average during the same period at approximately 0.9%. The England average for the same period was approximately 2.6%.

- The average time patients spent in the emergency department between February 2015 and January 2016 was higher than the average England NHS trusts for the same period. Time spent in the emergency department during this period ranged from approximately 135 to 178 minutes compared to the England average of 130 to 145 minutes for the same period.
- During winter 2014/2015 the trust was in the 25% of trusts in England with the most ambulances delayed over 30 minutes.
- Data provided by the trust prior to inspection revealed a large number of 'black breaches' in the department where ambulance crews were waiting more than 60 minutes to handover a patient. Between August 2015 and March 2016 there were 563 black breaches reported. Between 1 April and 17 July 2016 there had been 520 black breaches reported through the clinical commissioning groups (CCG) situation reports (sitreps).
- From April 2016 to June 2016, the trust reported zero 12 hour waits in the emergency department. However, on the second day of our inspection, we saw that 12 patients had been in the emergency department longer than 12 hours. Therefore, we could not be assured that the trust were robustly reporting waits in the department that exceeded 12 hours.
- The CCG sitreps report the ambulance service handover hours lost in the emergency department from 1 April to 17 July 2016 for all trusts. The data showed that there were 1383 ambulance hours lost at The Princess Alexandra Hospital. This was a 183% increase on the same period of 2015/16.
- Senior staff reported good relationships with the East of England Ambulance Service NHS Trust, reporting that when the department was under pressure they would try to send an ambulance officer to help with flow in the department with the cohorting patients. We were told that the emergency department previously had a 'Hospital Ambulance Liaison Officer' (HALO) in post. However, funding for this post had been withdrawn three months prior to our inspection.
- There was no standard operating procedure in place for the ambulance queues and priorities of patients in the queue based on times. This meant that escalation of these areas was not timely and impacted upon the safety of patients.
- In between our announced and unannounced inspection, the trust had written and implemented a standard operating procedure (SOP) pertaining to the arrival and clinical handover of patients arriving by ambulance. This detailed clear processes in relation to ambulance handover and escalation processes should demand and capacity in the department rise.
- Bed availability throughout the hospital was limited. On average, bed occupancy rates at the hospital were 92% between January 2015 to December 2015. This was above the England average of 88% for the same period. Senior staff in the department informed us that the main department area felt more like a short stay ward than an emergency department due to hospital capacity concerns.
- During our unannounced inspection we identified concerns that there were available beds on wards overnight, which had not been declared. There was no clear rationale provided as to why this was, but we were informed it did happen. When we returned for the second unannounced inspection there were several beds that had not been declared. This had a direct and negative impact on patients waiting for beds in the emergency department. This also had a negative impact on the emergency department flow.

Learning from complaints and concerns

- Between April 2015 and March 2016, 31 complaints had been received by the trust in relation to ED. The trust received 292 in total, which meant that the ED received 11% of all complaints. Themes from complaints included patient care, communication and behaviour of staff.
- The trust had a policy in place on the process of dealing with complaints. The policy clearly outlined how complaints should be investigated and by whom and expected time limits for response. All complaints were recorded on the incident system and allocated a reference number.
- Staff were aware of the complaints procedure and reported receiving feedback in relation to complaints that had been processed. We saw evidence of learning taking place as a result of complaints with clear

examples displayed in staff room areas. One complaint displayed within this area had clear learning actions for staff in relation to poor reported communication from staff by a patient. Actions included encouraging staff to provide patients with more information regarding failures, which in this case, was a broken down piece of equipment leading to the patient needing to re-attend at a later date.

- We spoke with one member of staff who had received a complaint against them. The staff member received feedback in relation to this complaint and was given the opportunity to explain their version of events.
- Patients and relatives had access to information on how to make a complaint made available to them in the waiting area.
- The trust provided data from a survey they had carried out relating to complaints, with raw data collected between 2015 and 2016. This data revealed that the majority of people reported that information on how to make a complaint was accessible and that the first contact from the trust was polite. It did reveal, however, that overall, people were unsatisfied on how quickly their complaint was processed within the trust agreed time scales.
- Discussions about concerns and complaints took place at 'safety huddle' meetings giving staff the opportunity to ask questions and seek guidance if required.

Are urgent and emergency services well-led?

Inadequate

We rated well-led for urgent and emergency care as requiring improvement because:

- There was a lack of appreciation of the risks, such as staffing, within the department from the senior team.
- Staff we spoke with were unaware of the trust's values.
- There was a business plan, vision and strategy for the service with some basic objectives for the ED to improve around four hour performance. However, it was limited to four hour performance and financial penalties, rather than linking it to patient safety and outcomes.
- There was a lack of audits and learning from local and national audits within ED.
- Key risks around not being up to date with Royal College of Emergency Medicine (RCEM) guidelines in ED had not been identified through the governance process. The inspection team identified concerns regarding staff not following the RCEM guidelines on ED crowding.

However, we also found that:

- Nursing staff reported that there were good relationships between nursing and consultant staff within the emergency department.
- The local risk register reflected many of the key risks for the service, with clear plans in pace to monitor these. These risks linked to the board level risks for the trust.
- There were processes in placed for patient and staff engagement.

Vision and strategy for this service

- The trust's values were that staff are respectful, caring, responsible and committed. Two staff we spoke with were not aware of these values. One member of staff said 'staff need a vision and end sight' whilst another stated 'staff leave because of pressure and a lack of capacity'.
- Observations of the emergency department revealed that the trust values were displayed within the department.
- Locally there was a clear business plan and strategy in place for the medical health group. The document, dated January 2016, detailed the key priorities for the health group in 2016/17. These included the development of primary care staff working in ED GP in streaming, formal introduction of additional senior medical staff at weekends and during night shifts, and implementation of new ambulance handover process. These actions were presented and being led by the clinical lead for the emergency department.
- This business plan linked to the vision and strategy for the medical health group, which identified key priorities and key milestones to be achieved during 2016/17. These would be monitored through the medical health group board meeting. These key areas included priorities and milestones for the ED around four hour performance, time in the department and reducing readmission rates.

Governance, risk management and quality measurement

- The medical health group, where the emergency department reported through, held monthly board meetings between the medical and emergency services. We examined the minutes of the last five meetings, which showed that staff from the emergency department attended and items relating to safety in ED, recruitment and safety were routinely discussed.
- We requested specific information on risk register meetings pertaining to the emergency department. Meeting notes revealed that the day following our announced inspection, the trust called an extra-ordinary meeting to discuss concerns identified during the inspection period. These concerns included vision of the waiting area, monitoring of ambulance patients awaiting handover and staffing vacancies was added to the risk register.
- The medical health group held patient safety and quality meetings on a monthly basis for the healthcare group. We examined the minutes of the last five meetings, which demonstrated that they were well attended by nursing, medical and support staff.
- There was evidence in the patient safety and quality meeting minutes that cross healthcare group learning of never events from other areas, as well as serious incidents. Infection control was routinely discussed as were exception reports on themes and trends with incidents such as pressure ulcers or falls.
- The minutes provided were focused towards the medical aspects of the healthcare group. There was lack of information and discussion noted in the patient safety and quality meeting minutes of safety of patients in the ED, particularly during times of high pressure and low staffing.
- The action log of the patient safety and quality meetings from March 2016 showed that clinical effectiveness was discussed. This included updates on National Institute for Health and Care Excellence (NICE) guidelines, though it was not clear if these related to medicine or the emergency department.
- There was no reference to quality and NICE guidelines in the minutes provided specifically for the emergency department. The service was not up to date with all current NICE guidelines as detailed in the safety domain of this report.
- The emergency department participated in a limited number of local audits, with most audits being undertaken by nurses. We were not provided with evidence of local audits undertaken by medical staff outside of the national minimum data set. The lack of local audits was not discussed or identified through the medical health group board meeting or patient safety and quality meeting minutes provided.
- We examined the risk register for March 2016, which identified four risks graded above 15, which was very high. These risks would normally be detailed on the trustwide board assurance framework and monitored at executive level. We reviewed the trustwide significant risk register from March 2016, which detailed the risks identified in ED.
- However, a risk identified in the ED and at trust level was not correct. The trust and ED team were of the view that the ambulance crews were responsible for the patients until handover had taken place. This was not in accordance with the Royal College of Emergency Medicine's guideline 'ED crowding' issued in December 2015. Managers of all levels to executive level within the department were not aware of this guideline or that the hospital was responsible for the safety and welfare of patients in the ambulance queues on their premises. Therefore the displayed risk on the risk register did not actually reflect what was required of the trust.

Leadership of service

- The emergency department was led by a clinical lead, an associate director of nursing, and a deputy director of operations. There was a matron reporting to these leaders along with a service manager.
- There had been many middle management changes over the last 12 months. However, one member of staff we spoke with reported this tier of management had now settled and people were more confident on specific roles and responsibilities of individuals.
- We spoke with one member of nursing staff who reported that they did not see the presence of executive team members within the emergency department apart from one senior member of staff who was 'willing to put gloves on and get stuck in'.
- Due to the lack of executive team presence, staff in the emergency department were not provided with support to enable them to carry out clinical roles on a supernumerary basis. The executive team were disengaged with the challenges the department faced on a daily basis nor did they always receive feedback about the challenges staff faced in the clinical areas. Staff were not keen to continue to raise concerns as they did not feel things would change. An example of this

was regarding staffing of the resuscitation area in the emergency department. The executive team were not aware of the concerns staff had regarding one member of qualified staff in this area.

- Consultants highly praised the new emergency department consultant lead, reporting they worked well together as a team. Nursing staff reiterated these sentiments.
- At the commencement of each shift, roles and locations for staff were clearly displayed on the board therefore allowing swift deployment of staff to the appropriate areas.

Culture within the service

- We heard positive feedback from nursing staff in relation to the support from consultants within the department. One nurse told us 'staff stay in the department because of great team spirit'. Another member of staff said 'I love working with my colleagues, we have a family type relationship'.
- Five consultants spoken with during our inspection reported morale in the department to be good. In particular, they reported that they all work well as a team.
- We spoke with two members of nursing staff within the emergency department who both reported that senior management within the department were approachable. Another member of staff said 'I feel valued and respected by staff within the department'.
- During our unannounced inspection, we noted that staffing had increased from one to two nurses in resuscitation. Staff members working in there were very happy about this and informed us that they had raised this as a concern for years but had not felt listened to. We spoke with the executive team about this feedback and they were not aware of concerns being raised in this area.

Public engagement

- Feedback cards were available in the reception and waiting area for patients and staff to complete. This was a box on the wall within this area in which visitors and relatives could post comment cards in various slots indicating their level of satisfaction with care and treatment provided.
- The trust's website provided information for patients on a variety on a variety of themes including weight loss, smoking cessation and dementia.
- The hospital held service user experience meetings twice per year. This was attended by patient panels, support groups, and GP representation from west Essex. The groups focused on how best to support the public and flow to and from the hospital as well as talk about complaints received, and how services could be made better.

Staff engagement

- Senior nursing staff and nurses reported that safety huddles occurred in the department to discuss new information or policies. The department aimed to hold these meetings once daily depending on demand and levels of activity in the department.
- The department's risk register was clearly displayed in the staff room and we were told that a staff briefing took place once per week. Information and subsequent learning from complaints was cascaded to staff either verbally or by email.

Innovation, improvement and sustainability

- The trust had recently initiated the 'Daisy Project'. The aim of this was to provide support for the victims of domestic violence. Patients had access to a worker from the Daisy project 24 hours a day, seven day a week.
- The emergency department had been working in partnership with local GP partners. The GP at the front door of the department worked to refer patients to more appropriate pathways when suitable. The department had access to six same day surgery appointments for every local GP practice in addition to the Stellar healthcare hubs for out of hours appointments.

Medical care (including older people's care)

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

Information about the service

Medical services at The Princess Alexandra Hospital NHS Trust included cardiology, gastroenterology and other medical care including care of the elderly services. 26,137 patients were admitted to medical services during 2015.

There were 12 medical wards across the hospital, of which we visited: EAU, Locke ward, Winter ward, Ray ward, B40, Melvin ward, Lister ward and Fleming ward.

We spoke to 23 members of staff and met with the senior management team. We spoke with 10 patients across the medical wards. We observed the environment, the interactions between patients and staff and infection prevention and control measures in place. We attended handovers and multidisciplinary meetings in addition to reviewing patient records. We reviewed other performance information supplied by the trust and stakeholders.

Summary of findings

We have rated medical care at The Princess Alexandra Hospital as requires improvement overall with safety and responsiveness rated as requires improvement and the other domains rated as good.

- Nurse staffing levels did not always meet the expected established staffing requirements on the wards. There was a high use of agency staff, especially on night shifts. We found that agency nurses were administering intravenous (IV) medications without providing evidence of training competencies, which placed patients at risk. However, the trust took immediate action to resolve this.
- There were gaps in the checking of the resuscitation equipment and medicines fridges. There were gaps in the records for the controlled drugs register checks.
- Mandatory training had not met the trust target across medical care services.
- Performance fell below the England average in some of the measures of the National Diabetic Inpatient Audit. The service performed worse than expected on the National Stroke Audit. However, the service was no longer providing an acute stroke service. Staff were not always aware of outcomes from local audits.
- Readmission for elective clinical haematology and non-elective geriatric medicine was above the England average.

Medical care (including older people's care)

- Appraisal rates had reduced since our last inspection. Seven day services were limited.
- There were high numbers of out of hours transfers reported. The number of ward moves a patient experienced during their stay was high.
- The trust acknowledged that there were issues with speciality input and bed availability as patients could not always be placed on the appropriate specialist ward. Medical services had not met the target for referral to treatment times.
- There was evidence of identified risks to the service. However, we found that some risks had not been identified and included on the risk register.
- We were concerned about some of the poor cultural practices of the nursing staff in the medical care services. For example, allowing agency staff to administer IV's without pre-approved competencies in place, not declaring beds when available impacting on the emergency department, and not declaring when they had additional staff who could support other wards short of staff.

However;

- There were processes in place to report incidents and serious incident investigation with learning from these communicated to staff. Patient monitoring systems were in place with a clear escalation process for the deteriorating patient, which we observed were used consistently.
- Staff were working to guidelines which followed national best practice recommendations. The service demonstrated good multidisciplinary working across the service.
- Pain relief was being monitored and managed well.
- Staff demonstrated a kind, compassionate and caring approach to patients. We observed that patient privacy and dignity was maintained at all times. Patients praised staff for their friendly manner and helpful and professional approach to their care.
- Patients told us that there was good communication about their care from staff who involved patients and their families in the care provided. There were faith champions across medical services to facilitate patients with emotional and spiritual needs.
- There were processes in place to learn from complaints. The staff had demonstrated a commitment to the dementia strategy.
- Medical services were to take on extra wards and reconfiguring the service to meet the demand for medical beds, and meet the needs of the population.
- Mixed sex breaches were avoided in endoscopy due to the trust being responsive in holding dedicated male and female lists at different times.
- There was a clear strategy for service and quality improvement. There was a clear leadership structure across the service.
- Staff showed a commitment to the service and demonstrated pockets of innovation in their area of work.

Medical care (including older people's care)

Are medical care services safe?

Requires improvement

We rated the safety of medical care services as requires improvement because:

- There were vacancies on all medical care wards. Medical wars were often operating under the established safer staffing level assessed by the trust. There was a high use of agency staff, especially on night shifts. We found that agency nurses were administering intravenous (IV) medications without providing evidence of training competencies, which placed patients at risk. However, the trust took immediate action to resolve this.
- There were gaps in the checking of the resuscitation equipment and medicines fridges.
- There were gaps in the records for the controlled drugs register checks on two out of the three wards we checked.
- Mandatory training had not met the trust target across medical care services.
- Patient records were disorganised and were not always filed in chronological order

However, we also found:

- There were processes in place to report incidents and serious incident investigation with learning from these communicated to staff.
- Patient monitoring systems were in place, with a clear escalation process for the deteriorating patient, which we observed were used consistently.

Incidents

- One never event was reported between March 2015 and March 2016. Never Events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. The incident was wrong site surgery in dermatology. The trust had taken steps to prevent recurrence by photographing areas to ensure the correct areas were identified before the procedure.
- There were 26 serious incidents reported in medical care services between March 2015 and March 2016. Five of these were grade 3 pressure ulcers and three were slips, trips or falls. There were systems in place to investigate these through root cause analysis. Recommendations from these incidents were shared across medical care services.
- There was an electronic incident reporting system in place for the trust. Four members of staff we spoke to about incident reporting all reported that they knew how to access this and report incidents.
- There had been 2794 incidents reported internally for medical care services between June 2015 and May 2016. Of these reported incidents 75% were categorised as no harm events.
- Safety huddles were used to discuss incidents and complaints on the medical wards. Three ward managers we spoke to reported that this was a valuable practice and took place every morning.
- We spoke to four members of staff about duty of candour; all were aware how to apply this. Duty of candour ensures that patients and/or their relatives are informed of incidents that have affected their care and treatment and are given an apology. There were information posters for duty of candour in corridors around medical wards and displayed within all ward areas visited.
- We reviewed four root cause analysis reports undertaken following serious incidents and these gave assurance that duty of candour was being conducted appropriately by the trust.
- There had been a trust wide learning event held in May 2016 that shared learning relating to falls across the trust. Learning events took place in ward areas so staffing was not depleted to attend these sessions.
- We reviewed the monthly mortality and morbidity meeting minutes for cardiology from January 2016 to March 2016, these evidenced staff learning from the clinical cases discussed.

Safety thermometer

- We saw that safety thermometer information was displayed on quality board on each ward with information from the previous full month. The NHS Safety Thermometer allows teams to measure harm and the proportion of patients that are 'harm free' from pressure ulcers, falls, urine infections (in patients with a catheter) and venous thromboembolism during their working day, for example at shift handover or during ward rounds..

- There were 31 pressure ulcers reported, two falls, 22 catheter associated urinary tract infections and six VTEs reported across medical services between March 2016 and May 2016.

Cleanliness, infection control and hygiene

- There were no cases of MRSA bacteraemia reported in medical care services between April 2015 and March 2016.
- We found that a patient was being barrier nursed in a general patient bay on Winter ward during the inspection. The patient had MRSA skin colonisation. We found that a decolonisation schedule was in place, and staff were barrier nursing the patient and using appropriate infection control techniques to minimise the risk to the patient and others.
- Due to the age and the layout of the hospital there were limited side rooms available for people who required isolation. There was an isolation protocol in place, which specified a priority list of conditions that required access to the side rooms. We observed that this was utilised for patients through the wards.
- Side rooms were used to isolate infected patients with clear signs used on the doors. However, we saw that doors to side rooms used for isolating patients were left open on Locke ward.
- There were 17 cases of Clostridium Difficile reported across the medical service between April 2015 and March 2016.
- MSSA rates for medical care wards across the trust were in the upper quartile of England, with low rates of infection reported.
- We saw staff cleaning clinical equipment and attaching "I am clean" labels after cleaning which recorded the date of cleaning.
- Hand gel dispensers were located on the walls and at patients' bedside. Hand hygiene audits were carried out monthly. However, there were gaps found in the audits between April 2015 and March 2016, where figures had not been submitted by wards. The general compliance rate was over 95%.
- We observed staff using personal protective equipment appropriately and disposing of these correctly after use. All staff were following the 'bare below the elbows' policy.
- There were two endoscopy rooms situated within the Alexandra day surgery unit. There was a clear pathway for clean and contaminated equipment to prevent cross contamination. The equipment was being decontaminated and stored in line with national guidance. Records were in place that provided full audit and traceability process.

Environment and equipment

- Within the Alexandra day unit endoscopy suite a new storage unit had been purchased for the endoscopes following Joint Advisory Group (JAG) recommendations. The patient area had been refurbished in the last 12 months.
- All dated single use items of equipment checked were in date and appropriately stored.
- We found a bagged pressure relieving mattress in the sluice room on B40 placed on the floor of the sluice room, which was not appropriate.
- We saw that moving and handling equipment was available and had been well maintained and tested to ensure it was safe to use. Other electrical equipment used for the care and monitoring of patients had been safety tested.
- We looked at the resuscitation trolleys on five wards and we found gaps in the daily equipment record checks on Lister ward, Fleming ward and EAU. Across these wards 13 gaps were found in the daily checks for June 2016.There was no further historical records of the daily checks as these had been removed by the resuscitation officer and they could not be provided when we requested them.
- We found a lockable cupboard in the clean store on Locke, containing prescription only medications and Control of Substances Hazardous to Health (COSHH) substances unlocked because the lock had broken. This was reported immediately to the ward manager for their action.

Medicines

- All medical care wards used the trusts prescription and medication administration record to facilitate the safe administration of medicines. Pharmacist interventions were clearly recorded on the charts to guide the staff in the safe administration of medicines.
- We looked at eight prescription and medication administration records. We found that they were clear and completed correctly and medicines had been administered with any omissions clearly recorded. This assured us that patients were receiving the medicines they were prescribed.

- However, during the inspection we identified that agency staff nurses were administering intravenous (IV) medicines without providing evidence of their competency training to safely administer IV medicines. The trust policy was that evidence of competencies must be provided prior to being authorised to administer medicines. This was acknowledged by the senior and executive staff. This policy was not being adhered to and staff were administering IVs without proof or evidence of competencies. The trust took action on the day of the inspection to cease the practice of agency staff administering IVs where competency training evidence was not provided.
- We were aware through the inspection that the trust was using high levels of agency at nights and weekends. Several staff reported to us that the number of agency staff caused problems with administration of intravenous drugs being given in a timely way. We undertook one of our unannounced inspections at night time and we observed that agency staff were no longer administering IV medicines if they could not provide evidence of their training. However, we observed that the administration of IV's was delayed due to the number of agency staff on duty without competencies in place. We reported this back to the trust for them to take immediate action to mitigate the risks, which they did do.
- We saw that all medication including controlled drugs were stored appropriately, controlled drugs were stored in a special cupboard and recorded in the controlled drugs record book. However, records reflected that the daily checks for controlled drugs had not always taken place on Lister ward and Winter ward. This was not in line with trust policy and on Lister ward out of date controlled drugs were found.
- We found that there were gaps in recording of temperatures for medication fridges on Ray ward and Lister ward.
- We observed nurses administering medications including controlled drugs and saw that patient wrist bands were used to correctly identify patient's prior medication being given.

Records

- Records were kept in both paper and electronic format. We found that paper records were kept securely either in lockable trolleys or in lockable offices. All electronic records were accessed by staff using a unique password. The electronic record was used for discharge documentation. Risk assessments and observation charts were kept at the patient bedside for easy access.
- The ongoing patient monitoring was recorded in a multidisciplinary record with continuation sheets used as required. We found the patient records were disorganised and were not always filed in chronological order. In addition, DoNot Attempt Cardiopulmonary Resuscitation (DNACPR) directives were difficult to locate within patient records, as they were not stored at the front of the records.
- The records that we examined evidenced that risk assessments were completed and reviewed frequently. These risk assessments included pressure damage, malnutrition and moving and handling.
- Patient records were audited monthly by the ward manager on each ward within the quality audit. We saw the quality audit results for all medical wards for April 2016 and these demonstrated that patient records were accurate and up to date. Risk assessments had been completed in a timely way.

Safeguarding

- The trust had a policy in place for the safeguarding of adults, which staff could refer to if there were any safeguarding concerns relating to patients. This was available electronically on the trust intranet.
- We spoke to four members of staff about safeguarding, all reported that they knew how to raise safeguarding concerns and would discuss concerns with senior staff if required.
- We spoke to the safeguarding lead nurse for the trust who reported that she could be contacted by staff and had regular contact with the local safeguarding authorities.
- Safeguarding training was included in the trust's mandatory training programme, with six wards achieving 100% of nursing staff that had completed the training.
- There were two social work teams covering East Hertfordshire and West Essex; the safeguarding lead reported they both had regular contact with the trust.
- We asked six patients if they felt safe in hospital; they all told us that they felt safe in the hospital and had no concerns about the staff and how they were treated.

Mandatory training

Medical care (including older people's care)

- The trust set a target of 90% compliance with mandatory training. Data from the trust reflected that this target had not been met in the core training across medical services. Training rates for moving and handling were 73%, infection control were 78%, equality and diversity were 70% and fire training were 75%. However, the training rates for dementia were 94% and safeguarding adults were 95% and safeguarding children level one were 96%, which was above the trust's target.
- Doctors were among the worst performing staff group with mandatory training with only 37% attending training overall across medical care services.
- We spoke to eight members of staff about training, and we were told that there was good access to training. One nurse told us that they could access e-learning from home, which was helpful.
- On Locke ward we saw evidence of 'micro teaching', which were short teaching sessions held on the ward facilitated by the ward manager or specialist teams. These sessions were included in the monthly ward report sent to senior management.

Assessing and responding to patient risk

- There was no pathway in place for patients with a gastrointestinal bleeding out of hours for the trust. There was no evidence of a contingency plan for these patients and this was not recorded in the risk register. This could present a risk when responding to an emergency patient with a bleed out of hours.
- National Early Warning Scores (NEWS) were used across medical wards. NEWS is a nationally standardised assessment of illness severity and determines the need for escalation based on a range of patient observations such as heart rate. All of the patient records that we reviewed showed that scores had been completed and escalated appropriately.
- Quality audits on documentation were conducted on the medical wards monthly; five patient records from each ward were audited including clinical observations, pain, infection prevention and falls. We reviewed the audits completed in April 2016 for the medical care wards which showed that National Early Warning Scores were completed. From the audits we saw that all patients that triggered on the NEWS were escalated for a clinical review.
- A care bundle was used for patients with infections 'Sepsis 6' aiding the staff to identify deteriorating patients early with an escalation process.

Nursing staffing

- The trust used the Safer Nursing Staffing Tool to assess the staff numbers required for each ward. Data supplied by the trust showed that less than a quarter of shifts had expected levels of staffing across medical wards in December 2015. However, the Chief Nurse had a clear recruitment plan to get nurses in, but they were challenged by immigration and work visa requirements as well as shortages for UK nurses.
- Nursing staffing levels for the day were displayed on a board on each ward, giving the planned and actual staff numbers. During the inspection we saw that wards were below the expected number of registered nurses for all shifts. Lock ward and ward B40 had one registered nurse below the expected level for each shift.
- There were 98.2 whole time equivalent vacancies for registered nurses across medical services.
- The number of vacancies included the 28 staff waiting for their Nursing and Midwifery Council (NMC) registration, as well as the recruited overseas nurses that had not yet started working for the trust.
- Nurses and managers throughout medical care services reported that the recruitment of nurses was a concern for them and vacancies were a risk. We found that there were 10 whole time equivalent registered nurse vacancies on the B40 and 12 on Winter ward.
- Clinical acuity and dependency is assessed three times per day using the Shelford Tool. This allowed the movement of staff to the area of need based on clinical acuity.
- Ward managers reported that staffing issues were escalated to the matrons and they were supportive with staffing during the day time. However, there were reports that there was less support from site managers at night. One ward manager told us that if the ward had the expected staffing level, nurses would be moved to other wards.
- Data sent from the trust showed that all medical wards had used agency nurses from September 2015 to March 2016. EAU had 28% agency staffing in October 2015 and Winter ward had 14% agency staffing during December 2015.

Medical care (including older people's care)

- We found checklists that evidenced agency staff were given a ward induction and a check list was completed prior to working on the wards.
- Staff sickness rates across medical care services varied from 3.3% to 4.8% between December 2015 and May 2016 according to the data received from the trust. This is above the trust average for staff sickness which is 3.0%.

Medical staffing

- The trust had suspended the stroke service at the time of inspection as they had been unable to recruit a specialist consultant in stroke care. The stroke service was being provided through another trust, which was working well at the time of the inspection.
- The senior managers identified challenges in recruiting consultants to the trust. However, a new gastroenterology consultant had been appointed prior to the inspection.
- Middle career doctors at 16% were above the England average of 6%. However, the medical staffing skill mix was broadly in line with the England average.
- Locum doctors were used regularly across most medical specialities, with the highest use of locum doctors in the EAU. The locum rates varied but the majority were above 7% usage, between September 2015 and March 2016.
- Consultants were on the medical wards from 9am to 5pm Monday to Friday with the physician of the day available on site between 5pm and 9:30pm and on call cover over night.
- At weekends the physician of the day was available on site between 8am and 8pm and on call overnight.
- Cardiology had a consultant of the week covering Fleming ward and CCU, with four consultants covering the speciality. However, there were no ward rounds at weekends and emergency patients were transferred to a local specialist centre. One consultant told us that there was access to telephone advice 24 hour a day seven days a week.
- We attended a night shift medical handover following issues raised by junior medical staff who were concerned that consultants were not always attending the handover. We found the handover well attended by staff and a consultant present.

Major incident awareness and training

- The trust had a major incident plan in place. This was regularly updated and available on the trust intranet page. Cards for actions of the medical staff, which were part of the plan, were kept either in the ward manager's office or within the clean storage room where the medications were kept.
- We spoke to five members of staff about major incident awareness. All of the staff knew where to find the major incident plans and how to action them if required. However, two staff members told us that they had not received major incident training.
- Staff received major incident training within the trust induction programme. Updates about the major incident plan were available to staff on the trust intranet and in leaflet format. Information about major incident training rates was requested from the trust. However, these were not supplied.

Are medical care services effective?

Good

We rated the effectiveness of medical care services as good because:

- Staff were working to guidelines which followed national best practice recommendations.
- The service demonstrated good multidisciplinary working across the service. This included support from community staff who attended meetings to discuss patient care.
- Pain relief was being monitored and managed well.
- Patients' nutritional and hydration needs were being met.
- Staff were qualified and had the skills they needed to carry out their roles effectively and were given training opportunities to meet their learning needs.
- Medical services continued to participate in national audits relevant to their speciality. A range of local audits were also undertaken.
- Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (2007) practices were following the requirements of the Mental Capacity Act 2005.

However, we also found:

- Performance fell below the England average in some of the measures across these audits.

- Staff were not always aware of outcomes from local audits.
- Readmission for elective clinical haematology and non-elective geriatric medicine was above the England average.
- Appraisal rates had reduced since our last inspection; though the staff were saying their appraisal rates were complete, the data provided did not support this.
- Seven day services were limited.

Evidence-based care and treatment

- Staff were aware of the National Institute for Health and Care Excellence guidance (NICE) relevant to their speciality and we saw they had access to guidance via the trust's intranet.
- We looked at trust policies including safeguarding adults, pressure ulcer prevention guidelines, and the treatment of infection guidelines and found they reflected best practice and were in date.
- Local protocols were in the process of ratification by the trust board for the endoscopy service, but all reflected best practice guidelines. This service was in the process of seeking Joint Advisory Group accreditation (JAG).
- Regular audits of documentation were undertaken on all wards to ensure care was following best practice and identify areas that required improvement. However, not all staff that we spoke to were aware that this process was undertaken.
- Data from the trust reflected that local audits were undertaken in relation to hand hygiene, stool audits and environmental audits. However, we found that there were 10 missing hand hygiene audits across the medical wards between April 2015 and March 2016. Four of these were for Winter ward.

Pain relief

- We reviewed eight patient medication prescription records which were complete, and did not contain any omissions.
- We observed staff performing patient intentional rounding where pain assessment took place. Patient records reflected that this took place every two or every four hours dependent on the patient's need. Intentional roundingis a structured approach whereby nurses conduct checks on patients at set times to assess and manage their fundamental care needs. We witnessed pain relieving medication being administered to a patient following intentional rounding.
- We spoke to five patients about their pain levels and pain relief. All reported that their pain had been well managed.
- The services were able to access the specialist pain team and they responded quickly when an assessment was required.

Nutrition and hydration

- The trust used the Malnutrition Universal Screening Tool to identify patients at risk of malnutrition. The tool was included in the nursing admission pack and completed on admission and monitored throughout the patient's stay.
- We saw that patients had access to water jugs at the bed side, these were within patients' reach. One patient told us that staff regularly renewed the water from the water cooler.
- We did not see any patients that were nil by mouth on the medical care wards we visited.
- There were regular rounds supplying patients with hot drinks. In addition patients were offered food and drink as part of the two hourly intentional rounding in place on the wards.

Patient outcomes

- We saw evidence of trust participation in national audits such as Myocardial Ischemia National Project and the National Diabetes Inpatient Audit.
- The Sentinel Stroke Audit Programme (SSNAP) from January 2015 to December 2015 gave the trust an overall rating of 'E' on a scale of A to E, with A being the best. However, the trust had suspended this service at the time of the inspection and patients were streamed to another trust with a specialist stroke service due to the issues appointing a specialist stroke consultant.
- There had been no further published data for the Myocardial Ischaemia National Audit Project since the last inspection.
- The National Diabetic Inpatient Audit (2015) showed that the trust has performed better than average in one of the 18 measures, and performed worse than average in five of the measures. The overall satisfaction of the service was 83% and the England average was 84.9%.
- The trust was participating in the National Dementia Audit, which was underway during the inspection. The first year had been completed of the two year audit process. The trust had been proactive in implementing a comprehensive dementia strategy.

Medical care (including older people's care)

- The trust was in the process of making an application for accreditation by the Joint Advisory Group (JAG) for endoscopy services. The management team reported that this had been rectified and process is due to be completed by November 2016.
- The length of stay for elective patients between September 2014 and August 2015 was 4.5 days, which was above the England average of 3.8 days. The Hospital Episode Statistics for standardised risk of readmission indicate how services compare nationally in providing care that is effective.
- The length of stay for non-elective patients between September 2014 and August 2015 was 6.0 days, which was below the England average 6.8 days. However the length of stay for non-elective patients within cardiology was 8.9 days and the England was 5.6 days. For geriatric medicine the average length of stay was 12.5 days and the England average was 9.9 days.
- The standardised relative risk of readmission for elective clinical haematology was 114 and non-elective geriatric medicine was 108, which were above the England average of 100 between August 2014 and July 2015. The risks of readmission for other elective and non-elective medical services were below the England average.
- The hospital standardised mortality ratio (HSMR) for December 2014 to November 2015 was 85.69 and statistically 'lower than expected'. The ratio was as expected or lower than expected for 13 months. However there was a significant difference for weekday (lower than expected) and weekend (within expected) HSMR for emergency admissions. The HSMR has fallen for the last 4 years from higher than expected 2011/12 to as expected in 2013/14 and lower than expected in 2015/16.
- The standardised mortality ratio (SMR) for all diagnosis between December 2014 and October 2015 was 87.45 and statistically lower than expected. The ratio was as expected or lower than expected for 13 months. In addition the patient safety indicators showed that deaths after surgery were within expected range and deaths in low risk diagnosis groups were within expected range
- The summary hospital-level mortality indicator (SHMI) for July 2014 to June 2015 was 105.0. and nationally the trust was in the second upper quintile.

Competent staff

- The data provided by the trust showed that the appraisal rate across medical services was 56% between April 2015 and March 2016. There had been a decline in appraisal rates over the past three years. The appraisal rate was 71% between April 2013 and March 2014. Ray ward was the highest for completed appraisals with 99% achieved.
- Clinical staff told us that they had received an appraisal in the last 12 months and ward managers told us that appraisal for staff was up to date. However, one ward manager told us that the staff appraisals had taken place but had not been updated on the computer system due to time constraints. The data provided by the trusts did not reflect that appraisals were up to date.
- The tissue viability nurses had implemented training around the positive effect of nutrition in wound management. The training lasted four days, spread over several months, and considered different elements of wound care, pressure ulcer prevention and nutrition.
- New staff on B40 were reported to have a six month preceptorship to ensure they were orientated to the ward area and developed specialist skills required for the ward area.
- The trust had developed a voluntary programme to develop dementia champions and four registered nurses on Ray ward were undertaking specialist qualifications in dementia care.
- Data received from the trust confirmed that four nurses within medical care services completed the new Nursing and Midwifery Council (NMC) revalidation process in April 2016.

Multidisciplinary working

- We attended a multidisciplinary team (MDT) meeting on Winter ward which took place every day; there was an update for each patient including their discharge plan. We observed input from a community matron; hospital and community based occupational therapists and physiotherapists as well as the ward co-ordinator.
- Records examined during our inspection, supported that MDT working was taking place effectively in medical services.
- We saw staff had close involvement with local care agencies and clear knowledge of local care homes.
- We spoke to one of the junior doctors who reported that there was a very multidisciplinary approach to care on

Ray ward and Lister ward. The feedback was positive about the communication between the allied health professionals, community nursing teams and the ward nurses.

Seven-day services

- We found there was a specialist weekend discharge team, the team was designated to cover medical ward specifically. This meant that patients did not have to wait until Monday mornings to be discharged if they were medically fit to go home.
- Consultants worked Monday to Friday with on call cover overnight and at weekends.
- The endoscopy service was operational six days a week but was not yet a seven day service due to staffing levels. However, a seven day service was planned for the future once staff had been recruited.
- There was no hospital at night service, which junior doctors reported had a negative impact on their workload at night.
- The cardiac service was covered by the medical consultant on call at weekends and out of hours. However, one of the cardiac clinical nurse specialists told us that most of the medical consultants had cardiac care training.
- Staff reported good access to therapies such as physiotherapy, occupational therapy and speech and language therapy Monday to Friday, with reduced access at weekends for physiotherapy and speech and language therapy.
- Medical staff reported that there was poor access to phlebotomy service at weekends. This had led to some patients not getting required blood testing at weekends. One of the matrons told us that phlebotomy service was often under staffed at weekends due to staffing issues. One of nurses reported that health care assistants were being trained to undertake phlebotomy on the wards.
- There was access to psychiatry through a doctor's referral to a team that was based in the hospital's mental health centre.

Access to information

- Staff had access to information from the medical records, which were mostly stored on site and could be requested 24 hours per day.
- Staff utilised a smart card system to access online records as well as diagnostic results and discharge information in a timely way.
- Agency staff did not have access to the electronic information but could request for information through one of the trust nurses if required.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We asked staff about Deprivation of Liberty Safeguards. Of the four we spoke with, all four were able to demonstrate clear knowledge and understanding of this. Deprivation of Liberty Safeguards protect the rights of adults using services by ensuring that if there are restrictions on their freedom and liberty; these are assessed by professionals who are specially trained to determine the restriction is needed.
- We saw two patients who had been assessed as requiring Deprivation of Liberty Safeguards. The application for the safeguard had been actioned in a timely way by the trust staff. However, there was one patient that had been waiting over two months for a specialist assessment. The trust's safeguarding lead reported that there was a delay in patient assessment by the local authority but there had been continuous liaison between the trust and the local authority in regard to the safeguards, and updates on this were recorded regularly in patient records.
- We saw that a mental capacity assessment had been carried out for patients who were unable to make decisions for themselves. We saw these assessments had been completed before the Deprivation of Liberty Safeguard application had been made to ensure that any decisions made were in the best interests of someone who lacked mental capacity.
- We spoke to three patients about consent and all of them reported that staff gained consent before undertaking any procedure or personal care.
- Staff received Mental Capacity Act training via classroom teaching. Information supplied by the trust showed that 90% of staff in medical care service had completed the training.

Are medical care services caring?

Good

Medical care services have been rated good for caring because:

Medical care (including older people's care)

- Staff demonstrated a kind, compassionate and caring approach to patients.
- We observed that patient privacy and dignity was maintained at all times.
- Patients praised staff for their friendly manner and helpful and professional approach to their care.
- Patients told us that there was good communication about their care from staff who involved patients and their families in the care provided.
- There were faith champions across medical services to facilitate patients with emotional and spiritual needs.

However, we found that:

- There was a theme in complaints relating to staff communication issues with patients and their relatives.

Compassionate care

- Staff were polite and friendly in their approach to the delivery of patient care. Staff used appropriate language that was not jargon or clinically based to ensure patients understood what was going to happen.
- We observed that staff protected patients' privacy and dignity by ensuring curtains were closed within the bays. Doors to side rooms were closed when personal care was being provided.
- Five patients we spoke to reported that they felt their privacy and dignity had been well maintained by staff.
- One member of staff on EAU told us that due to the way the ward worked there was movement of patients 24 hours of the day. However, to reduce noise levels doctors had a dedicated room to make telephone calls and have discussions, rather than to use the central work station.
- Patients told us they felt safe and well cared for by staff. One patient told us that "the staff put their heart and soul into it". Another patient told us that the care was "faultless, I cannot praise it enough".
- The Friends and Family Test response rate from March 2015 to February 2016 was 39.2%, just below the national average of 33.7%. Reponses varied from the wards with many medical wards achieving 100% of patients that would recommend the service to 65.4% in March 2015 for Winter ward.
- One junior doctor told us they would stay behind to assist patients with mouth care and to ensure patients were comfortable before going home.

Understanding and involvement of patients and those close to them

- Four patients we spoke to reported that there had been good communication of information to them and their families. Patients reported that doctors and nursing staff answered any questions they had regarding their care and treatment.
- On Ray ward there had been a new initiative called the "ward surgery" to facilitate communication between relatives and ward staff including the doctors. The surgery ran from 3pm to 4:30pm five days a week. The ward manager reported this had been well attended by patients and families.
- We spoke to one relative of a patient who praised the staff about being made to feel welcome and involving them in the care.
- We found one of the main themes in the complaints received by the trust for medical service related to staff communication with patients and their relatives.

Emotional support

- There was a trust wide chaplaincy service; we saw this advertised on notice boards within the wards.
- We saw that there were faith champions on the wards to facilitate emotional and spiritual care.

Are medical care services responsive?

Requires improvement

Medical services have been rated requires improvement for being responsive because:

- There were delays in speciality input as patients could not always be placed on speciality wards. This meant that people's individual care needs could not always be met.
- Medical services had not met the target for referral to treatment times. There were 1443 bed moves between 10pm and 8am between June 2015 and March 2016.

However, we also found that:

- There were processes in place to learn from complaints and the learning was communicated to staff effectively.

- The staff had demonstrated a commitment to the dementia strategy, implementing changes to the ward areas to support patients with dementia.
- Medical services were to take on extra wards and reconfiguring the service to meet the demand for medical beds, and meet the needs of the population.

Service planning and delivery to meet the needs of local people

- The trust was working with outside agencies to deliver a hospital at home service to facilitate early supported discharges. This service delivered care to patients in their own home, for example the administration of intravenous antibiotics, which would otherwise mean that patients would need to remain in hospital.
- Though we were aware this service was no longer continuing their contract, which had expired, with the trust but no plans were in place to support those patients at home. The service routinely saw between 25 and 40 patients per day.
- There was a planned non-invasive ventilation service to be placed on Locke ward. Staff had completed training and changes to the ward infrastructure had been made to accommodate this service. The medical management team reported that the service is due to launch in September 2016.
- The medical management team reported that Saunders ward was due to be changed to a medical ward in August 2016 to reduce the pressure on medical beds.
- The trust had suspended the stoke service at the time of the inspection. However, arrangements had been made with the local clinical commissioning group to transfer stoke patients to specialist service at another trust nearby.

Access and flow.

- Patients were admitted to medical care services through the emergency department or via GP referral. Daily meetings were held and attended by ward staff from the medical wards to discuss discharges and patient flow.
- The management team told us that they had all been recruited into substantive posts, which had not been the situation before January 2016. They felt that they were in a position to implement changes to improve access to patients and flow through the medical wards. They were working with an outside specialist to build a model of length of stay and admission to the trust.
- The trust acknowledged that there were issues with speciality input as patients could not always be placed on the appropriate specialist ward. However, the medical management team told us this was particular focus for the team. They had started to plan changes to aid patient flow, for example haematology patients will be placed on Winter ward to allow all beds on Harvey ward to be dedicated to gastroenterology.
- A new computer system had been implemented to accurately record patient admissions and length of stay data. However, the medical management team reported there had been some interruptions in recording and reporting when this was first implemented but these were now resolved.
- Between March 2015 and February 2016, 10% of patients had one ward move, 8% had two or more ward moves during their admission.
- Concerns were raised to us during the inspection that consultants across medicine were not commencing their ward rounds until after 10am. This we were informed was resulting in delays to the discharge processes for patients. Decision about discharge was needed earlier to reduce the number of discharges after 7pm and again after 10pm. There were 1443 bed moves between 10pm and 8am between June 2015 and March 2016.
- The data the trust sent us showed there had been no mixed sex breaches reported in medical services between April 2015 and March 2016.
- A specialist weekend discharge team had been created to ensure patients were discharged when they were fit to go home. This aided the flow of patients through medical care services at weekends.
- Data submitted by the trust for medical care services for incomplete referral to treatment time target between December 2015 and March 2016 showed that were between 66.7% and 88.9% across medical care services the target is 92%.

Meeting people's individual needs

- The trust had a dual role nurse specialist in learning difficulties and dementia in post. This member of staff had a high profile across medical care services due to the dementia strategy programme of work.
- The trust had a comprehensive strategy for dementia care; this had been led by the learning difficulties/ dementia lead nurse and the frailty lead nurse.

Medical care (including older people's care)

- Staff members had volunteered to become dementia champions. Each of the champions had to complete a six month training programme including a work based project. This led to the creation of the reminiscence room on Lister ward.
- Close links were being forged between the end of life care team and the dementia strategy to develop a dementia end of life pathway to allow patients and their families to plan care in advance.
- Dementia friendly clocks had been placed in many areas of the hospital and blue trays were used for patients' meals to support patients with dementia.
- The frailty service had six beds on ward B40 dedicated for frailty patients with the aim to discharge patients within 72 hours of admission with input from community based services.
- We observed the lunch time meal being served on Ray ward and saw that patients were assisted to eat if this was needed. Blue trays were used to aid identification of the food for patients with visual impairment or dementia.
- Patient information leaflets were available with trust information such as the Patient Advice and Liaison Service and some relating to diagnosis/condition. On Locke ward contact information and visiting times were given to patients' relatives on arrival to the ward.
- There was access to a translation service to facilitate patients that required assistance with the English language. One member of staff reported that the service was good.
- On Harvey ward there was a room for relatives to make hot drinks, there was a sofa bed for relatives to stay overnight if required. This room was developed by the ward team following feedback from relatives and there is consideration to create similar rooms on other wards in the trust.
- There were designated quiet rooms on most of the wards for patients and their relatives to use away from the bays. This allowed quiet discussions between patients and their families and staff. On Lister ward there was a low stimulation quiet room with reminisce aids. This room was developed to facilitate a calm environment for anxious patient especially those with dementia.

Learning from complaints and concerns

- There were 111 complaints received by medical care services. The three main themes related to communication between staff and patient or their relatives, poor discharge arrangements and untimely appointments and diagnostics.
- Patients we spoke to felt able to raise concerns or make a complaint. However, one patient reported that they had asked how to make a complaint and the ward manager discussed the concerns but the patient reported that no explanation was given about the complaints process.
- Six members of staff that we spoke to felt able to manage most patient complaints but felt able to escalate complaints to a senior member of staff if this was required.
- Feedback from complaints, which were discussed in the patient safety and quality meetings, were cascaded to the ward managers who demonstrated action plans to mitigate further complaints relating to the issues raised.
- Complaints were discussed at ward level meetings with staff and the ward managers we spoke to were able to give examples of recent complaints and resolution. Any complaints were discussed at the morning safety huddles on the wards.
- We saw posters with information about the Patient Advice and Liaison Service in the main corridors of the trust and displayed on the wards.

Are medical care services well-led?

Good

Medical care services were rated good for being well-led because:

- Medical services had a clear strategy for service and quality improvement.
- There was a clear leadership structure across the service. Staff showed a commitment to the service and demonstrated pockets of innovation in their area of work.
- There was a clear strategy for quality and improvement of the service with regular review meetings that were well attended by the leadership team.

However, we also found that:

- There was evidence of identified risks to the service. However, we found that some risks had not been identified and included on the risk register.
- We were concerned that the matrons and associate directors of nursing were aware of the concerns regarding agency nursing competencies to administer IVs but failed to escalate this to the associate director of nursing.

Vision and strategy for this service

- The medical management team told us their strategy was to work closely with external services to support the 'care closer to home' initiative across West Essex.
- There were plans to introduce a frailty unit close to the emergency department in the future, to prevent admissions that were not of a medical need and to ensure that support services were mobilised to support these patients in their home environment.
- We saw that medical services had a clear strategy for service and quality improvement. We saw evidence of regular update meetings which were well attended by the medical management team to gage the progress of ongoing projects.

Governance, risk management and quality measurement

- There was a governance structure within medical services, which was embedded. The medical health group and patient safety and quality group meeting were held monthly which reported into to the trust committee on patient safety.
- There were audits conducted monthly on the wards to monitor quality and patient safety. These audits ranged from patient records which were monitored to assess compliance in areas of risk assessment and escalation of a deteriorating patient to the hand hygiene audit. These audits formed part of ward monthly reports that were completed by the ward managers.
- Medical services had a risk register with defined actions to mitigate the severity of the risk. These were reviewed at regular intervals. We were informed that the two largest risks were staffing and the aging buildings. However, we found that some identified risks were not included on the register, for example the lack of gastro-intestinal bleed pathway and out of hours cover.
- There were measures in place for ward based risks to be escalated to the trust board. Ward managers completed monthly reports which included the ward based risk register. The risk profile for the wards were managed by the medical services leadership and reported in to trust board meetings. We saw evidence of this in meeting minutes and the risk registers reflected ward based risks.

Leadership of service

- The medical service was part of the medicine health group, and was led by a clinical director, associate director of nursing, and deputy director of operations. The senior team were supported by service matrons, clinical leads for each medical specialty and service managers.
- There was a clear leadership structure in place for medical care services. The medical managers demonstrated a clear awareness of issues and innovations taking place at a ward level. There were clear communication systems to cascade information to ward staff.
- The medical leadership team recognised the need for budget control and launched "the turnaround challenge" in March 2016. The aim the challenge is to do more for less without compromising on quality of patient care or experience.
- We saw strong leadership from the ward managers and they were supported by the matrons who were committed to delivering a high quality service. All of the ward managers we spoke to reported that they were proud of their team due to the dedication and commitment they had shown.
- However, we were concerned that the matrons and associate directors of nursing were aware of the concerns regarding agency nursing competencies to administer IVs but failed to escalate this to the associate director of nursing.
- Ward managers reported that they were well supported by their managers and there was a strong presence of the matrons on the medical wards.
- Staff told us they felt well supported by their ward managers, feeling they were a valued member of the team and felt able to raise any concerns they had.
- Junior doctors reported that they were well supported by the consultants and felt able to raise any concerns.

Culture within the service

- The staff were aware of the trust values and demonstrated these during the inspection to the team and their patients. All staff were polite, friendly, helpful and open to questions, showing a genuine commitment to the organisation.
- Staff we spoke to were proud of the projects they had been involved in to improve quality of care and the experiences of patients in their ward area.
- We spoke to junior doctors who reported that they were well supported by consultants. One junior doctor told us he had attended a number of serious incident meetings and found these a good tool for learning in a supportive no blame environment.
- During the unannounced inspection, we identified cultural concerns in that staff were not actively declaring vacant beds when they became available. As a result this impacted on the delivery of the emergency department which was not appropriate.
- We also noted that some wards were not always declaring staff numbers to avoid staff being moved to cover shortages in other areas. This was also noted for the surgery service and was not good practice.

Public engagement

- There were monthly patient panel meetings held by the trust to facilitate patient engagement to review and improve services. The panel also reviewed anonymised complaints, examining how they were handled and requested patient feedback on the process. Communication was managed through the patient experience team.
- There was patient experience training and workshops for staff including interviews with patients and families who have made complaints, with clinical staff about responding to complaints, training in listening and facilitation of complaints.. The workshop gave staff an opportunity to gain an understanding of the experience being in hospital from a patient's perspective.

Staff engagement

- The medical healthcare group evidenced communication with all staff groups across the service with a listening event in February 2016. Staff workshops and interviews were used to gain feedback from the staff about leadership, governance and innovation. The management team were in the process of delivering an action plan following this event.
- We saw good staff engagement with the dementia strategy; staff had volunteered to become dementia champions, undertaking a six month training programme incorporating a project to improve dementia care in their area of work.
- There were monthly ward meetings to cascade information to staff supplemented by a ward newsletter and a staff information board. Daily safety huddles were also used to discuss important information.

Innovation, improvement and sustainability

- There had been six beds allocated to the frailty service on B40 for rapid assessment and implementation of a care structure for patients in their own home. The vision of the medical leads was to locate a unit close to the emergency department to facilitate rapid access to specialist care without the need for a hospital admission.

Surgery

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

Information about the service

The Princess Alexandra Hospital NHS Trust provides a range of acute and specialist services to people living in West Essex and East Hertfordshire. Surgical specialties include general surgery, elective and trauma orthopaedics, plastics, ophthalmology, ear, nose and throat, oral surgery, orthodontics, urology and dermatology.

At time of inspection the surgery service consisted of four surgical wards, divided into elective and emergency admissions. However, this was to reduce to three wards on 18 July 2016 as Saunders ward was planned to convert to a medical ward. The trust had also reconfigured the previous surgical short stay unit, on Melvin ward, to become the clinical decisions unit managed by the urgent and emergency care division. There is a same day admissions unit situated on Nettleswell ward and day surgery was provided in the Alexandra day surgery unit There is a pre-assessment unit, ten theatres within the main theatre suite and sterile services on site.

During this inspection we visited all four ward areas within the surgery service including the theatres and day surgery. We spoke with 28 members of staff, including medical and nursing staff, seven patients and four relatives. We also reviewed 11 sets of medical records, 14 prescription cards and information requested by us and provided from the trust.

Summary of findings

Surgery services required improvement overall. Safety was rated as inadequate, with effective, caring, responsive and well led were rated as requires improvement.

- Nursing staff levels had direct impact on patient safety on Kingsmoor and Saunders ward with delayed care. Daily nursing numbers did not match patient acuity consistently.
- Management of incident reporting, categorisation, investigation and learning was not robust. Monitoring of staff competencies was poor.
- Mandatory training rates were low across surgery.
- Storage of intravenous (IV) fluids on Saunders ward was not secure. Medication prescription and administration was not time specific.
- The difficult intubation trolley in theatres was not appropriately stored or regularly checked.
- Not all guidelines were updated in line with national guidance.
- The trust results in the National Emergency Laparotomy Audit indicated four out of 11 measures reported were rated amber.
- Appraisal rates were poor.
- Consent on the day meant there was a very limited opportunity for patients to consider all the information prior to the procedure taking place.
- Call bells were not answered in a timely manner.
- Patients were not always aware of which ward they would be admitted to after surgery.

Surgery

- Referral to treatment times (RTT) standard of 92% was met in only four of 11 specialties.
- Theatre utilisation was impacting on service delivery and 42 theatre sessions had been cancelled in May 2016. Discharge planning was not consistent.
- Out of hours transfers between 10pm and 7am were high with 908 reported in four months. The number of patients being held in the post anaesthetic care unit (PACU) for more than 12 hours was higher than expected.
- Admissions directly to PACU was having an impact on service delivery, with patients being admitted directly due to the lack of critical care bed availability. The longest recorded stay in a four month period was 72 hours and 30 minutes.
- There was instability within the senior management team. Oversight to risk and quality management was limited. Staff at a local level were not supported to ensure that risks were identified, reported and managed in a timely manner.
- The lack of attention to policies and procedures remaining up to date meant there was a potential risk of patient safety. Failure to retain and recruit staff was impacting on staff morale.

However;

- Dedicated pharmacist support on Kingsmoor ward had benefits of empowering staff, increasing knowledge and reducing the inappropriate prolonged use of intravenous medications There were weekly 'bleep free' training sessions for junior medical staff.
- Staff delivered care in a compassionate, supportive and considerate manner. Patients provided consistently positive feedback about their care and treatment. Patients were involved in making decisions about their care, and said that care had been explained to them in a way that they could understand. Friends and Family Test data (FFT) showed an average of 97.8% of patients on surgical wards said that they would recommend the service.
- There was an embedded enhanced recovery programme in place for colorectal and gynaecology patients. Hydration cards reduced the risk that patients were fasted for extended periods.
- The trust was performing in line with or better than the England average across all indicators in the Bowel Cancer Audit and similar to England average in the Hip Fracture Audit.
- Cardio pulmonary exercise testing (CPET) was used as part of pre-assessment to identify proactively those patients that may require intensive treatment unit (ITU) care following surgery.
- There were several staff champions for various conditions. There was a team dedicated to support patients with learning disabilities. Staff were passionate about their roles and wanted to provide good patient care.
- The tissue viability specialist in theatres was proactive and had animated innovative ways to train staff.

Surgery

Are surgery services safe?

Inadequate

Safety in surgery was rated as inadequate because:

- Reduction in nurse staffing had direct impact on patient safety on Kingsmoor and Saunders ward with delayed care. Whilst funded establishment reflects the appropriate nursing skill-mix for the workload on Saunders and Kingsmoor wards; the current vacancy position and variable availability of temporary staff results in inconsistent achievement of planned staffing levels.
- Management of incident reporting, categorisation, investigation and learning was not robust.
- Monitoring of staff competency to ensure staff had appropriate skills to care for patients was poor.
- Of all the units 31% had an average mandatory training completion rate below 65%. Nursing staff average completion was 72% and medical staff completion rate was 63% against a target of 95%.
- Training rates for medical staff on moving and handling were low at 18% and no medical staff in surgery were recorded as being trained in safeguarding children level three.
- Storage of IV fluids on Saunders ward was not secure.
- Medication prescription and administration was not time specific and listed morning, lunch, afternoon and teatime, which meant a risk to patient safety.
- There was no evidence of a system in place to ensure formal checks for competency in IV administration were in place, which meant a potential patient safety risk.
- The difficult intubation trolley in theatres was not tamper proof and equipment was not clearly or appropriately stored.
- The quality of mortality and morbidity meetings was poor.

However, we also found:

- Dedicated pharmacist support on Kingsmoor ward had benefits of empowering staff, increasing knowledge and reducing the inappropriate prolonged use of intravenous medications.
- There were weekly 'bleep free' training sessions for junior medical staff.

Incidents

- There had been seven serious incidents (SI) reported between March 2015 and March 2016 for the surgery services. These included sub-optimal care of a deteriorating patient, pressure ulcer management, a medication incident, invasive surgical procedure and alleged abuse. The incidents varied in nature with no overarching themes identified. However, one of the incidents, reported in July 2015, was still pending review which meant that it had not yet been categorised.
- In March 2016 a never event in theatre occurred where the incorrect implant was used during a joint replacement. Never Events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. Staff had introduced several measures to help reduce the risk of a similar incident reoccurring. These included introducing a 'pause for prosthesis' and an updated standard operating procedure. Communication of learnings occurred via the patient safety and quality newsletter and the chief executive presented this as a regional discussion to share learning. The team had also discussed possible changes to packaging with the manufacturer to make details clearer.
- An electronic system for reporting of incidents was in place. Staff understood the mechanism of reporting incidents, this was confirmed verbally, both at junior and senior level. There had been 475 incidents reported within the surgery health care group between January 2016 and March 2016.
- Senior staff completion of incident investigation was not consistent in all areas. At the time of inspection there were 70 incidents outstanding on the electronic system on Saunders ward. This meant that incident reporting, categorisation, investigation and learning was not consistent, or undertaken in a timely manner, which could affect patient safety.
- Ward staff completing incident reports for women admitted following referral to the gynaecology team were required by senior staff to mark the incident as gynaecology rather than the ward name. Three ward staff informed us that they were not aware of this directive.
- There was limited learning from incidents. Senior staff had used team meetings to communicate learnings. However, reduced staffing numbers had meant that

team meetings were infrequent. On Saunders ward team meetings were only reintroduced just before the inspection following a change of senior staff. One member of experienced staff on Kingsmoor ward could not provide any examples of recent incidents.

- Nursing and medical staff were aware of their responsibilities under duty of candour. The nursing sister on Kingsmoor ward gave an example of one particular incident and complaint. Senior staff had met with the patient and family members to discuss their concerns. Part of the learnings identified had been increasing comfort rounds to include a check at 6am to ensure patients' personal needs were met before handover at 7:30am.
- Staff stated that the consultant involved with the never event in theatre had met with the patient and provided a full explanation and apology.
- Duty of candour posters were on display throughout the surgical wards. These posters outlined the requirements and actions the trust would take to communicate with patients and families following incidents.
- We reviewed the mortality and morbidity meetings for the health group. Meetings are held every month for surgery. We were not assured that the meetings were of a good quality. There was limited information presented and discussed about each case, and key concerns were either not discussed or not recorded.
- For example, a patient admitted with pain was not diagnosed with a serious condition for five days following admission. There was no detail as to why the patient received a delayed diagnosis and there was no discussion about whether or not the delay in diagnosis affected their prognosis or outcome. Again with this case there was no discussion regarding incident or serious incident status, which would be expected for events like this.

Safety thermometer

- Quality indicator dashboard results were on display in each surgical area. Displayed safety crosses for methicillin resistant staphylococcus aureus, Clostridium difficile, falls and pressure ulcers informed patients and relatives of current performance.
- The quality and safety dashboard utilised a RAG (red, amber green) rating to indicate performance. In February 2016, Kingsmoor and Saunders ward were red for pressure ulcers with both wards having one patient with a pressure ulcer grade 2 or above. There had been none in January 2016.
- The quality and safety report, dated 20 January 2016, highlighted the prevention of falls and pressure injuries as a high risk due to the continued short staffing levels. There had been six patient falls in Kingsmoor in December 2015 and two patient falls on Saunders ward in the two weeks prior to inspection.
- There was appropriate documentation of venous thromboembolism (VTE) risk assessment in ten of the eleven patient records reviewed. However, not all preventative measures were undertaken. For example, two out of five patients reviewed during a ward round were not wearing anti-embolus stockings which help reduce the risk of a blood clot forming.
- Theatre staff undertook a Waterlow score (pressure ulcer risk assessment tool) for patients during the perioperative phase as part of the theatre documentation. The patient had an assessment and score at pre-assessment and any additional equipment, such as a pressure-relieving mattress, was pre-ordered for those patient identified as a high risk. This meant that delay with provision of specialised equipment was minimised and helped reduce the risk of a pressure ulcer.
- The safety thermometer for surgery showed that between July 2015 and February 2016 there were 10 patients recorded as having new pressure, seven patients developed a catheter related UTI, and four patients sustained a fall resulting in harm.
- There were 197 falls within the last financial year within Surgery. 139 were reported as causing no harm, 57 resulting in minor harm, and 1 fall resulting in moderate harm.

Cleanliness, infection control and hygiene

- Surgical wards were visibly clean and uncluttered. "I am clean" stickers were visible on equipment to signify it was clean and ready for use
- Nursing staff adhered to trust policies and guidance on the use of personal protective equipment (PPE), and to the 'bare below the elbow' guidance, to help prevent the spread of infection. However, compliance by medical staff was not as consistent. Only one doctor, out of four, used hand gel during a ward round.

- There was adequate provision of PPE such as gloves, aprons and visors throughout. Side rooms were available and in use for any patients requiring isolation due to infection. When utilised for isolation clear signs were in place alongside PPE equipment to remind both staff and relatives that there were strict infection control processes in place.
- Infection rates across surgery services were low. Data from April 2015 to March 2016 showed that across surgery there had been no cases of (MRSA), MSSA and three cases of Clostridium difficile (C. Difficille).
- Tye Green ward is a mixed elective surgical admissions ward that included Orthopaedic admissions. The hospital maintained a strict admission criteria to the ward with all patients being swabbed and cleared for methicillin resistant staphylococcus.
- Daily checklists for cleaning of side rooms were in place on Tye Green ward and had been signed and dated by staff. On all wards there were cleaning checklists in place which meant that ongoing monitoring was in place to reduce the risk of infection.
- Surgical site infection surveillance data was collected for patient's post total hip and total knee replacement and collated by the orthopaedic clinical nurse specialist. The trust results, post knee replacement, for 2015 was 1.9%, slightly higher (worse than) the England average at 1.6% and the previous year's result of 0.45%. Hip replacement result was 1.8% again higher (worse than) the England average at 1.1% and the previous year's result of 0.8%.

Environment and equipment

- Staff carried out daily checks of resuscitation trolleys and emergency equipment within the surgical wards and theatres. These checks were consistent across all areas.
- The difficult intubation trolley within theatres is required for emergency use. Daily checks of this equipment were not consistent. Records showed that throughout May 2016 the checks had only occurred on ten days across the complete month. This was raised with senior staff on site, who stated that it had been noted and reiterated to the team and an improvement had been seen in June with 19 days checked out of the first 21.
- The pre-assessment service was located separately from the main hospital. The service shared a corridor with other specialities and staff stated that at times space was an issue. Emergency equipment was available including an emergency grab bag, automated external defibrillator (AED), suction and oxygen cylinder. An AED is a small portable electronic device that analyses the heart rhythm and delivers a shock only when needed. Nursing staff recorded weekly checks to ensure they were complete, in good working order and ready for use.
- The difficult intubation trolley was not tamper proof and immediate emergency equipment was stored incorrectly within the drawers of the trolley rather than easily accessible on the outside. This meant that there was a potential risk to patient safety as a delay could occur if all equipment was not readily available
- Certain theatre stack system equipment was out of date for servicing by the Electro-Biomedical Engineering (EBME) department. EMBE had sent a notification email, on 24 June 2016, extending testing to every four years. A new policy for electrical safety testing was in process and would outline these changes. However, it was not clear that this conformed to manufacturers guidelines and the policy was not due to be ratified until July 2016.

Medicines

- The prescription and medicine administration records for 14 patients on two wards (Saunders and Kingsmoor wards) were reviewed. All prescriptions were legible, signed and dated with allergies documented. However, not all medication prescribing was time specific, for example the abbreviations MLTN (morning, lunch, teatime and night) were documented. On administration nursing staff did not document specific times which meant patients may be at risk of receiving multiple doses. We raised this as a concern during the inspection.
- Medicines were stored correctly and securely throughout the majority of surgery wards and theatres. However, on Saunders ward the intravenous (IV) fluid storage room was unlocked despite a notice on the door stating it should be locked at all times. This meant there was a potential that fluids could be tampered resulting in risk to patient safety as security was not robust.
- Documentation records were in place that demonstrated daily monitoring of temperatures of medication fridges to ensure that medications were stored at the correct temperature. This included details of the acceptable temperature ranges and actions

required should the temperature fall out of this range. Records reviewed were completed correctly. However, the monitoring of ambient room temperatures in areas where medications were stored was not consistent.

- New fluid warming cabinets were in use within theatres that enabled temperature monitoring. Daily recording was in place. However, we brought to the attention of the theatre matron that the acceptable ranges were not specified, which meant staff had no easy point of reference. Matron stated this would be addressed to ensure there was no confusion regarding acceptable ranges.
- Pharmacy provided a top-up service for ward stock. Any other medication orders were completed on an individual basis. This meant that patients had access to medicines when they needed them while in hospital.
- There was a dedicated pharmacist based on Kingsmoor ward to provide support and advice directly to both patients and staff. They had introduced several initiatives to drive improvements in medicine management. One example was a focus on inappropriate or continued use of intravenous medication. A sticker, that prompted a medical review of the ongoing clinical need for the IV, had helped reduced prolonged administration.
- With this direct support nursing confidence had improved and staff felt empowered to challenge the medical team if they had any queries regarding medications. This pharmacist was due to transfer to the intensive care unit the week after inspection and staff were disappointed this direct support was discontinuing.
- Paracetomol was seen prescribed as a 'to take out' medication (TTO) (medicines given to patients on discharge from their hospital stay) for a woman discharged from clinical decisions unit which was confirmed by senior staff as not following the trust's medication guidance of requesting patients use their own paracetomol once discharged.
- Prescribed antibiotics were indicated on a discharge letter for TTO but on reviewing the notes the antibiotics were completed prior to the patient discharge.
- There was a temporary staff checklist in place for agency staff. This included references to infection prevention requirements, record keeping and handover and provision of information for emergency procedures such as resuscitation equipment and National Early Warning Score (NEWS) triggers. This was a tick box checklist and as such did not provide evidence of skills and competence of agency nurses. For example one tick box was "completed an assessment of my competence to administer medicines including intravenous therapy". There was no evidence of a system in place to ensure formal checks for competency in IV administration were in place.
- We were aware through the inspection that the trust was using high levels of agency at nights and weekends. Several staff reported to us that the number of agency staff caused problems with administration of intravenous drugs being given in a timely way. We undertook one of our unannounced inspections at night time and we observed that agency staff were no longer administering IV medicines if they could not provide evidence of their training. However, we observed that the administration of IV's was delayed due to the number of agency staff on duty without competencies in place. We reported this back to the trust for them to take immediate action to mitigate the risks, which they did do.
- When we returned on our second unannounced inspection we observed staff using the checklist although the staff on Kingsmoor ward were not pleased about the additional work this had created. When asked if there had been incidents involving agency staff and IV's a nurse told us "yes" but that they do not have the staff to safely manage IVs without agency support. We provided this feedback to the chief nurse for them to ensure that the procedures are embedded across all wards.

Records

- We reviewed 11 patient records; VTE assessments, patient care rounding, dementia screening for patients over 69 years of age, care plans with post-operative instructions were completed correctly in all records reviewed.
- Contact numbers for the appropriate medical teams were documented to enable easy contact by nursing staff.
- The majority of records reviewed were legible with entries signed, named and dated to provide tracking if required. However, anaesthetic entries were lacking for a patient on Kingsmoor despite several notes made by the surgical team.
- The preassessment team stated that there were issues with the electronic referral system for preassessment.

This had been raised with the information technology team but had been difficult to address. This meant that inappropriate referrals added capacity pressure to the team.

- Security of patient records was not robust on Nettleswell admissions unit. Notes were stored overnight in preparation for surgery the next day. The room where the records are stored had a key pad control for security. However, the door was found to be left open during the day which meant there was a potential risk to information security.
- Trust policies and procedure were available via the trust intranet. Hard copies were also available in folders on the surgical wards. Many of these were not reprinted when electronic updates had occurred and were out of date.

Safeguarding

- Safeguarding training was mandatory for all staff. There were varying levels of training requirements dependant on staff roles. Data provided for surgery services stated that 100% of medical staff had received safeguarding adult training, and 61% of medical staff had been trained to safeguarding children level two. No medical staff in surgery were recorded as having received safeguarding children training at level three.
- For nursing staff 94% of staff had received safeguarding adult training, and 58% of nursing staff had been trained to safeguarding children level two, and 58% of nursing staff had received safeguarding children training at level three.
- Safeguarding champions were in place across the service as staff who could give additional advice and support.
- National Institute for Health and Care Excellence (NICE) guidance issued in March 2014 outlined best practice in relation to delivering health services to individuals who have experienced or are at risk of being victims of domestic abuse. The Daisy Project was first introduced in the trust in 2013 to support victims of domestic harm. As part of this project, training is provided for all staff as part of their mandatory training on domestic abuse as part of the vulnerable patient study days in order to support those patients who disclose domestic abuse. Daisy champions were in place to give advice and support to patients and colleagues across the service.

Mandatory training

- Mandatory training was via face-to-face or e-learning format depending on the subject matter. Topics included information governance, equality & diversity, dementia training, fire safety, basic life support, safeguarding vulnerable adults level one, safeguarding children levels one, two and three (staff group dependent) and infection control and manual handling.
- Compliance was variable across the service and various staff groups; medical and dental staff had the lowest average training completion rate of 63%, and nursing staff were at 72%. None of the staff groups met the trust target of 95%. The best performing staff group was allied health professionals with a completion rate of 100%.
- Training rates for medical staff included hospital life support (76%), dementia (50%), fire safety (55%), infection control (57%), moving and handling (18%), information governance (52%), equality and diversity (63%). Training rates for nursing staff included hospital life support (60%), dementia (85%), fire safety (66%), infection control (64%), moving and handling (63%), information governance (74%), equality and diversity (79%). Of the groups 31% of all units had an average training completion rate below 65%.
- Anaesthetics was the worst performing unit with an average completion rate of 50%.
- Opportunities for manual handling training were limited as the training post was vacant at the time of inspection and staff stated that opportunities and space on training was difficult. Data displayed for June 2016 on Kingsmoor ward showed compliance of 67.8% for manual handling.

Assessing and responding to patient risk

- The National Early Warning Score(NEWS) system was in place across the surgical areas to identify any change in patient condition and ensure timely appropriate escalation for deteriorating patients. In 11 sets of adult notes reviewed, NEWS scores were documented and calculated correctly. The orthopaedic medical team reviewed NEWS scoring as part of the ward round.
- There was a pilot scheme across the trust to introduce an electronic patient observation system. This had commenced on 16 June 2016 and Kingsmoor ward was one of three wards taking part. The system utilises IPads to document patient observations and an alert triggers, to the nursing, outreach and medical teams, if the results indicate deterioration. This meant that there

would be a timely patient review. Staff were positive about the pilot, albeit in the very early stages, and said they viewed this as a positive move to increase patient safety.

- There was a five-day pre-assessment service for all elective surgery except ophthalmology. This was a nurse led service, through patient questionnaire and appointments, to identify patients at higher risk from surgery or anaesthetic. There were two anaesthetic clinics, on a Tuesday and Wednesday, where patients identified as high-risk were seen by a consultant anaesthetist. This meant that a full nursing and medical review occurred for identified patients ahead of surgery to enable care planning to begin to optimise patient safety as far as possible.
- On Kingsmoor ward senior staff had introduced a structure and allocation for quality safety checks such as controlled drugs and fridge temperature checks, to improve compliance. Walk round handover had been introduced and a mid-day safety huddle commenced to improve communication and handover of patient conditions.
- The 'Five Steps to Safer Surgery 'procedures, including the World Health Organisation (WHO) checklist, were used across theatres and day surgery. Briefing paperwork documented a full team briefing before and after the operating list. There was effective communication between the team. Theatre records were completed and a printout obtained from the electronic theatre system and attached to the patient's notes, which included all details from the perioperative phase.
- A monthly audit of the safer surgery (WHO) checklist via the electronic system demonstrated compliance ranged between 99 and 100% between June 2015 and March 2016. The WHO was integrated within the electronic theatre system and therefore required completion for each patient before the system could progress. There were no observational audits undertaken to provide assurance of the quality of the check completed and therefore no trend reporting. Senior staff stated that monitoring was via a non-compliance report. However, data supplied related directly to the completion of the electronic record and did not demonstrate deeper analysis.
- Swab, needle and instrumentation checks to account for all items during and after surgery and records were completed and recorded appropriately. Instrument checklists were fully completed in four out of five checklists reviewed. This meant that a check of all instrumentation had taken place at decontamination and packing stages and pre and post procedure, to minimise the risk of any missing items.
- One patient on Kingsmoor ward had specific needs due to their height and weight. A comprehensive pre assessment had taken place by the medical team and full considerations for safety prior to and immediately following surgery had taken place. However, there was inadequate management for moving and handling of the patient post-surgery. The nursing team had not ensured that an adequate hoist was available. When questioned, they planned to "cope" and move the patient using slide equipment and four members of staff. Due to current staffing levels this meant that when this took place all staff would be involved, leaving no nursing provision for the remainder of the ward. We raised this to the senior team on site and equipment was ordered immediately.
- There was an incident reported following a two hour delay on the surgical wards with gynaecologists assessing gynaecology in-patients on the surgical wards. This incident occurred out of hours when medical staff were busy within maternity. Staff confirmed delays occurred more frequently out of hours.

Nursing staffing

- Nurse staffing numbers and vacancy rates were a concern across surgery services and the trust. Data provided by the trust identified 60.73 whole time equivalent (WTE) vacancies across the service. The highest number of vacancies being band 5 nurses at 30.84 WTE. Staff sickness rates were below trust average for all surgical areas except pre-assessment. The post anaesthetic care unit had the highest average sickness rate of 8%, followed by Tye Green ward (7%), Penn ward (6%) and Kingsmoor ward (5%).
- There were several surgical areas highlighted as a concern. Surgery had the highest average turnover rate of 54% of all core services trust wide. This was due to an exceptionally high turnover rate in Saunders ward of 304%. Saunders ward had one substantive member of nursing staff with 33.27 WTE vacancies. Kingsmoor ward had nine qualified nursing vacancies and four health care assistant (HCA) vacancies.
- Nursing numbers reduced overnight across the surgery wards. For example, on Saunders ward, planned

numbers were five trained nurses during the day shift and three at night, with two HCAs on both. This was similar across other wards, with planned numbers of three registered nurses overnight. However even with sharing of staff across the organisation to minimise risk the actual position was always at least two trained overnight. Patient acuity remained the same and we were not assured that current staffing numbers across the trust would allow for adequate flexing to meet patients' needs.

- Bank and agency staff covered as far as possible, however, gaps remained. At the time of inspection, on Saunders ward, there were two trained nurses and one HCA below the planned numbers for the day shift and one trained nurse below the numbers for the night shift.
- At times it was only possible to ensure that one member of the trained nurses was a substantive member of the team on each shift with the rest consisting of agency staff or staff relocated from elsewhere. On Saunders ward only one member of staff on shift could undertake intravenous medications.
- In main theatres, sixteen staff had left in three months. A third of these staff were offered employment at a nearby independent hospital, with increased salary and benefit packages. Four of the sixteen had transferred to London and some had sought other development opportunities.
- Implementation of the electronic system (safe care) was underway across the trust. The tool estimated appropriate staffing numbers depending on patient acuity. This system linked with the electronic roster (E-roster) and enabled senior staff to view staffing numbers, both planned and actual, on each ward across the service. Senior staff and the duty team had access to the system and could look at variance and staffing gaps across all wards and reallocate staff dependent on the areas of greater need. At the time of inspection, the data was printed and taken in paper format to the safer staffing meeting three times a day. The nursing lead for the project stated that this was still in its infancy and needed to be embedded.
- There was a process for immediate escalation of staffing issues via the clinical matrons to the site management team. A revised shift report was introduced was introduced in May 2016 to document specific issues, such as staffing numbers, incidents or points of note throughout a shift. This was collated into a monthly data exception report to escalate any concerns.
- Notices, at each ward entrance, displayed levels of staffing and vacancies, which meant that patients and visitors were aware of the current situation. These were updated on a monthly basis.
- The trust was monitoring the effects of staff in numbers against a number of quality and safety metrics and reporting to the quality and safety committee. The report submitted on 20 January 2016 recognised a high probability that reduced staffing would impact on the ability to safely risk assess and document care delivered with regard to pressure injuries.
- Reduced nursing levels impacted directly on patient safety and nursing care. The ward sister for Saunders ward stated their shifts were 100% clinical with no administration or office time. This meant that risk oversight such as incident reporting and investigation was not possible and patients had experienced delays with medication and basic care needs.

Surgical staffing

- The trust had an ongoing recruitment plan for additional medical staff. The significant gaps were at junior medical staff level (SHO and FY1). At the time of inspection, surgical services had three junior medical staffing vacancies; one foot and ankle vacancy and one colorectal vacancy.
- Shortages in the medical staff rota were covered by both bank and agency locum staff. Data provided by the trust showed that between January 2016 and June 2016, 37% (506) medical staff shifts were filled by bank staff, 54% (704 shifts) were filled by agency locum staff and 9% (120 shifts) remained unfilled.
- First year medical staff stated that they generally worked alone but that more senior staff were contactable when required. Registrars led daily ward rounds with consultant ward rounds happening two or three times a week. Clinical teaching at the patient bedside was observed during ward round. The Friday case review meeting enabled the opportunity for open questions and learning.
- Junior medical staff stated that the hospital was popular for training and dedicated weekly training 'bleep free' took place. Emergency cover was good with a consistent rota and two consultants providing alternate cover.

Major incident awareness and training

- Staff knowledge of major incidents and their responsibilities varied cross the service. Information was available in folders and action card format in all ward areas. However, not all staff knew where these was kept. One band 6 nurse could not describe what may constitute a major incident and thought these were "dealt with by external staff I think".
- A service level agreement was in place to provide a contingency plan in the event of a major failure to equipment, washers and autoclaves, within the central sterile services department. Details on the risk register outlined a unit that was no longer in existence. When challenged, staff stated that the arrangement was clear on the service level agreement. This meant we were not assured appropriate systems were in place and the risk register could cause confusion for staff in a real situation. We notified matron for theatre to ensure that actions would be taken to update the risk register.

Are surgery services effective?

Requires improvement

Surgery services were rated as requires improvement for effective care because:

- Not all guidelines were updated in line with national guidance to ensure best practice.
- The trust results in the National Emergency Laparotomy Audit indicated four out of 11 measures reported were rated amber, 50-69%, and three were red at less than 49%
- There was no effective monitoring to gain assurance of staff competency and staff appraisal compliance rates were poor on the surgical wards.
- Consent on the day meant there was a very limited opportunity for patients to consider all the information prior to the procedure taking place.
- Five patients, identified by nursing staff as requiring a Deprivation of Liberty Safeguards assessment had received one.

However:

- There was an embedded enhanced recovery programme in place for colorectal and gynaecology patients.
- Hydration cards reduced the risk that patients were fasted for extended periods.
- The trust was performing in line with or better than the England average across all indicators in the Bowel Cancer Audit and similar to England average in the Hip Fracture Audit.
- Cardio pulmonary exercise testing (CPET) was used as part of pre-assessment to identify proactively those patients that may require intensive treatment unit (ITU) care following surgery.

Evidence-based care and treatment

- There was an enhanced recovery programme for colorectal and gynaecology specialities in line with the NHS Institute for Innovation and Improvement professional standards. The aim of enhanced recovery is to improve patient outcomes by shortening the recovery process, benefitting both patients and staff. Information was provided to patients regarding pre-assessment, preparation before surgery and a day-to-day programme for recovery and post discharge.
- The Difficult Airway Society (DAS) launched new guidelines for management of unanticipated difficult intubation in 2015. However, the difficult intubation trolley in theatre had 2004 guidelines attached which did not reflect current practice best practice guidelines.
- The audit plan and tracker for surgery showed that there were 36 audits being undertaken in the service each year. These included all national audits and a range of local audits
- The service undertook local audits. For example on peripheral cannula care, cell saver utilisation, safer surgery, acute kidney injury and consent. There were action plans in place for the audits and these were shared through audit meetings that were held in the healthcare group every two months.
- The National Early Warning Score (NEWS) system was in place across the surgical areas to monitor acutely ill patients in accordance with NICE guidance CG50.
- Effectiveness of the service is monitored at the surgery and critical care health group patient quality and safety review panel. However, the information detailed for the effectiveness of surgery was limited, with limited information recorded for patient outcomes in the January, February 2016 meeting or the October to December 2015 meeting. The effective elements were predominantly focused on critical care and Intensive Care National Audit and Research Centre (ICNARC).

Pain relief

- Records demonstrated that patient pain scores were calculated, documented and appropriate pain relief provided to patients.
- A patient controlled analgesia (PCA) pump delivers a measured dose of analgesia on patient demand. Staff recorded hourly documentation of patient observations whilst PCA was in use to ensure regular monitoring of the patient.
- One patient on Kingsmoor ward stated they felt limited staffing had affected timely pain relief being offered post-surgery. They said that it had taken three to four hours to receive analgesia after they had returned to the ward.
- A small pain team, supported by a clinical nurse specialist and clinical fellow, delivered a service six days a week. A regional pain study day for the East of England had taken place at the trust and positive feedback received. The service was in its infancy but was growing.
- Gynaecology in-patients were provided with pain relief and provided with guidance on pain management on discharge.
- The service undertook a project to reduce mortality in general surgery during 2015/16. The audit showed the mortality within the service reduced 30% as an outcome, which was positive.

Nutrition and hydration

- Patients requiring general anaesthetic are required to fast before surgery. Hydration cards, given to patients in Nettleswell admissions unit (NAU), informed patients the cut off time for drinking clear fluids. This meant that patients were not fasted for extended periods prior to surgery. The surgery and anaesthetic team reviewed the list order at the beginning of the day during the team brief and the cards were completed. Patients could drink clear fluids until the time indicated on their hydration card.
- The Malnutrition Universal Screening Tool (MUST) is a five-step screening tool to identify adults at risk of malnutrition. Of eleven records reviewed, all had an assessment of nutritional status completed. Four had a fluid balance chart, which was recorded appropriately to monitor those with specific dietary and hydration requirements.
- Protected meal times were in place on the surgical wards to enable staff to be available to help patients with eating and drinking. Special dietary requirements of patients were recorded on the white board to ensure that all staff were aware.

Patient outcomes

- The trust participated in a number of national audits including the National Hip Fracture Audit, National Emergency Laparotomy Audit and the National Bowel Cancer Audit. Results in the Bowel Cancer Audit (2015) indicated that the trust was performing in line with or better than the England average across all indicators.
- The Hip Fracture Audit in 2015 indicated that the trust was performing similar to the England average with some good performance regarding provision of assessments (pre-operative assessment, bone health medication assessment and falls assessment all scored above the England average).
- Three indicators where the trust scored lower that the England average were admitted to orthopaedic care within four hours where the trust scored 23.5% compared to the England average of 46.1%, this was a fall from 2014 (29.6%). Patients developing pressure ulcers, the trust scored 3.3% compared to the England average of 2.8% but this was an improvement on 2014 (5.1%). The trust mean length of acute stay was 18.3 days compared to the England average of 15.7. However, this had again improved from 2014 (22.7).
- The trust had mixed performance in the 2015 National Emergency Laparotomy Audit. The audit compares inpatient care and outcomes of patients undergoing emergency bowel surgery in England and Wales in order to promote quality improvement. The audit rated performance on a RAG rating (red-amber-green) Green rating indicated a performance result between (70%-100%), amber between (50%-69%) and red (0%-49%). The trust results identified good performance (green) in four out of 11 measures, amber in four and poor performance (red) in three (case ascertainment, post-operative admission to critical care and assessment by specialist).
- Cardio pulmonary exercise testing (CPET) was used as part of pre-assessment to identify patients that may require level 2 or 3 care following surgery. This meant that an ITU bed was organised in advance. This demonstrated a process to improve high risk surgery outcomes.

Surgery

Competent staff

- The nurse lead for E-roster and safe care was based on Kingsmoor ward to provide support to the nursing team. This arrangement had been in place for 10 weeks prior to the inspection and had begun to have a positive impact. Appraisals had risen from 0% to 42% in this time. Regular safety checks, such as controlled drugs and fridge temperature checks were structured and compliance had increased.
- Across surgery as a whole the appraisal rates were 54%, which was worse than our last inspection where rates were recorded at 62%.
- There were no documentation records of staff competency on Kingsmoor ward. Senior staff had taken the decision to complete competency reviews for all staff, as it was difficult to know who had completed training and had specific skills.
- Appraisal rates were poor across the service with compliance rate for staff on Penn ward at 7%. On Saunders ward only two out of fifteen staff (13%) had received an appraisal. However, appraisal rates for theatre were 95% and in the post anaesthetic care unit (PACU), they were 75%. However, in pre-operative assessment appraisal rates were 25%.
- There was no specialist urology nurse in post at the time of inspection. The position had remained vacant following the previous member of staff leaving. Consultants for the service expressed that this had a detrimental effect on service provision.
- In theatres the theatre manager or matron reviewed the curriculum vitae (CV) for agency staff prior to allocation of shifts. Individuals received an orientation and were assessed informally for competency. Matron provided an example of a recent agency staff member that did not display the experience that stated on the CV. This was reported to the agency and the individual asked to leave after the one shift.
- The assisted practitioner's role was in place within theatre to increase the number of staff able to scrub and participate in operations. This also provided flexibility of staffing and enabled development of health care assistants. Two staff had completed the course and were qualified at the time of inspection and a third was in training.
- Training of junior medical staff was a focus within orthopaedics. The result of a London survey of orthopaedic trainees had named one of the consultants at the trust as trainer of the year. Clinical teaching took place at the bedside during consultant ward rounds

Multidisciplinary working

- There were weekly multidisciplinary team (MDT) meetings. The MDT for colorectal surgery included representation from radiologists, surgical team, oncologists and nurse specialists. Newly diagnosed patients, post-operative patients and onward referral of patients were discussed to ensure continuity and consistency of care.
- White boards were in use on all surgery wards to indicate which patient required specialist input. There were daily multidisciplinary team ward rounds to plan care and to feedback and update on patients' needs. However, as wards were mixed specialty several teams completed ward rounds at separate times which meant it was difficult for all members of the wider MDT to always attend.
- Effective communication between teams was in place. The surgical wards were mixed specialty wards divided into either elective or emergency admission. For example, Tye Green ward had orthopaedic patients alongside general surgery patients. This meant that the wider team had to work and communicate together as different surgeries have different patient needs. This meant that the medical teams also had to be responsive to support the nursing staff. Contact details were displayed on the white boards on the wards to enable staff to reach the appropriate medical team at all times.

Seven-day services

- Physiotherapy and occupational therapy services were available seven days a week. In addition, there was an on call, out of hours, service from the physiotherapy team.
- There was no provision of ear nose and throat or ophthalmology out of hours or at weekends. This meant that patients attending during this time were transferred to other providers. There were established pathways in place to facilitate this.

Access to information

- Medical and nursing staff wrote in the same care pathway, which meant that patient care was documented chronologically and could be easily followed.
- Staff had access to documentation and care records for patients to ensure continuity of care. There were computers throughout the individual ward areas to access patient information including test results, diagnostics and records systems.
- Discharge letters were sent electronically to GPs to ensure continuity of care and patients were given a copy to take home with them.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patient consent prior to surgery should ensure that the patient has sufficient time and information to make an informed decision. Patients not seen in person at pre-assessment had consent taken on the day of surgery on Nettleswell admissions unit. This meant there was a very limited opportunity for patients to consider all the information prior to the procedure-taking place. One out of three patients spoken with on Nettleswell ward stated they had received information beforehand.
- Following a consent audit, undertaken between May and July 2015, standardised, printed consent forms for elective primary total knee and total hip replacement were introduced. These outlined the specific risks associated with this type of surgery. We reviewed 11 sets of notes and consent was completed appropriately, with risks discussed and signatures obtained from the consenting surgeon and patient.
- Staff on Saunders ward stated that there had been three patients since March 2016 with a Deprivation of Liberty Safeguard. Staff were aware of their responsibilities and who to contact to ensure assessment was appropriate.
- At the time of inspection, one patient on Kingsmoor had a Deprivation of Liberty Safeguard in place. However, staffing numbers restricted the ability for one to one nursing. Staff on the ward stated that there were a further five patients that may require a Deprivation of Liberty Safeguard but assessments had not taken place due to the lack of nursing staff.
- One patient on Penn ward had a Deprivation of Liberty Safeguard in place but it had expired on the 23 May 2016. When challenged, the senior team on site responded that the delay was with the local authority and as the patient's needs had not changed since the application the patient still met the criteria of the acid test. An incident form had been completed and the situation was being monitored via the daily safeguarding sit rep for all senior staff to review including the matrons.

Are surgery services caring?

Requires improvement 

Surgery services were rated as requiring improvement for caring because:

- Whilst we found that three out of four wards delivered care in a compassionate, supportive and considerate manner, we found that the care of patients on Saunders Ward was not aligned to that of the other surgical wards.
- The average Friends and Family Test score for Saunders Ward dropped by 20% for the period February to May 2016 and scores for this ward were significantly below the national average as a result.
- Only 72% of staff would recommend the service to their friends and family.

However;

- Patients provided consistently positive feedback about their care and treatment.
- Patients were involved in making decisions about their care, and said that care had been explained to them in a way that they could understand.
- Friends and Family Test data (FFT) showed that between May 2015 and May 2016, an average of 97.8% of patients on surgical wards said that they would recommend the service. This was above the national average.

Compassionate care

- Friends and Family Test results between May 2015 and May 2016 demonstrated an average of 97.8% of patients on surgical wards would recommend the service. This was above the NHS average during the same period. However, between February and May 2016, on average only 75.8% of patients on Saunders Ward said that they would recommend the service and 17% of patients said that they would not. This was significantly below the national average.
- Data from the Staff Friends and Family Test revealed that between January and March 2016, 72% of staff

would be likely to recommend services at the trust to their own friends and family. Whilst these figures are an improvement from the data referred to after our previous inspection in August 2015, they remain below the national average of 79% of staff recommending services during the same period.

- Most staff displayed an encouraging, sensitive and supportive attitude towards patients. For example, a health care assistant (HCA) was heard to say "don't worry, you're fine, take your time, we can turn back if you want" as she assisted a patient walking with a frame.
- Staff interacted with patients in a respectful and considerate manner. For example, by asking patients how they would like to be addressed. Patients knew who their consultants were, and confirmed that nurses introduced themselves showing good communication and involvement between the patient and their clinicians
- Staff consistently used curtains to ensure privacy and dignity for patients, particularly during physical or intimate care and sought patients' preference before opening the curtains again following care.
- Patients consistently gave positive feedback throughout the inspection about the care provided by staff. Staff were described as kind, caring and courteous. One patient said, "I cannot speak highly enough of the staff". However, on Saunders Ward patient feedback was less positive.
- We received one concern which related to an in-patient following admission to a surgical ward. The concern was around the delay in being seen following referral and the care provided in the surgical ward with limited support available from the gynaecology service.

Understanding and involvement of patients and those close to them

- Patients confirmed that staff used language and communicated in a manner that enabled them to understand their care, treatment and condition. For example, one patient said that a doctor had asked them to recap the information given about their treatment as a way of making sure they understood.
- Patients confirmed that they had been involved in decision making about their care and treatment. One patient said they felt the final decision about whether surgery should go ahead was theirs and added, "I feel like I have been listened to all along".
- Medical and nursing staff included patients in conversations during ward rounds and gave clear explanations of diagnosis.
- The trust results for the majority of questions in the 2015 CQC Inpatient Survey relating to understanding and involvement of patients and those close to them were in line with other hospital providers. However, the trust scored worse in comparison to other hospitals for doctors answering patient questions in a way they could understand, but this was not observed in practice during the inspection.

Emotional support

- Staff provided appropriate and timely support for patients to cope emotionally with their care and treatment. For example, a nurse prioritised the need to provide reassurance to one of their patients as they were being collected from the ward for tests as they were aware that the patient was anxious about the tests they were due to undergo.
- The trust performed in line with other providers in the 2015 CQC Inpatient Survey for questions relating to emotional support and talking about worries and fears.
- A chaplaincy service was available for all faiths, patients, relatives and staff. The service had a chaplain on-call 24 hours a day, provided bedside religious support for patients and a hospital sanctuary that was open at all times.
- Staff could access informal counselling, reflection on practice, assistance with personal or work-related issues, and debriefing following difficult times via the chaplaincy service.

Are surgery services responsive?

Requires improvement

Responsiveness in surgery was rated as inadequate because:

- There were concerns regarding the impact of staffing levels on patient care, particularly on the ability of staff to respond to call bells quickly. Actions identified in response to call bells were vague, not measurable or allocated to individuals.
- Patient flow from theatres into appropriate wards and units was disjointed. Patients were not always aware of which ward they would be admitted to after surgery.

- Incomplete Referral to Treatment Times (RTT) standard of 92% was met in only four of 11 specialties. The surgery service was having difficulty in delivering the 62 day cancer standards consistently. However, the trust had an agreed recovery plan in place.
- Data analysis of RTT was not to a degree that effectively monitored and identified improving or decreasing trends.
- Theatre utilisation was impacting on service delivery and 42 theatre sessions had been cancelled in May 2016.
- Delayed admissions to critical care was impacting on the delivery of the post anaesthetic care unit (PACU).
- Discharge planning was not consistent and the management of one patient admitted in June 2015 was poor.
- Out of hours transfers between 10pm and 8am were high with 908 incidences reported between February and July 2016.
- Information leaflets were not available in multiple languages.

However;

- There were several staff champions for various conditions across the surgical wards. These staff had additional training to support patients and staff.
- There was a team dedicated to support patients with learning disabilities.
- Themes, trends and learning from complaints were shared across the health group.

Service planning and delivery to meet the needs of local people

- Saunders Ward was not in use as a surgical inpatient area during the inspection and plans were in place to convert to a medical ward permanently from 18 July 2016. The ward had been utilised from January 2016 as an escalation area. The surgical healthcare group leads had plans to review the ambulatory pathways, the 23-hour wards and bed provision for level one patients to ensure that service delivery was maintained.
- The surgical healthcare group leads stated that a reduction from four to three surgical wards would be achievable without a negative impact on service. This was because capacity pressures at the trust meant that there were already medical patients admitted to surgical wards on a regular basis. At the time of inspection, seven patients on Kingsmoor ward and 11 patients on Saunders ward were medical outliers.
- Over the Christmas period elective surgery had reduced sufficiently to enable Tye Green ward to close between 24 December 2015 and 4 January 2016.
- Management of eye services were due to transfer to the surgical healthcare group from July 2016. Established patient pathways were in place with external NHS providers for both ophthalmology and ENT services at the weekend. If patients were stable they would transfer to the alternative provider. However, if a patients' condition was unstable then the team would come to the trust to review the patient.
- The trust in partnership with commissioners and external regulators had an agreed outsourcing and insourcing plan to support delivery of the 18 trajectory across many surgical specialities.

Access and flow

- Every patient waiting for treatment has the right to expect that treatment within 18 weeks of being referred, known as referral to treatment time (RTT). In June 2015, the Secretary of State for Health agreed a recommendation that the incomplete pathway operational standard should become the sole measure of patients' constitutional right to start treatment within 18 weeks. As a result NHS providers are no longer required to report RTT pauses or suspensions for admitted and non-admitted patients.
- Incomplete performance data as of the 30 June 2016 demonstrated that the trust reported compliance against the agreed trajectory and external recovery plan with a performance of 90.2%. However this remained below the national standard. A breakdown of this indicated the trust was meeting the standard of 92% for 18-week waits in four of the eleven specialties; these were breast surgery (98.8%), colorectal surgery (92.3%), optometry and vascular surgery (both 100%). The lowest performing was general surgery at 67.6%.
- Of a total of 9854 patients, 6553 had been treated within 13 weeks, 1516 between 14 and 18 weeks, 1783 patients had breached (between 19 and 52 weeks) and 2 patients had breached the 52 week target (one patient in orthopaedics and one in urology).
- Once a referral to treatment waiting time clock has started it continues to tick until either the patient starts first definitive treatment or a clinical decision is made that stops the clock. The internal validation team monitoring RTT performance had highlighted that a data collection issue may be affecting results. There had

been instances where incorrect outcomes, entered by clinicians in clinic, had affected the clock. However, there had been no analysis into these occasions to ascertain whether the errors had a positive or negative impact on the RTT, so it could not been determined if these errors were an improving or decreasing and if results would be better or worse than reported.

- The service performance report for 2015/16 showed that in the last year 612 patients were identified as breaches over 52 weeks. All patients were reviewed to determine if harm was sustained. Of the 612 patients, 530 did not sustain harm. However, 82 (13%) sustained a degree of harm.
- For surgical cancer care on the 62 day standard between April 2015 and February 2016, the urology service achieved five months out of 11, head and neck achieved six of 11 months, lower gastrointestinal (GI) disorders, and breast services achieved the 62 day target on all months during this period. However. the trust had an agreed recovery plan in place.
- Within urology there is a 99% target set for delivering cystoscopy and urodynamics. Between July 2015 and March 2016 the cystoscopy service delivered one month within the target during this period, achieving between 87.3% and 100%. The urodynamics service achieved one month with an average of 77.5% and 100%. There was an action plan in place to improve performance quality within this service.
- The lack of a robust patient target list and lack of oversight of patients waiting was included on the surgery risk register. The trust were developing a guide for clinicians to improve the accuracy of validating the patient outcome in clinic. Included in this was the suggestion to get validation as soon as possible following the patient's clinic appointment to ensure pathways were correct as soon as possible.
- The reduction in theatre staff had affected theatre utilisation and service delivery with 42 theatre sessions cancelled in May 2016. Senior theatre staff stated that no individual surgical speciality had been specifically affected, and cancelled sessions were across all specialties as the skill mix of the staff involved was varied across both anaesthetic and scrub abilities. Decisions to reduce lists were based on theatre capacity and referral to treatment review to try and ensure the patient risk was minimised. Additional weekend lists were organised to provide additional sessions.
- Patients were admitted on the morning of surgery to Nettleswell admissions unit (NAU). Staggered admission was in place, which meant that patients waiting time had reduced. Patients were required to attend at 7am for the morning lists, and around 11am for the afternoon lists. Patients were admitted by the nursing team and then seen by the surgeon and anaesthetist and consent obtained. Four morning theatre lists took place on 29 June 2016. Of the 13 patients, 12 had arrived at 7am and one at 11am. All three patients spoken to were happy with their care and communication from the team on the unit.
- Identification of a specific ward post-surgery was not always available before the patient went to theatre. Staff on NAU informed patients of ward location once there had been an update from the bed manager with allocation of beds. If no decision had been made prior to the patient going to theatre, relatives were given the units telephone number to call for an update until 2.30pm when the unit closed. After this time relatives had to ring the bed manager to enquire which ward their relatives had been admitted to. This meant additional concerns and worry for patients and relatives on top of a stressful situation.
- Staff labelled patient belongings, which were stored on NAU and delivered to the appropriate wards once known. When no ward was identified by 2.30pm all bags were taken to Tye Green ward and secured in the sister's office to enable safe storage.
- The percentage of elective admission patients with cancelled operations was higher than the England average in eight out of nine quarters from January to March (Q1) 2013 to 2014. However, this looked to be improving and the number of patients that had their operations cancelled was slightly better in 2015 to 2016 in comparison.
- Data provided by the trust up until July to September (Q3) 2015/16 showed absolute numbers of 154 cancelled operations 141 of which were rebooked within 28 days, 13 patient were not. The three highest specialties for cancellations in this period were general surgery (37), trauma and orthopaedics (28) and gynaecology (25). Reasons for cancellation included bed shortages (42 cases), unavailability of intensive treatment unit (ITU) beds (20),theatre capacity and

over-runs (16). Only eight cases were recorded against medical and nurse-staffing shortages. However, this data was not reflective of the high staff losses in the first quarter (January to March) of 2016.

- Discharge planning to ensure discharge in a timely manner was not always effective. One elderly patient on Kingsmoor ward had been an inpatient for a year since admission in June 2015. Documentation demonstrated that there had been no regular MDT and the last entry from a discharge facilitator was three weeks prior to inspection. Both occupational therapy and physiotherapy teams had documented the patient was fit for discharge, with the plan for residential care. The patient did have some complex issues and nursing staff had stated that a consultant providing specialist care from another provider site had been difficult to contact. However, it was clear that there was poor leadership around the management of this patient.
- When a woman was admitted for a gynaecological procedure, such as a termination of pregnancy, their journey generally started with their elective admission to Tye Green Ward. However, we identified that women were not being sent back there as their bed was often given away to a patient from the emergency department (ED). The woman would then be held in PACU for a longer period of time before being transferred back to another ward that had an available bed.
- We spoke with the chief executive officer about this who informed us that it was common that patients would be held in PACU and go back to a different bed due to capacity issue in the hospital. This was to avoid breaches in the ED. However, this meant that the planned elective lists were not being organised in a way that was responsive to the needs of patients. For example women who had had a termination could be placed on a gastroenterology or orthopaedic ward to recover, which was not acceptable for a planned list and is not responsive to patients' needs.
- Between February 2016 and July 2016 the number of patients held in PACU for more than 12 hours was 30, and 17 had been held in PACU for more than 24 hours.
- There were admissions directly to PACU due to a lack of space on critical care, which was impacting on service delivery of PACU. Between January and April 2016 there were 58 admission to PACU for level 2 and 3 patients awaiting critical care beds. The longest recorded patient delay was 72 hours and 30 minutes.
- On reviewing gynaecology inpatient placement between January and June 2016, we found that women were admitted across seven different wards and specialties where staff did not have specialist gynaecology training. There was no dedicated gynaecology ward, which meant that women were spread across the surgical wards. This meant that consistent care for women with gynaecological surgery concerns could not be provided.
- Between February 2016 and July 2016, 1% of patients had one ward move during their inpatient stay. There were also 908 out of hours transfer between 10pm and 8am, which was high at 11% of admissions during this period.

Meeting people's individual needs

- The trust had signed up to John's Campaign, which meant that carers of patients with dementia were able to visit outside of normal visiting hours and overnight stays were accommodated where possible.
- Patients on Kingsmoor ward had direct access to a pharmacist, which meant that medicines decisions, questions or concerns were answered quickly. This had a positive impact on the waiting time of medications to take away (TTA), with times dropped by 53% at ward level.
- There was a separate area within Nettleswell admission ward for patients that had received a hydration card and were allowed to drink. This offered some privacy and meant that patients drinking were not in view of fasting patients.
- There were several staff champions for various conditions across the surgical wards. These included falls champions, continence champions, stoma champions and dementia champions. These staff had additional training to support patients and staff.
- There was a team dedicated to support patients with learning disabilities. The wards displayed a poster which gave a telephone contact number for the team to enable staff to contact them when necessary.
- The trust scored lower (worse) than other trusts in the 2015 CQC inpatient survey for response time to call bells with 16%of patients waiting over 5 minutes and 1% stating no response at all. Five members of staff stated that staffing shortages were affecting patient care, including on the ability to respond to call bells in a timely fashion. Senior surgical nurses raised the issue of 'buzzers being ignored and not being answered' during

a surgical senior nurse meeting in June 2016. Actions agreed were vague, not measurable or allocated to individuals but simply stated "more vigilance around bells being answered".

- One patient on Saunders ward waited over five minutes for an answer to a call bell. Another described having to wait for wound dressings to be changed but they did not feel that this was a significant issue as they were able to mobilise independently and felt that there were more urgent patients requiring staff attention. Another patient stated they had waited from 9am to 2pm to be provided with a walking frame and were left struggling without one. The nurses had not communicated that the physiotherapy team would see them prior to having one provided.
- On Kingsmoor ward one patient described having to call several times during the night before a nurse responded and they were left holding a full urine bottle for 35 minutes.
- Information leaflets on a range of conditions were available in the pre-assessment clinic for patients. These included anaesthetic options, information for major spinal surgery, joint replacements and high intensity focus ultrasound (urology).
- None of the information was available in other languages and there were no adaptations for patients with eyesight issues. Staff stated they asked relatives to help with translation when English was not a patient's first language. They also said that they referred to internet translation sites if necessary.

Learning from complaints and concerns

- Complaints across the surgery health care group had decreased from 136 in 2014/15 to 102 in 2015/16. Staff stated that this improvement had arisen from improved complaint management and single point of contact. The backlog of complaints had been reduced by 70%. The service had also seen an increase in compliments to the service.
- Pre-assessment was located in a separate building on the hospital site. Staff stated that a common patient complaint was that it was difficult to find and had made suggestions for improved signage or relocate to the main hospital.
- The end of year performance report for surgery detailed themes and trends for complaints. This document and the learning from these themes were shared across the healthcare group.

Are surgery services well-led?

Requires improvement

Surgery services were rated as requires improvement for well-led because:

- Multiple appointments, changes of staff and interim posts within the senior team meant there was a level of instability and inconsistency in leadership.
- Oversight to risk and quality management was limited, which meant that there was a risk to patient safety from staff shortages, both nursing and medical.
- Staff at a local level were not supported to ensure that risks were identified, reported and managed in a timely manner.
- The lack of attention to policies and procedures remaining up to date meant there was a potential risk of patient safety
- Failure to retain and recruit staff was impacting services and low levels of staffing were directly affecting patient care and staff morale.

However:

- Staff were passionate about their roles and wanted to provide good patient care. Staff provided good local peer support.
- The tissue viability specialist in theatres was proactive and had animated innovative ways to train staff.

Vision and strategy for this service

- Each surgical ward displayed a mission statement and the trust values. The trust had five strategic goals that were excellence in safety and outcomes, patient and carer experience, operational performance, value and staff morale.
- There were four value statements; caring, committed, respectful and responsible displayed in all the surgical wards. Nursing staff were aware of the values and behaviours expressed that the overall aim was to provide excellent care.
- There was a strategy and vision for surgery outlined in the surgery and critical care health group business plan 2016/17. Included in this were increased networking for vascular and urology services and closer working with local private providers for outsourcing to support

capacity gaps. There were also several strategies for improvement of several on site such as a renal cryo surgery, ENT hub, diabetic foot service to support the vascular service and one-stop prostate clinics.

Governance, risk management and quality measurement

- The structure within the division had undergone recent changes and the patient safety and quality team had reformed. Governance oversight consisted of individual clinical improvement group (CIG) monthly meetings which then fed into the healthcare group patient safety and quality group which then fed into the monthly health group board (strategic level).
- Data requested from the trust included minutes of governance meetings since February 2016 for the surgery healthcare group. Information provided included CIG meeting minutes for urology, anaesthesia and critical care, ENT and trauma and orthopaedics. These meetings discussed risk, governance and quality issues such as incidents, staff raising concerns about patient safety and clinical audit outcomes. Actions were identified at each meeting and an update was seen to be provided on all actions at the following meeting.
- There was a surgical risk register and some senior staff were able to identify their top risks, which included staffing and training. However, staffing numbers had affected the level of oversight on the wards. For example, staff on Kingsmoor ward had not raised concerns regarding the staffing and equipment issues for a patient with specific needs and stated that they "would cope". There was no consideration or oversight of the potential risk to other patients when all staff were attending to this patient's needs.
- Senior staff worked 100% of shifts in a clinical capacity, which meant that incident management was neither robust nor timely to ensure patient safety.
- The lack of competency and appraisal meant that there was no assurance that staff skills matched patient need.
- Poor quality of patient care and patient experience due to insufficient staff was on the risk register rated as an amber risk, as was the inability to recruit to vacant medical posts within general surgery. The trust had a surgery workforce plan 2016/17 that outlined the basis for each staff group and a financial forecast into 2017. The aim for nursing staff was for 2.0 WTE additional starters compared to leavers each month, which would result in 50% vacancies filled by year-end. The plan was monitored by the trust recruitment group.
- The lack of attention to policies and procedures remaining up to date meant there was a potential risk of patient safety and we were not assured that this was a focus to be addressed.

Leadership of service

- An associate medical director, anaesthetic patient safety and quality clinical lead, director of operations and an associate director of nursing provided leadership of surgical services. This provided representation from operations, medical and nursing disciplines. However, there had been instability in this leadership due to numerous staff changes.
- An interim director of operations and an interim associate director of nursing were in post at the time of inspection. This meant that there was an element of instability within the leadership team.
- The director of operations position was vacant, recruitment was underway with interviews planned for early July, and the associate director of nursing was on long-term sick leave. There had been multiple appointments to the role of assistant director of operations, one of which only remained in post for two months.
- Communication to senior staff was inconsistent. Weekly ward manager meetings had discontinued when the associate nursing director had gone sick. The appointment of an interim had meant that these were reintroduced at the beginning of June 2016.
- One consultant stated that a large number of experienced nursing staff had left over the last two years, which had left a skill gap and was affecting patient care. They stated that the number of matrons had increased but this group were not functioning at a clinical level. They gave an example from the day before inspection on Kingsmoor ward. The consultant had requested that a patient drain be removed. This was not undertaken and the medical staff had undertaken this the next day.
- Matrons were visible each day on the wards. However, senior nursing staff said that individual support from the surgery matrons varied. Individual one to one meetings were not undertaken. Staff in pre-assessment stated that support at matron level was good whilst a senior

member of the nursing team on the wards stated that they felt undermined. They provided an example where one matron had told a member of staff to discontinue a task that they had been allocated by the ward sister without any discussion.
- Team meetings were attempted across all surgical wards but due to staffing pressures had not been undertaken consistently. For example on Penn ward staff met in November but then not again until March 2016. Whereas theatres staff met on a monthly basis during this time, with the exception of one month

Culture within the service

- There was a staffing consultation underway regarding the permanent conversion of Saunders ward to the medicine healthcare group. Matrons stated that they had been involved with the decision process, however, it had been a difficult period to ensure competency of staffing. The sister from the previous short stay admissions unit (Melvin ward) had been moved to Saunders ward to provide some continuity.
- Consultant staff stated that morale was low. They felt listened to by management but felt there was a delay in any response. One consultant said they felt undervalued; the lack of junior doctors was affecting the continuity of care although they did state that there was a firm level of registrars.
- Communication was not always proactive, for example one consultant stated that the decision to reallocate the consultant office and remove computer equipment had been via email without any notice. There had been no discussion with the consultants affected.
- There was a strong culture of support amongst nursing staff peers. Staff were passionate about their roles and wanted to provide good patient care. The nursing teams at ward level provided support to each other and senior staff worked clinically alongside the ward staff.
- Morale in theatre was low and the loss of a large number of staff to the private sector had compounded the situation. Retention of staff was difficult when competing with larger salaries offered elsewhere.
- Two ward staff on Tye Green said they felt unsupported by the on call matrons, which had led to low staff morale.
- During the unannounced inspection we identified cultural concerns in that staff were not actively declaring vacant beds when they became available. As a result this impacted on the delivery of the emergency department which was not appropriate.
- We also noted that some wards were not always declaring staff numbers to avoid staff being moved to cover shortages in other areas. This was also noted for the medical care service and was not good practice.

Public engagement

- There were patient information leaflets across the surgery wards and in every area feedback cards were available for patients. There were plans to introduce an electronic patient feedback system from July 2016.
- There were monthly patient panel meetings held by the trust to facilitate patient engagement to review and improve services. The panel also reviewed anonymised complaints examining how they were handled and requested patient feedback on the process. Communication was managed through the patient experience team.
- There is a range of patient experience training for staff including interviews with patients and families who have made complaints, with clinical staff about responding to complaints, training in listening and facilitation and as well as on.

Staff engagement

- There were meant to be monthly ward meetings to cascade information to staff supplemented by a ward newsletter and a staff information board. However, it was noted that not all areas of surgery had these due to time and availability in the service. Daily safety huddles were also used to discuss important information.
- Senior surgical ward staff spoke of not being part of the gynaecology shared learning or receiving development opportunities to improve the patient experience when caring for gynaecology patients.

Innovation, improvement and sustainability

- The implementation of surgical assistant training for unqualified staff in theatre had provided flexibility and sustainability in the workforce to ensure continuity of provision of services.

Surgery

- The tissue viability specialist in theatres was proactive and had been innovative with training aids and methods to train staff. They had developed models to visually represent the varying degrees of tissue damage as this often had greater impact on staff.

Critical care

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

Information about the service

The critical care unit (CRCU) at The Princess Alexandra Hospital is split into an intensive care unit (ICU) for level three patients requiring one-to-one care and a high dependency unit (HDU) for level two patients requiring complex care on a less intensive basis, who may have a single failing organ or require post-operative care. The HDU has five beds and the ICU flexes to seven beds according to need. The ICU includes one isolation side room.

Between June 2015 and May 2016 the CRCU admitted 653 patients and there were 98 patient deaths. It was not a statistical outlier for morbidity and mortality, meaning that these rates were within or below the expected range.

A critical care outreach team (CCOT) provided support to the CRCU seven days a week between 7.25am and 12 am. The service was due to become 24-hour by the end of September 2016 and had recruited to a level of 8.4 whole time equivalent staff to achieve this.

During our inspection we visited CRCU including the HDU and ICU. We spoke with eight nurses and support staff, and five doctors. We also spoke with a physiotherapist, two domestic staff; two administrative staff; one patient and two relatives.

We also observed care and treatment; reviewed care records; and analysed data provided by the trust, before, during and after the inspection.

Summary of findings

Overall we rated critical care services at The Princess Alexandra Hospital as inadequate. Safety, responsiveness and well-led have been rated as inadequate. The service was rated as requiring improvement for effectiveness and good for caring. We found a marked deterioration of this service from our previous inspection. We found:

- There was evidence of poor medicines management practices, which posed potential serious risks to safety. Concerns included unsafe practices with morphine, carelessness in the storage and transfer of potassium chloride, and access to controlled drugs by non-registered staff.
- There was poor and inconsistent documenting of patient records. Although the CRCU had not reported any pressure ulcers in the last 150 days, the unit had a low rate of Waterlow scoring meaning patients at high risk of pressure ulcers may not have been identified.
- There was little evidence of learning from incidents and sharing feedback among staff meaning there was an increased potential risk of incidents reoccurring.
- The difficult airway trolley was disorganised, incomplete and had items on it that were not part of the trolley. We saw that the last check carried out on the trolley was five months prior to the inspection. Daily checks were not being carried out on resuscitation trolleys.

Critical care

- We were concerned about the competencies and induction processes for agency staff as the unit was not conducting internal competency checks. The quality of mortality and morbidity meeting minutes was poor.
- There was a lack of effective multidisciplinary (MDT) working. Physiotherapists did not have sufficient input to maximise patient outcomes and physiotherapy staffing did not meet national standards, which could have an impact on patient rehabilitation needs. Documentation of MDT working in patient records and handovers was poor. Ward rounds did not routinely involve MDT input. Staff gave negative feedback about the training they received to maintain competencies.
- Appraisal rates were the lowest in the trust at 23%.
- Bed occupancy was consistently at 100% or over. Critical care patients regularly had to be treated in the post anaesthetic care unit (PACU) because of the lack of bed space. The longest length of stay in the PACU was over 72 hours.
- There were mixed-sex accommodation breaches on the unit owing to the lack of capacity, and no evidence of action taken to mitigate this.
- Delayed discharges were a significant risk owing to the problems with access and flow on the unit. There was a high rate of out of hours discharges at over twice the rate on average for similar units nationally. There was no clear formal system in place for learning from complaints and concerns in order to improve the service for patients.
- There was a lack of information sharing between the service leads and the staff on the unit. The risk register did not include several of the risks to patient safety we observed during our inspection such as the poor culture surrounding medicines management and controlled drugs, and the inconsistent documentation of patient records.
- Attendance at meetings was variable particularly at busy times on the unit. There was no evidence of active steps being taken to engage and gain feedback from the public to improve the service.
- We were concerned about some aspects of the culture as some members of staff told us leadership was not visible or approachable, and felt unsupported.

However:

- There was good awareness among staff of safeguarding and of what to do in the event of a major incident. Medical staffing was at full establishment and met national standards as set out by the Faculty of Intensive Care Medicine (FICM). Staff worked to meet individual needs.
- The critical care outreach team (CCOT) played an active role in referring patients to counselling or community services after treatment if required.
- The unit participated in the Intensive Care National Audit and Research Centre (ICNARC) to benchmark its outcomes against other trusts nationally.
- Mortality rates were consistently within or below the expected range. Staff were confident with managing patients' pain and there was clear documentation of pain relief in records we reviewed.
- Staff were competent in completing Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards assessments.
- We observed caring interactions between staff and patients and their families. Relatives generally spoke positively about the behaviour and attitudes of staff on the unit. Staff took the time to fully explain procedures to patients and families and provided emotional support.

Critical care

Are critical care services safe?

Inadequate

We rated critical care as inadequate for safe because:

- There was evidence of poor medicines management practices which posed potential serious risks to safety. Concerns included unsafe practices with morphine, carelessness in the storage and transfer of potassium chloride, and access to controlled drugs by non-registered staff.
- There was poor and inconsistent documenting of patient records particularly among some consultants in the unit, meaning it was not always clear if patients had been assessed by a consultant within the recommended timeframe of 12 hours from the time of admission. There was a new admission clerking document but only two of the five we reviewed had complete consultant assessments.
- Although the CRCU had not reported any pressure ulcers in the last 150 days, the unit had a low rate of Waterlow scoring meaning patients at high risk of pressure ulcers may not have been identified. Owing to poor record-keeping, we could not be certain that the CRCU was monitoring pressure ulcers closely enough.
- There was little evidence of learning from incidents and sharing feedback among staff meaning there was an increased potential risk of incidents reoccurring. The rate of reported incidents was particularly low (29 between June 2015 and May 2016) and we were concerned that there was not a proactive approach to reporting incidents.
- The difficult airway trolley was disorganised, incomplete and had items on it that were not part of the trolley. We saw that the last check carried out on the trolley was five months prior to our inspection. When we raised this to the nurse in charge, we were told that there was no one person accountable for maintaining the trolley. As staff would be reliant on this equipment in the event of a difficult airway emergency the state of the trolley could put patients at risk.
- Daily checks were not being carried out on resuscitation trolleys. We looked at the log for the trolley and found checks had not been documented on four days of the previous 14 days.
- We were concerned about the competencies and induction processes for agency staff as the unit was not conducting internal competency checks. For example, we spoke to an agency nurse who was not able to tell us how they would raise the alarm in the event of a cardiac arrest.
- The quality of mortality and morbidity meeting minutes was poor.

However, we also found:

- There was good awareness among staff of safeguarding and of what to do in the event of a major incident.
- Medical staffing was at full establishment and met national standards as set out by the Faculty of Intensive Care Medicine (FICM).

Incidents

- There were no never events reported between June 2015 and May 2016. Never Events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. There were 92 incidents reported to the National Reporting and Learning Service (NRLS) between June 2015 and May 2016. The majority of these (17) resulted in no harm. Three resulted in moderate harm and nine resulted in low harm. Most incidents (21) were in relation to treatment and procedure.
- There was one serious incident between June 2015 and May 2016. This was an allegation of abuse by staff towards a patient in the CRCU. This was still being investigated at the time of our inspection. However, the nurse in charge told us that a lesson that had been learned and shared as a result of this incident was the need for a chaperone during procedures on patients at all times.
- We were told that root cause analyses (RCAs) of incidents were reviewed at scrutiny panel meetings and learning was shared through the monthly unit bulletin, staff meetings, morbidity and mortality meetings and word of mouth. However, there was no clear system for the sharing of lessons learned and feedback from incidents. Staff on the unit told us that they did not receive feedback on incidents they had reported, although they felt confident reporting them. The clinical practice educator told us she was copied into all Datix incident reports but was unable to give a recent

example of any learning from these. The lack of feedback and sharing lessons learned meant there was a greater chance of preventable incidents reoccurring in the future.

- The nurse manager told us that junior staff would not be expected to make decisions and have conversations with patients and relatives relating to the duty of candour. In one patient's notes we saw that a duty of candour discussion with a patient's family had been noted relating to overnight transfer.
- We reviewed the mortality and morbidity meetings for the healthcare group. Meetings were held every month and were held jointly with critical care. Nurses did not generally attend these meetings and there was no formal process for sharing any lessons learned or action taken.
- We were not assured that the meetings were of a good quality due to the limited information in the minutes provided to us. There was limited information presented and discussed about each case, and key concerns were either not discussed or not recorded. We saw a few examples of good discussions recorded but these were limited.

Safety thermometer

- The NHS safety thermometer is a local improvement tool for measuring, monitoring and analysing patient harms and harm-free care. The safety thermometer data was on display in the unit.
- The unit reported two category 2 to 4 pressure ulcers between March 2015 and February 2016, identified using the safety thermometer. By the time of our inspection, the unit had achieved 150 consecutive days with no pressure ulcers. The nurse manager told us that reducing pressure ulcers had been a key focus for the unit. However, a pressure ulcer standards audit from April 2016 showed that Waterlow scores (used to assess the risk of patients acquiring pressure ulcers) had not been completed within the six-hour recommended timeframe in 40% of cases.
- There were no falls with harm or urinary tract infections in patients with catheters reported between June 2015 and May 2016.

Cleanliness, infection control and hygiene

- There were no incidences of MRSA or Clostridium difficile between April 2015 and March 2016. The results of the most recent infection control audit were 90%.
- Between April and December 2015, the rate of unit-acquired infections in blood was 0.4 per 1000 patient days, better than the average of 0.7 for similar units nationally.
- The CRCU was performing slightly better than the trust average for cleanliness audits between January and March 2016 (an average of 98.5% compared to 96.1%).
- We observed good hand hygiene, supported by hand hygiene audits showing the CRCU scored a monthly average of 99% in hand hygiene audits between April 2015 and March 2016.
- We observed good use of protective personal equipment (PPE) and staff cleaning equipment thoroughly after use. However, we also saw nursing staff with long hair that was not tied up while they were caring for patients.

Environment and equipment

- There was a shortage of space around critical care beds, specifically in relation to the HDU. This was on the risk register for the unit but staff told us compliance could not be achieved without an entirely new site for the CRCU. There was no evidence of actions to limit the impact of this.
- The ICU was tidy, organised and well laid out and the sluice room was visibly clean and well-maintained. However, the HDU was cramped and it was recognised by the trust that the only way to completely fix this would be to open a new site.
- The unit had a buzzer entry system and keypad access for staff. However, during our inspection, it was mainly not in use and the door to the unit was left unlocked. This was a risk for the security of the unit and patients.
- There were health and safety hazards observed during the inspection, including a fire extinguisher on the floor in the staff room and a store room door propped open for extended periods. The housekeeping/cleaning cupboard did not have a lock and there was easy access to chlorhexidine sterilising tablets on the shelves.
- The storage rooms and pharmacy store were dusty.
- Curtains around bed spaces were not all labelled which meant the unit was not tracking how long they had been up and staff confirmed that there was no routine checking process for this. Staff told us that curtains were changed routinely for infected patients. However, this was impossible to validate without clear labelling.
- There was no formal cleaning schedule; housekeeping staff told us that one staff member was responsible for

mornings and another for afternoons. This meant there was a greater chance of cleaning duties being missed, particularly if one of the usual housekeeping staff was on leave.

- We reviewed the resuscitation trolley check log and found daily checks had not been documented on five occasions in the two weeks prior to our inspection, which took place on 28 to 29 June 2016. There were also three occasions between April and June 2016 where weekly checks were not carried out. Daily checks for the blood gas machine were completed and signed.
- The airway trolley was untidy and disorganised which could pose a risk in the event of a difficult airway emergency. The last check carried out on the trolley was documented in January, over five months before the inspection. The nurse in charge told us that medical staff were responsible for maintaining the trolley but recognised the lack of accountability to one person was an issue and this had been brought up at doctors' weekly morbidity and mortality meetings. We asked staff at the time what they would do in the event of a difficult airway and they confirmed they would be reliant on this trolley.
- Service leads told us there were issues with leaks on occasion because of the age and condition of the premises meaning sections of the unit would have to be closed. We saw an example of an incident form submitted for a ceiling leak in the visitors' room dated November 2015.

Medicines

- In a review of six medicine administration charts, we saw good documentation of all medicines given as prescribed. Patient drug allergies were clearly recorded, although in one set of notes a red allergy label had been used for a patient without allergies. The nurse told us that this was because the unit had run out of plain white labels, but this could cause confusion for another member of staff looking at the notes.
- We observed that intravenous antibiotics were left out on the side for 14 minutes before being removed by the sister on the unit.
- Controlled drugs (CDs) were not adequately secure. The keys to the CD cupboard were on the same set of keys as those to the general pharmacy store, which meant unregistered staff could access CDs. We asked about the keys and were told that each day a 'key holder' was appointed, who was always a registered nurse. However, when another member of staff needed to access medicines they could just ask for the keys, which was not good practice.
- Epidural fluids were stored alongside the general intravenous CDs, which is not good practice. There were also non-CDs stored in the CD cupboards.
- We reviewed the CD logbooks and found two occasions between April and June 2016 where 24-hourly checks had not been completed as per national standards. There were several more occasions where 12-hourly checks (as per the local policy) had not been done. We asked the sister in charge about this and she was aware this was the case but told us that when staff were "too busy" they could not prioritise these checks.
- A half-used morphine syringe which was prepared earlier in the day had been left in the CD cupboard on the ICU. We asked the clinical practice educator about this and were informed it was acceptable practice for the unit, for up to 24 hours. We raised this with the Chief Nurse during the inspection.
- A nurse we spoke with did not know what Rivaroxaban was used for. It is an anti-coagulant (prevents blood clots) that must not be given with any other anti-coagulant. It is good practice for units to include alerts on the drug administration charts for Rivaroxaban, although there was no evidence that other nurses on the unit were also unaware of the purpose and risks of the medicine.
- We were concerned about the lack of awareness and potentially unsafe practices regarding concentrated potassium chloride as the clinical educator told us she was happy to lend it to the emergency department. Concentrated potassium chloride should be treated as a controlled drug. It is very dangerous and must be treated with great caution as highlighted by an NHS Patient Safety Alert (2002).
- Fridge temperature checks had not been recorded on four of the 14 days prior to the inspection. During our inspection we saw that a fridge on the ICU was reading 11 degrees. The fridge was subsequently taken out of use. However, this was concerning as we could not be certain medicines were being stored safely.
- Minutes from staff meetings showed that concerns had been raised about drugs being kept in patients' bedside trolleys following discharge. As a result staff had been reminded to lock all drugs away securely following discharge.

- The unit did not have a dedicated pharmacist, although one had recently been appointed. This lack of oversight of and responsibility for medicines was evident in the safety issues relating to medicines that we observed on the unit.

Records

- The unit had very recently started using a new admission clerking document but this had only been completed in two of the five documents we checked. This meant there was no evidence that consultants assessed patients within 12 hours as recommended by national standards set by the Faculty of Intensive Care Medicine (FICM). The clinical leads for the department were aware that this was a problem, particularly for evening consultant rounds and had recently introduced a new documentation form to improve record keeping. However, they told us a "culture change" among consultants was required to ensure they documented their attendance.
- We observed a foundation year one (FY1) doctor completing the patient assessment for a patient in the isolation room before the ward round had taken place rather than at the time of review by a consultant.
- There were separate discharge documents for nursing and medical staff. The nursing document was comprehensive but not all medical staff gave consistent input to the medical document.
- Staff within the trust's infection prevention and control team told us they clearly documented when they had seen an infected patient by using a yellow sticker on the notes. We reviewed the notes of a patient in the isolation room of the ICU and saw documentation that he had been seen by the infection control team, although the yellow sticker had not been used.
- We saw evidence of good practice with confidential and personal information. Patient records were kept in a drawer in each patient trolley and the end of their bed, and we saw reminders on boards for staff to shred handover documents.
- We saw consistent completion of venous thromboembolism (VTE) risk assessments in patient notes.

Safeguarding

- Among critical care staff there was a 99% completion rate for training in safeguarding adults and level one safeguarding children. There was an 81% staff completion rate in level two safeguarding children and no staff were trained in level three. However, the unit did not treat children. A review of training schedules showed that staff who were not up-to-date were booked in for safeguarding training later in 2016.
- Staff were aware of who to contact if they were concerned about a potential safeguarding issue and worked closely with the hospital safeguarding leads, particularly when dealing with complex cases of Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards assessments. The unit had just appointed a safeguarding champion to provide staff with a direct point of contact for safeguarding concerns.
- The hospital's Daisy project (recognising and responding to patients at risk of domestic violence) was included as part of the vulnerable patient study day. However, we found awareness on the unit to be inconsistent; one member of staff thought the Daisy project related to female genital mutilation (FGM).

Mandatory training

- The average completion rate across all mandatory training modules for all staff groups in the unit was 84%, which was worse than the trust's target of 95%.
- Allied health care professionals had an average completion rate of 100% in training modules, the highest within the CRCU and above the trust target of 95%. Within the critical care outreach team (CCOT), two staff groups (additional clinical services; and administrative and clerical) had an average completion rate above the 95% target set by the trust (100% and 98% respectively).
- Information governance, and equality and diversity training had the lowest completion rates of all mandatory training modules (70% and 74% respectively). The highest rates across all training modules were in safeguarding adults and safeguarding children level one (99%).

Assessing and responding to patient risk

- The trust had recently started using the electronic vital signs system to identify deterioration in patients. This helped nursing staff in decision making and quicker escalation to medical staff and to the CCOT. There was a deteriorating patient policy and there were plans to implement a CCOT-specific policy once it was running on a 24-hour basis.

- The unit was about to launch the 'Hospital at Night' programme, in which the CCOT was also heavily involved. This programme aims to enhance patient safety out of hours by focusing on medical cover and a multidisciplinary approach.
- The CCOT provided rapid support for deteriorating patients in all hospital areas.
- There were 2011 patients referred to the CCOT in 2015 compared to 844 in 2011.
- There was a cardiac arrest buzzer in the HDU but not in the ICU. This was sufficient as ICU patients were receiving one-to-one care so a buzzer was not needed for escalation. However, an agency nurse we spoke with did not know whether there were buzzers or where they would find them in the event of a cardiac arrest.

Nursing staffing

- Data provided by the trust showed that critical care was understaffed in trained nurses by 35.42% (a shortfall of 19.57 whole time equivalent (WTE) staff) compared to the staffing budget for the unit. This was worse than the average level of nurse understaffing (23%) across the trust's core services. There was a rolling recruitment programme for both international and local nurses. Staff reported feeling pressured by understaffing.
- The CRCU was also understaffed by health care assistants (HCAs) by 58.35%, a shortfall of 5.10 WTE staff.
- According to the FICM national standards, Level 3 patients require a registered nurse to patient ratio of minimum 1:1 to deliver direct care. An audit of compliance from April 2016 showed that the unit was mostly compliant with this but "in exceptional circumstances (approximately once a month)" the unit did not meet this level. The audit reported that the unit consistently achieved the ratio of minimum 1:2 for Level 2 patients.
- The unit used the Shelford Safer Nursing Care Acuity Tool to plan staffing requirements according to patient need. This was assessed on the ICU and HDU twice daily via safe care software and the health roster. We reviewed rotas from April to June 2016 and found there was appropriate nurse staffing for the level of patient acuity. During our inspection, the actual nurse staffing numbers matched the planned staffing requirements. Nursing staff rotated every two months between the HDU and ICU to maintain their clinical skills.
- According to the FICM national standards, there should also be an additional supernumerary registered nurse for units with between 11 and 20 beds. An audit of compliance from April 2016 showed the unit did not always meet this standard and during our inspection, the supernumerary nurse was responsible for a patient. A lack of supernumerary nurse means reduced senior oversight of the unit and support for staff.
- The average turnover rate for nursing staff (across the CRCU and CCOT) was 14%, which was better than the trust average of 20%.
- Staff sickness rates for the last financial year (April 2015 to March 2016) were at 5% for the CRCU, which was higher than the trust average of 3%. For CCOT staff the sickness rate was 2% and the average across the CRCU and CCOT was 3%.
- Nursing staff were supernumerary for four weeks when newly qualified to ensure nurses could develop basic skills and competencies to safely care for critically ill patients. This supernumerary period could be extended if required. However, the FICM national standards suggest six weeks as a minimum supernumerary period.
- Data provided by the trust showed that between 1 May 2015 and 17 June 2016, agency and bank nursing staff covered a total of 21,290 hours. Overall, monthly agency use between September 2015 and March 2016 ranged from 5.67% to 10.03%, which was significantly higher than other departments in the trust.
- An audit of compliance with the FICM Core Standards for Intensive Care Units from April 2016 showed that the unit was sometimes staffed by 20% to 30% agency nurses, and was especially reliant on agency staff to cover night shifts. This meant it was not always meeting national standards which state that critical care units should not utilise more than 20% of registered nurses from bank/agency on any one shift when they are not the hospital's own staff.
- There was no evidence of clear consistent induction processes for agency staff. Data provided by the trust showed that the unit was reliant on the agencies supplying the nurses to ensure staff were compliant and up-to-date with training, although all agencies were subject to a framework annual audit procedure as approved by the London Procurement Partnership. There was one agency nurse on shift at the time of our inspection who was working through induction documentation, as they were new. They told us that they did not know if they were permitted to administer intravenous medicines (IVs) and would need to ask her

supervisor for guidance if an IV was required. When we returned for the unannounced inspection, a new internal IV competencies checklist for agency staff had been introduced.

Medical staffing

- Care in the unit was led by a consultant in intensive care medicine, in accordance with the FICM standards.
- We saw a recent audit which showed that consultant/patient ratio was 1:12. This was compliant with the FICM standards for intensive care units (which state that consultant/patient ratio should not exceed a range between 1:8 and 1:15 to ensure patient safety). The unit was fully staffed with eight consultants, all of who were registered with the FICM and had anaesthetic involvement. This went above and beyond the standard required by the FICM Core Standards that only the lead needs to be FICM-registered.
- The unit was fully staffed for medical staff and did not rely on locums (medical staff who provide temporary cover). During the day, the unit was staffed by a consultant anaesthetist, a registrar, an anaesthetic Core Trainee and one or two foundation year one doctors (FY1).We reviewed recent medical staff rotas, which confirmed this. This staffing pattern also applied out of hours (weekends, evenings and bank holidays)
- At night time, a consultant covered the unit with a registrar. If a patient needed to be transferred to another hospital, the junior doctors must have completed a transfer course or worked within the ICU and had this signed off by an ICU consultant.
- A registrar was on call 24 hours a day but was also responsible for covering other areas of the hospital in the event of an emergency.
- At times when Level 2 and 3 patients were in the post-anaesthetic care unit (PACU) owing to lack of bed capacity in the CRCU, an anaesthetist registrar was allocated to the PACU.
- Two daily staff handovers took place but did not involve all available staff and handover procedure was inconsistent. There was a computer-generated handover document and we saw that this was used effectively by all middle grade doctors but only by some consultants. There was no formal handover between the ICU and HDU but as the same staff rotated between the two this was not a problem.
- We were told that consultant-led ward rounds took place daily around 8am to 9am. However, when we visited the HDU around 12.30 pm the ward round had still not taken place. The trust told us that delays can occur if there is clinical pressure within the unit or in the hospital as a whole.

Major incident awareness and training

- Staff were able to say what they would do in the event of a major incident and knew where the major incident folder was on the unit. Service leads felt confident about staff awareness in this area.
- We reviewed the local emergency and major incident policy and found it to be robust with clearly defined steps to follow. Staff were able to access the major incident plan via the intranet and a folder on the unit.
- The unit had not run any recent tests on the major incident plan.

Are critical care services effective?

Requires improvement

We rated critical care services as requires improvement for effective because

- There was a lack of effective multidisciplinary (MDT) working. Physiotherapists did not have sufficient input to maximise patient outcomes and physiotherapy staffing did not meet national standards, which could have an impact on patient rehabilitation needs. Microbiologist, dietitian and pharmacist input were also inconsistent as there were no dedicated services for the unit at the time of our inspection.
- Documentation of MDT working in patient records and handovers was poor. Service leads recognised this as a problem but there was no clear action plan to address this. Ward rounds did not routinely involve MDT input.
- Staff gave negative feedback about the training they received to maintain competencies and the unit had the lowest appraisal rates in the trust.
- Appraisal rates were the lowest in the trust for part of this, with rates as low as 23%. The rate at the time of the inspection was 64%.

However, we also found:

- The unit participated in the Intensive Care National Audit and Research Centre (ICNARC) to benchmark its outcomes against other trusts nationally.

- Mortality rates were consistently within or below the expected range.
- Staff were confident with managing patients' pain and there was clear documentation of pain relief in records we reviewed.
- Sixty per cent of nursing staff were postgraduate qualified in critical care nursing.
- Staff were competent in completing Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards assessments.

Evidence-based care and treatment

- The unit used the East of England quality indicators to monitor patient data. They also participated in the ICNARC Case Mix programme, National Cardiac Arrest Audit and Aston Organisation Development Team Effectiveness Audit (measurement of effective team practice on a critical care unit. Internal performance monitoring was done through a joint surgery and critical care dashboard.
- An audit of compliance with the National Institute of Health and Care Excellence (NICE) Clinical Guidance 83 (rehabilitation after a critical illness) showed that there was no specific rehabilitation care pathway for all patients. The unit was also non-compliant with assessing the non-physical dimensions of patient rehabilitation before discharge such as anxiety and depression. However, the unit was compliant with ensuring information was communicated with other relevant hospitals and services, and had a follow-up system for longer-term patients, led by the CCOT. Patients at risk of morbidity were assessed by a physiotherapist and had a comprehensive reassessment before discharge from the unit.
- The unit used the Confusion Assessment Method for the ICU (CAM-ICU) tool to screen patients for delirium in accordance with the FICM national standards. This involved a series of assessment questions for awake/alert patients. However, an audit from April 2016 showed that CAM-ICU scoring was not recorded in 60% of cases. Identifying and managing delirium is important for critically ill patients as it has been linked to longer stays in hospital and prolonged neuropsychological disturbances after leaving intensive care. Low levels of CAM-ICU scoring meant there was a risk of delirium not being identified and the appropriate interventions not being applied.
- An intentional rounding system had recently been introduced and staff reported that it was working well. Intentional rounding is an evidence-based structure which aims to check on patients and ensure their fundamental care needs are met. In a review of five sets of patient notes we found good documentation and signing off of intentional rounding.
- The unit used internal ward audits to monitor compliance with NICE Clinical Guidance 50 (acutely ill patients in hospital).

Pain relief

- The unit had access to a multi-professional clinically led acute pain service and used the hospital pain scoring system, which was led by anaesthetists.
- We found that recording of pain scores in patient notes was in line with the trust policy on pain scores and pain relief. Staff were confident with managing pain appropriately and escalating concerns to senior staff if they were unsure.
- We reviewed the minutes of anaesthetic clinical audit meetings and saw discussion of updates and complex cases in acute pain management to share learning and maintain staff awareness of pain management.

Nutrition and hydration

- The unit used the Malnutrition Universal Screening Tool (MUST) risk assessments to identify patients at risk of malnutrition and ensure patients received the appropriate nutrition and hydration for their needs (for example nasogastric or total parenteral nutrition). However, the unit was unable to show us nasogastric tube records as they were only documented in individual patient notes.
- In all six sets of patient notes we reviewed, fluid and food intake was recorded appropriately. However, staff told us that they recognised that the lack of a dedicated dietitian could impact on patient nutrition in certain cases and there was no specific dietitian input in the notes.

Patient outcomes

- The CRCU regularly submitted data to the Intensive Care National Audit and Research Centre (ICNARC) and was up-to-date with data submissions meaning it was able to benchmark its outcomes against similar units in other trusts. This was done by administrative staff and verified by consultants.

- The ICNARC report for April 2015 to March 2016 showed that the unit consistently had mortality rates within the expected range or below. In May 2016 the unit admitted 50 patients (seven patients were already in the unit) and reported 10 deaths. In June 2016 there were two patient deaths.
- ICNARC data showed that, between April 2015 and December 2015 1.9% of admissions to the CRCU were unplanned readmissions within 48 hours of discharge. This was slightly worse than the average rate on similar units (1.2%). In the 12 months prior to inspection, the unit reported nine readmissions from wards within 48 hours.
- According to national standards, admission to intensive care should occur within four hours of the decision being made as minimal delays are associated with better patient outcomes. In a review of patient admission documents we found this was variable; for example a patient who arrived at 9.30pm did not have an admission form completed until 5.30am. Between December 2015 and May 2016 the rate of patients admitted within four hours was 74.3%.
- Patients should be reviewed by a consultant in intensive care medicine within 12 hours of admission to the unit. Service leads told us this target was generally achieved. However, we saw that consultants did not always document in patient notes when assessments had taken place.
- One consultant told us that 30 to 40% of ward calls taken were for patients at the end of life whose DoNot Attempt Cardiopulmonary Resuscitation (DNACPR) forms were not completed, as ward staff had been told to ask critical care consultants for advice when they were unsure. This reduced the time available for consultants to spend on the CRCU with critical care patients.

Competent staff

- Out of a total 52 nursing staff on the unit, 31 (60%) had completed their post registration award in critical care nursing and four were awaiting results. This was compliant with the FICM national standards (which state that a minimum of 50% registered nursing staff on a CRCU should have this award).
- All nursing staff appointed to the unit had a four-week period of supernumerary practice before being substantive staff. We were told that this could be extended if required, although this was not fully compliant with the national guideline of a six-week supernumerary period.
- At the time of our inspection, overall training rates were at 80.7% across all staff groups in critical care. Blood transfusion training rates were particularly low at 51% of registered staff and 33% of unregistered staff.
- Between April 2015 and March 2016, 29% of staff in the unit had received appraisals, significantly lower than the year before (62%) and the lowest of all core services across the trust. By the time of our inspection this had increased to 64%. However, this was still too low to ensure all staff were up-to-date with required competencies.
- We reviewed records of staff training for specialist equipment, which were poorly maintained and missing dates and signatures. It was unclear whether staff had attended training, how many staff had been signed off, and how up-to-date the records were. For example, the Prismaflex (equipment used to treat patients with acute kidney injury) training records were signed and dated against only two of 43 staff names on the list.
- Braun pump training records were not consistently signed and some were dated 2010. In the syringe pump records, two names on the list had a day and month recorded for training but no year listed. The poor quality and illegibility of these records meant we could not be certain that staff were competent in handling specialist equipment.
- Junior doctors told us that training was “piecemeal” rather than in timetabled blocks and training was aimed more at anaesthesia than critical care specifically.
- The unit had a dedicated clinical practice educator, as recommended by national standards, who was responsible for coordinating the education and training for nursing staff to ensure they were fully competent to care for critically ill patients.
- Meeting minutes from April 2016 showed discussion about delays for new staff being able to undertake intravenous (IV) competencies. To address this issue the unit was planning an IV study day to ensure all new staff have completed their basic safety competency level one and two trust competencies, preceptorship programme (a structured period of training and support for newly qualified nurses) and the critical care quiz.

- We saw a schedule for competencies and skills for CCOT staff which included a quarterly tracheostomy study day on Locke ward to help maintain competencies.
- All consultants were up-to-date or had a date in place for revalidation. There was a scheduled programme in place for the Nursing and Midwifery Council (NMC) revalidation of nursing staff.

Multidisciplinary working

- Physiotherapists were shared between the critical care and surgery teams. The trust told us that they prioritised critical care patients and spent at least 45 minutes with patients. However, staff told us that they were unable to spend much time with critical care patients. They visited the unit once a day or if called. Physiotherapy across surgery and critical care was staffed at 0.68 whole time equivalent (WTE) band seven; 1.6 WTE band six; one WTE band five; and one WTE band three. This meant the unit was not meeting the staffing level recommended by the FICM core standards of one WTE physiotherapist to four beds.
- Physiotherapists had no input with the critical care Commissioning for Quality and Innovation (CQUIN) rehabilitation program or weaning plans. Therefore the unit was not meeting the FICM national standards for physiotherapy input which state that patient capacity is maximised by physiotherapist input into weaning and rehabilitation strategies.
- We spoke with a physiotherapist who told us they were stretched so had minimal input into multidisciplinary (MDT) working but would input into ward rounds as required if they were with the patient. The service leads for the unit confirmed that while physiotherapy staff were invited to MDT meetings for long-term patients (two weeks or longer on the unit) they could not usually prioritise these. There was no formal means of ensuring MDT input, although we were told that physiotherapists were "proactive" in supporting the unit.
- The unit had recently recruited a full-time dedicated critical care pharmacist. At the time of our inspection they had not yet started in the role but staff were confident this would help improve MDT input.
- There was no dedicated dietitian for the unit and, in our review of three sets of patient notes on the HDU and three on the ICU, we did not see any dietitian input. The nurse manager told us this was a recognised issue for the unit and that if the unit requested a dietitian to assess a patient it sometimes took two or three days.
- There was no dedicated microbiologist. The unit could request input from two microbiologists but medical staff told us that it was difficult to get valuable microbiology input for critical care patients. We saw no evidence of microbiology input in the six sets of patient notes we reviewed.
- The CCOT attended handover meetings and the joint surgery and critical care team meeting weekly. They also attended DNACPR meetings. Both CCOT members and critical care leads spoke positively about the CCOT's increased input into MDT working.

Seven-day services

- Consultants worked block shift patterns to ensure continuity of care for their patients. There was always a consultant and registrar available seven days a week and two or three FY1 doctors five days a week. If the unit was especially busy on weekends they would sometimes be supported by an obstetrics or theatres registrar. At night an on-call consultant would be able to attend within 30 minutes.
- The unit received support from the critical care outreach team (CCOT) who worked between 8am and 12am seven days a week. The CCOT was staffed by 5.42 WTE band seven nurses and shortly before our inspection had recruited additional staff to provide a 24-hour service due to start in September 2016.
- The CCOT reviewed all patients discharged from ICU and HDU at least once daily until clinically stable. The CCOT also took referrals of acutely deteriorating ward patients following triggering of the National Early Warning Score (NEWS) tool in other hospital areas. CCOT attended all cardiac arrests & undertook root cause analysis (RCA) on each one. They accompanied patients on level three transfers to tertiary centres.
- There was an on-call chest physiotherapist at weekends and we were told they were sometimes able to provide mobility support. However, the overall availability of physiotherapists did not meet the FICM national standards.
- At the time of our inspection the unit did not meet the FICM national standards for pharmacy support (which specify a minimum of 0.1 WTE 8a specialist clinical pharmacist for each single Level 3 bed and for every two Level 2 beds). However, a dedicated critical care pharmacist had recently been recruited.

Access to information

Critical care

- The unit used paper documentation at each patient's bedside but also used the Cosmic electronic patient record system. However, staff told us that there had been issues with the Cosmic electronic system including patients' names being wiped off the database.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- In a review of patient notes we found that Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards assessments were completed appropriately.
- There was evidence of good family communication in gaining consent in the patient records we reviewed.
- Staff were confident in carrying out mental capacity assessments and would regularly give advice to ward staff where they were uncertain about MCA and Deprivation of Liberty Safeguards .
- Overall MCA training rates for critical care staff were 77%, which included the critical care outreach team (CCOT).

Are critical care services caring?

Good

We rated critical care services as good for caring because:

- We observed caring interactions between staff and patients and their families.
- Relatives generally spoke positively about the behaviour and attitudes of staff on the unit.
- Staff took the time to fully explain procedures to patients and families and provided emotional support.

However, we also found:

- We heard some feedback that care was not always as compassionate at weekends.

Compassionate care

- Relatives reported that staff were generally approachable and caring, with one describing staff as "smiley". However, one relative said that although care was also good at weekends, the attitudes of both doctors and nurses were "different" from during the week and thought this was because of higher numbers of agency staff at weekends.
- Staff told us about how they had recently worked closely with the end of life care team to ensure a patient could return home to die with dignity.
- We observed generally good interactions between staff and patients, such as asking questions, chatting to them throughout procedures and using curtains to ensure patients' dignity was protected.
- During our inspection staff kept the radio turned on for extended periods of time with no indication that patients wanted to listen to it.
- The CRCU did not conduct a Friends and Family Test (FFT) or similar survey to find out if patients would recommend the service. This was because patients are rarely discharged home immediately from the CRCU and would be asked to rate their experience once situated on an inpatient ward, so the unit wanted to avoid the same patients' feedback being double counted.

Understanding and involvement of patients and those close to them

- We spoke with a parent of a critical care patient who had been in the unit for three weeks. She told us that communication with doctors and nurses at all times was "excellent". Another told us that he was kept well informed of any changes in his wife's condition and always felt able to ask questions.
- We observed a doctor explaining kindly and patiently to a patient's relative that the patient was behind the curtain because they were performing a procedure and informing the relative how long the procedure was likely to take. We also saw documentation of family conversations in the patient notes we reviewed.
- There was an organ donation 'champion' whose contact details were displayed on the information board. Staff and relatives could contact her to discuss a patient's organ donation wishes.
- The unit relied on comment cards and ad hoc feedback from patients and relatives; there was no evident system for obtaining regular feedback in order to consistently improve services.
- We reviewed four sets of patient notes for evidence of communication with family and found this was clearly documented in all four.

Emotional support

- The unit was supported by an in-house chaplain and staff always offered this service to patients and relatives.

Critical care

- Staff recognised their role in supporting the holistic needs of the patient and their family.

Are critical care services responsive?

Inadequate

We rated critical care services as inadequate for responsiveness because:

- Bed occupancy was consistently at 100% or over and, while the unit still had funding for only six ICU beds, it regularly had to flex to the full seven beds.
- There were mixed-sex accommodation breaches on the unit owing to the lack of capacity, which service leads had not highlighted as a risk.
- Critical care patients regularly had to be treated in the post anaesthetic care unit (PACU) because of the lack of bed space, which in turn led to elective surgical procedures being cancelled. The longest length of stay in the PACU was over 72 hours.
- Delayed discharges were a significant risk owing to the problems with access and flow on the unit. Between June 2015 and May 2016, the unit reported 213 discharges delayed by over 24 hours (32.6% of all admissions). This included 80 discharges delayed by over 48 hours and 45 delayed by over 72 hours.
- Delayed access to the unit was also a problem as patients who had been treated in accident and emergency (A&E) were on occasion treated in the PACU while waiting for a high dependency or intensive therapy bed.
- There was a high rate of out-of-hours discharges at 6.4% of eligible admissions, which was over twice the rate on average for similar units nationally.
- There was no clear formal system in place for learning from complaints and concerns in order to improve the service for patients.
- Accommodation and visiting facilities for families and carers were limited.

However, we also found:

- Staff worked to meet individual needs, for example through translation services or individualised 'passports' for patients with learning difficulties.
- There had been only one non-clinical transfer out of the unit between June 2015 and May 2016.
- The critical care outreach team (CCOT) played an active role in referring patients to counselling or community services after treatment if required.

Service planning and delivery to meet the needs of local people

- The CRCU took part in the East of England Operational Delivery Network (ODN) to help work towards safe, effective and coordinated care for patients.
- The service was working with the trust board to reduce the numbers of admissions to the unit wherever possible by expanding the CCOT to review patients in other areas of the hospital.
- The unit ran follow-up clinics for patients who had spent 10 or more days in the unit and four or more days on ventilation and the CCOT was involved in referring patients to appropriate post-treatment counselling or community services where required. We reviewed two sets of patient notes from follow up-clinics, which included detailed discussion of the patient's health and wellbeing since being discharged.

Meeting people's individual needs

- During our inspection there was a mixed-sex breach on the HDU. A mixed-sex accommodation breach occurs in a critical care unit when there are male and female patients in the same unit and one or more of them become a level one 'ward-able' patient no longer requiring the same level of complex care. The CRCU had reported this on the trust risk register dated June 2016.
- A translation service was available 24 hours a day for patients whose first language was not English.
- The unit used individualised 'passports' for patients with learning difficulties to help staff meet patient needs and involve families or carers as fully as possible.
- We saw useful information for relatives and carers on a board in the unit and in the visitors' room. This included contact details of link nurses for particular requirements such as dementia or nutrition.
- Visiting hours on the ICU were between 3pm and 8pm. On HDU, visiting times were 3pm to 4.30pm and 6.30pm to 8pm.
- There was a relatives' overnight room for family members to stay if they lived at a distance. However, accommodation and visiting facilities for relatives were limited. One relative told us that "accommodation could be improved" for those living at a distance.

- However, it was more often being used as a doctors' room, although staff told us that relatives would have priority if they needed to stay. The unit had also negotiated discounts with local hotels to help relatives who did not live nearby.
- During our inspection, staff explained to us that they had arranged to put in place a low-rise bed for a patient who had just had a Deprivation of Liberty Safeguard in place. We reviewed this assessment and found the patient had been appropriately assessed as lacking capacity.
- Awareness of dementia was inconsistent on the unit. A nurse told us it was covered in induction but that they had not been trained specifically in dementia. Results of an internal care bundle audit from April 2016 showed that in 60% of cases, there was evidence of dementia screening and in 20% there was no evidence (with a further 20% not applicable). Training records showed that 82.4% of registered nurses had completed dementia training.
- The unit did not routinely use a depression/anxiety screening tool but if depression was identified in initial assessment, staff were able to contact appropriate psychology teams for support.
- The service was planning to introduce improvements in patient care such as rehabilitation, and had recently introduced a 'sleep bundle' including eye masks and earplugs to improve patients' quality of sleep.

Access and flow

- Between April 2015 and April 2016, 133 Level 2 and Level 3 patients were ventilated in the post-anaesthetic care unit (PACU) for over two hours owing to lack of capacity on the CRCU. Of these patients, the longest period spent outside the unit was 72 hours and 30 minutes in January 2016.
- Information provided by the trust showed that these were mainly post-operative patients but also included patients who had been treated in A&E and required stabilisation while waiting for a high dependency or intensive therapy bed. Between July 2015 and June 2016 there were 13 patients transferred directly from A&E to recovery beds because of a lack of critical care beds.
- When this happened an anaesthetist was allocated to the unit and a critical care trained PACU nurse would be with the patient.
- Bed occupancy issues were regularly discussed at team meetings and were highlighted as a concern by all staff groups during our inspection. The ICU was only funded for five beds but regularly had to open the full seven beds.
- Meeting minutes showed clear consideration of discharge arrangements and evidence that staff were reminded not to accept patients as ward-able until it was documented by a doctor. Patients could then be treated as Level 1 and follow the discharge pathway.
- Data submitted by the unit to the Intensive Care National Audit and Research Centre (ICNARC) showed that, between April 2015 and March 2016, 6.4% of eligible admissions resulted in out-of-hours discharges to the ward. This was worse than comparable units nationally at 3.0% on average. Between January and June 2016, there were 88 out-of-hours discharges between 10pm and 7am.
- Between June 2015 and May 2016, the unit reported 213 discharges delayed by over 24 hours (32.6% of all admissions). This included 80 discharges delayed by over 48 hours and 45 delayed by over 72 hours. There were an additional 250 discharges delayed for between four and 24 hours (38.3% of all admissions). In total the rate of delayed discharges was 70.9% which was slightly better than at the time of our previous inspection (78%) in July 2015. There were 635 bed days lost as a result of delayed discharges.
- In the 2015/16 end of year performance review of the surgical and critical care health group, the unit highlighted the need for support from the trust to improve patient flow in critical care. Service leads told us that the four-hour discharge time had improved as a result of a new service manager being appointed and better input from commissioners. However, the ICNARC report for April 2015 to March 2016 still identified the service as a significant statistical outlier on delayed admissions and discharges. Between January and June 2016 there were 177 discharges delayed for over four hours.
- Between June 2015 and May 2016, there was only one non-clinical transfer out of the unit.
- Between December 2015 and May 2016, the rate of patients admitted within four hours was 74.3%.
- From June 2015 to May 2016, 37 elective surgery procedures were cancelled owing to a lack of critical care beds, out of a total 11350 planned elective procedures for that period. However, there had only

been one cancelled elective operation for the period April to June 2016. We could not be sure that the service was planning effectively to meet the needs because of the high number of cancelled surgeries.
- Since April 2016, the use of theatre recovery areas for ventilated patients had been minimised as elective operations were cancelled if there was no bed space available. However, it was confirmed by staff in both theatres and critical care that there were occasions when the use of theatres was inevitable because of emergency cases.
- The unit had been asked to help provide non-invasive ventilation on a temporary basis. This service was being re-established in respiratory medicine, which would help reduce pressures on the critical care unit.
- They had also been caring for chronic renal patients and had recently arranged a transfer agreement with another hospital for this treatment, which service leads hoped would improve access and flow in the unit.

Learning from complaints and concerns

- The unit provided feedback cards for patients and relatives and contact information for raising complaints was available on the information board. However, there was no formal way of ensuring feedback was shared with staff on the unit. There was no clear formal system in place for learning from complaints and concerns in order to improve the service for patients.
- There was a 'you said, we did' notice on the information board. In response to suggestions from relatives and visitors, the unit had installed a television in the relatives' room.
- Between April 2015 and March 2016, the unit received three formal complaints. Data submitted by the trust in July 2016 showed the unit had received no further complaints between April and June 2016. The unit followed the trust-wide complaints procedure.

Are critical care services well-led?

Inadequate

We rated critical care services as inadequate for being well-led because:

- The lack of information sharing between the service leads and the staff on the unit had deteriorated since our previous inspection. There were no clear governance processes for ensuring feedback from complaints and lessons learned from incidents were shared with staff.
- The risk register did not include several of the risks to patient safety we observed during our inspection such as the poor culture surrounding medicines management and controlled drugs.
- There was no effective ward to board governance system in place. Senior and executive leadership team were unaware of the issues identified by inspectors on the unit.
- Attendance at meetings was variable, particularly at busy times on the unit, meaning staff were less likely to receive important updates or feedback.
- There was no evidence of active steps being taken to engage and gain feedback from the public to improve the service.
- We were concerned about some aspects of the culture as some members of staff told us leadership was not visible or approachable, and felt unsupported. We had raised this issue at our previous inspection in July 2015. However, we found no improvement and some deterioration in the morale of staff.
- Both medical and nursing staff reported problems with learning and development opportunities.

However, we also found:

- Service leads told us about key areas of focus for the future including plans to help reduce bed pressures and a focus on the "softer" factors of patient rehabilitation.
- We received some positive feedback from staff about the teamwork on the unit. In particular members of the critical care outreach team (CCOT) reported feeling included and well-supported.
- The use of a consultant dashboard was an example of good practice.

Vision and strategy for this service

- There was no evidence of a defined strategy for the unit and staff did not show awareness of a vision for the unit.
- However, service leads were able to describe some areas of focus for the future, including introducing a level one unit as part of a perioperative care initiative to reduce bed pressures and re-establishing non-invasive ventilation to the respiratory medicine department.

Critical care

Governance, risk management and quality measurement

- We reviewed the trust risk register and found no awareness of many of the risks we had identified; for example in relation to medicines management, and resuscitation equipment. Service leads were aware of the problem of inconsistent documentation in patient records but this was not included on the risk register.
- The service leads highlighted the environmental risks owing to the lack of space in the HDU. However, there was no evidence of any active steps to minimise the impact of this (such as increased use of curtains to improve privacy and dignity).
- The unit completed a joint nursing quality dashboard with the surgery team, which was used to monitor key indicators such as patient falls, pressure ulcers and hospital-acquired infections, staff vacancy and sickness rates.
- Attendance at staff meetings was variable which meant reduced sharing of information and risks in the unit. Staff told us they were often unable to prioritise meeting attendance owing to other responsibilities.
- Governance processes for ensuring sharing feedback from complaints and lessons learned from incidents were lacking and staff told us they did not routinely receive feedback from incidents reported or complaints received.
- Service leads were clear about the key risks and areas of focus for the unit. However, there was no evidence of ensuring that plans for the unit were shared among staff groups.
- While the unit conducted audits to identify areas of non-compliance with guidance produced by the National Institute for Health and Care Excellence (NICE) guidelines, there was no evidence of robust action plans to address the outcomes of these. This meant that there was no evidence of how quality in the service could improve.

Leadership of service

- The critical care service sat within the surgery and critical care health group. The service was led by a clinical director, associate director of nursing and a deputy director of operations. The senior team were supported by a matron and clinical lead for critical care.
- Staff gave mixed feedback about the leadership in the unit. We spoke with 13 members of clinical staff and of those a few staff reported that leaders were visible and approachable and CCOT members felt "well supported" by service leads. However, one staff member we spoke with reported that managers were "lovely" but could also be "intimidating" and felt that at times the junior members of staff were "left to get on with it".
- Staff were generally positive about the appraisals they received. However, the low appraisal rates in the unit did not support this.
- There was no 'ward to board' governance system as the senior and executive leadership team were unaware of the issues relating to medicines, record keeping and lack of learning and feedback. This meant there was reduced senior oversight of the risks on the unit.
- At the time of our inspection a matron for surgery was acting as the Associate Director of Nursing, while the Assistant Director of Nursing for the Health Care Group was on leave. The matron for critical care was supporting the wider health care group.

Culture within the service

- In a review of ward sisters' meeting minutes from April 2016, there was discussion of concerns that some senior staff were 'unapproachable'. There was evidence of improvement suggestions including reminders to senior staff and encouraging reporting unacceptable behaviour, but it was unclear if these had been adequately implemented.
- The unit had a dedicated clinical nurse educator responsible for coordinating education and training for nursing staff in the unit. However, we received mixed feedback from nursing staff about the education and training they received as a result, with one reporting that the educator needed to be more "proactive" and "visible"
- One foundation year one (FY1) doctor told us that the unit provided an "excellent clinical training environment." However, another told us that while there was a good induction in terms of practical issues such as rotas and booking leave, discussion about educational aims and expectations was minimal.
- Trainee doctors reported that the "majority" of consultants provided a welcoming training and working environment but there were exceptions. We spoke with a registrar who described consultants as "supportive".

- There was a poor culture in relation to safety risks on the unit and a lack of responsibility or accountability. For example, when we raised the medicines management issues to staff they seemed unaware this was bad practice.
- Service leads acknowledged that a culture change was required among consultants to encourage full consultant documentation in patient records and better input at the patient bedside. They also felt that a culture change across the trust was needed to prioritise critical care discharges and improve the access and flow issues. However, there were no evident active steps being taken to improve the culture.
- We saw some evidence of good team support; for example, we saw a new agency nurse shadowing an experienced nurse who was explaining clearly where things were and taking her through the steps of where to record notes as she was caring for a patient. However, we also received feedback that the small size of the unit encouraged "cliquey" behaviour from some staff.

Public engagement

- The unit received sporadic feedback via comments cards in the relatives' room. However, there was no evidence of any patient/family forums or formal processes in place to gain input from the public and from service users.

Staff engagement

- There was a seminar room on the unit for study days and training sessions. The unit had been running monthly nurse study days and turnout for the last two sessions had been very high.
- The clinical nurse educator recognised there was minimal development opportunity for more experienced staff owing to funding.
- The unit conducted informal exit interviews for staff leaving the unit and reported that some junior staff felt unsupported by senior staff; in particular, that consultants ignored them on ward rounds. This was a concern raised in staff meetings.

Innovation, improvement and sustainability

- Since July 2015, the unit had been running a critical care rehab group, designed to improve the service provided by the monthly critical care follow up clinic and to move critical care rehabilitation forward within the trust to ensure that national recommendations were met. The group involved multidisciplinary input from speech and language therapists, physiotherapists, nursing staff and anaesthetists to work towards improvement.
- The unit was particularly proud of the progress and work of the critical care outreach team (CCOT) and their increasing role across the hospital.
- The consultants within the unit utilised a consultants dashboard, which allowed the medical team to monitor patients and outcomes on a daily basis. This was innovative and good practice.

Maternity and gynaecology

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

Information about the service

The Princess Alexandra Hospital maternity service offers antenatal care with 15 beds on Chamberlain ward and birthing care with nine refurbished delivery rooms on the Labour ward. The birthing unit facilities include three en suite birthing rooms with birthing pools, including a bay of six postnatal beds and a shared assessment lounge for women receiving midwife led care. Samson ward is a 22 bed postnatal ward. The trust provides community midwifery services to women in the Essex and Hertfordshire areas.

The birthing unit is adjacent to the maternity suite and is a low risk, low intervention area developed to offer a safe birth option in a home from home environment for women in good medical health with an uncomplicated pregnancy. Each shift is staffed by three midwives and a maternity care assistant, supported by a ward clerk and a ward domestic. It has a separate identity and location to that of the labour ward, offering a relaxed and safe place for women to give birth in, which has proven to facilitate normal labour and birth without the need for medical intervention.

Between April 2015 and March 2016, the service delivered 4,207 babies and had a slightly higher than average multiple birth rate with 1.7% of all births being more than one baby compared with a national average of 1.6%.

Gynaecology provided a range of services, including hysteroscopy, cystoscopy, gynaecology ambulatory unit, early pregnancy and termination of pregnancy. The trust had no allocated inpatient gynaecology beds. Gynaecology patients were placed throughout the hospital following surgery or emergency treatment. The trust tried to allocate women to the surgical female ward (Penn) but this was not always possible. On average the trust has between five and 15 women admitted daily as inpatients for gynaecological reasons. Inpatient gynaecology care has been reported under surgery in this report.

We reviewed the antenatal services provided by the Rectory Lane Clinic, and we have informed the trust that this location is no longer required to be registered due to the services now provided.

During this inspection we used a variety of sources to gather evidence in order to assess and rate the maternity and gynaecology services at The Princess Alexandra Hospital. This included reviewing 28 women's health records, of which 10 were from women in maternity and 18 were from women in gynaecology.

We spoke with nine women, 20 members of nursing, midwifery and support staff and six doctors which included consultants and trainees. We also spoke with the leadership team for nursing, midwifery, operations and the lead clinician for the service. We looked at a wide range of documents, including policies, minutes of meetings, action plans, risk assessments, audit results, social media and patient choice websites.

Maternity and gynaecology

Summary of findings

Overall we rated maternity services at Princess Alexandra Hospital as outstanding. With caring and well-led rated as outstanding. Safety, effectiveness and responsiveness were rated as good.

- Incident reporting and learning from incidents was embedded within the service. The maternity safety thermometer data was visible and showed how the service used data to improve quality and safety.
- The environment within the unit was secure and meant that there was a reduced risk of a vulnerable patient leaving or of a baby abduction.
- The service was consistently providing 60 hours or more of consultant time to the labour ward per week. Staffing levels were monitored and managed effectively, with positive and proactive recruitment strategies in place.
- Outcomes for women who used services were generally better than expected when compared with other similar sized services. However caesarean section rates were higher than the national average. Women were encouraged and supported to deliver naturally and commence breast feeding post birth.
- Breastfeeding rates were better than the England average and natural vaginal delivery rates were the best in the East of England and comparable with the national average for England. The service had an outstanding process for auditing, learning from national reports and recommendations as well as keeping up to date with current guidelines.
- The Maternal Newborn and Infant Clinical Outcome Review Programme (MBRRACE) report for 2015 showed this trust reported a 10% lower than average stillbirth, neonatal and extended perinatal mortality rate.
- Pain relief for women in labour and women having gynaecology procedures was planned and managed well.
- The termination of pregnancy service was outstanding and followed all elements of national guidelines and legislation.
- Staff providing both maternity and gynaecology care were dedicated, compassionate, caring and they consistently went beyond the call of duty to deliver the best experience possible for the women. All women we spoke with provided us with positive feedback about the staff who cared for them. The Friends and Family Test was consistently above the England average for scores in all aspects of antenatal, birth and postnatal care.
- The service consistently received more compliments than complaints. The processes for emotional support to women who terminate pregnancies were also outstanding. The gynaecology outpatient service provided outstanding care to women who used the service.
- The service had actively planned how to manage the fluctuating and increasing demand on service capacity. The services were delivered working in partnership with commission teams and community services within Essex and across the borders.
- The waiting times for emergency and elective gynaecology were good and meant that patient's pathways were generally delivered within 18 weeks. The service had a robust process for recognising investigating and learning from complaints.
- The service had developed the gynaecology outpatient provision into a standalone service working within the women's healthcare group which was outstanding. This had a significant benefit to the care and pathway experienced by women using this service.
- Governance and risk management systems within maternity and gynaecology services were robust and well established. The service was continually looking to improve the experience of women who used the service. Staff were aware of the trust's vision and values.
- The medical, midwifery and operational leadership team were respected and staff spoke highly of the clinical leads for the service and how involved and approachable they were, which created an open culture. It was evident that staff worked well together within this aspect of the service. Staff described how their objective was to be an outstanding service.
- Risks were added to the risk register, monitored, managed with clear actions in place to minimise risk. The service worked well, engaging with the women who used this service linking with local mother and baby groups to seek feedback on services provided by the hospital.

Maternity and gynaecology

However:

- We found that no gynaecology ward meant that 1,522 in-patients admitted in the last six months were cared for on seven different wards. The lack of a gynaecology in-patient ward meant that women did not always receive timely care while accommodated in various wards across the trust.

Are maternity and gynaecology services safe?

Good

Safety of maternity and gynaecology services was rated as good because:

- The service had a clear process for reporting, recording and investigating incidents embedded within the service.
- The maternity safety thermometer data was seen and showed how the service used data to improve quality and safety.
- The environment within the unit was secure, reducing the risk of any vulnerable patient leaving or a baby abduction.
- The service was consistently providing 60 hours, or more, of consultant time to the labour ward per week.
- The practice development midwife supported all staff attending mandatory training. This was good and was seen as included on the electronic staff rostering system.
- Medicines management was robust, with records of medicines, storage, and security observed in line with national and trust guidance.
- Staffing levels were monitored and managed effectively, with positive and proactive strategies with open recruitment days and continuous advertisement seen.
- The four staff spoken to confirmed the quality and safety team feedback was to the trust board twice monthly.
- Staff handwashing and cleanliness was mostly good and supported by regular audits.

However, we also found:

- In gynaecology low levels of dust were seen in areas across the service and patient curtains were seen undated and soiled.
- There was one obstetric theatre that staff described as not fit for purpose. If women required an elective transfer to the main theatres it took approximately 15 minutes to complete.
- Three staff members were observed wearing jewellery which was not in line with the trust's uniform policy.

- Data on temperature checks of the warmer fluids fridge was missing for 15 days in May 2016.

Incidents

- The trust used an electronic incident reporting system. All 20 staff we spoke with about incident reporting confirmed they could access the system through any hospital computer.
- Staff understood their responsibilities to report incidents. They described to us what an incident was and when to raise one.
- Agency staff were not able to access the incident reporting system and were required to ask a trust member of staff to complete an incident when required.
- The service displayed a trigger list in all areas to support staff in recognising the need to report an incident and the steps to progress appropriately.
- The service investigated all serious incidents using root cause analysis techniques and identified lessons to learn. We spoke with staff about the serious incidents and all, including midwives, doctors and members of the leadership team, could give examples of changes to practice as a result. An example discussed with staff was a misdiagnosis of miscarriage within the trust. It occurred at the weekend with no access to scan for confirmation. The accident and emergency department now have protected scan slots for women who come on the weekend when the gynaecology ambulatory service is closed.
- An executive director, head of midwifery and nominated staff attended a daily serious incident meeting. Staff were invited to attend for development opportunities as part of the mandatory training.
- The service followed duty of candour guidelines. We saw investigation records showing staff had informed families of the incident, investigation, and outcome. Duty of candour is a legal duty on the trust to inform and apologise to patients if there have been mistakes in their care that have led to significant harm.
- The monthly perinatal mortality and gynaecology meeting minutes were seen for seven meetings between July 2015 and April 2016, which contained discussions and case reviews by multidisciplinary team members. The minutes also highlighted changes in practice needed to improve patient outcomes.
- The number of incidents reported for this service at the previous inspection was confirmed as low for a service of this size. Between April 2015 and March 2016 there were 1,186 incidents reported, which was comparable with other trusts delivering a similar sized service. There were 66 reported gynaecological incidents categorised as minor or no harm between April 2015 and March 2016.The main themes included late starts for outpatient clinics, patients not receiving follow up appointments and communication errors which related mostly to gynaecology outpatient activity.
- The maternity service had reported four serious incidents between March 2015 and March 2016. The four events included a baby born by emergency caesarean section following a failed forceps delivery resulting in poor condition at birth with admission to the Neonatal Intensive Care Unit (NICU). The neonatal team completed a full root cause analysis on all babies born in poor condition who required full resuscitation and admission to NICU. They presented the outcome findings of that report to the serious incident group. The remaining two serious incidents were subject to a current investigation.
- The maternity team reported no 'never events' between January 2015 and June 2016. Never Events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- On reviewing the May 2016 maternity dashboard there were other possible incidents, for example three incidents of major haemorrhages of more than four litres of blood, which potentially could have been defined as serious incidents.

Safety thermometer

- The NHS safety thermometer is a national initiative and local improvement tool for measuring, monitoring, and analysing harm free care. Results were displayed on notice boards and within staff areas. There was no specific thermometer for gynaecology as there was no inpatient gynaecology ward in the trust.
- Maternity services used the maternity specific NHS safety thermometer, which allows service providers to determine harm-free care indicators but also records the number of harm specifically associated with maternity care.

- We reviewed the maternity dashboard and found there was monitoring of key areas, for example, staffing levels, post-partum haemorrhages and caesarean section rates.
- The maternity dashboard was up to date so current information was available to staff and patients and indicated that patient outcomes were in line or above other similar sized units.

Cleanliness, infection control and hygiene

- The service reported no Clostridium difficile infection and no MRSA bacteraemia cases in the previous year (2015- to 2016).
- There were cleaning schedules in place and we observed cleaning taking place during the inspection.
- Most staff were compliant with the trust's infection control polices and protocols. Staff were observed with good hand hygiene, used personal protective equipment appropriately, and were mostly bare below their elbows. However, we saw three members of staff wearing jewellery that was not in line with the trust uniform policy.
- Equipment not in use was stored in a curtained area on the birthing unit's postnatal bay with no detail on the equipment of when it was last cleaned.
- All areas within the service had a monthly hand infection control and hand hygiene audit. The results showed that the services achieved 99 to 100% compliance for 2015 and January to June 2016.
- There was light dust seen on surfaces across the maternity services.
- In the gynaecology ambulatory service we saw soiled privacy curtains. Staff confirmed curtains were changed on a three to six monthly cycle, unless escalated outside of that time due to contamination. Curtains were not dated on the label provided. We brought this to the attention of the senior staff for immediate action, and the curtains were changed.

Environment and equipment

- There was one maternity theatre within the labour ward, which was used for emergency procedures. The theatre was small; there was no separate scrub area or preparation area and this was on the risk register.
- There was an additional room nearby known as 'room nine', which was an old theatre and was being upgraded for women who required critical care.
- We reviewed three resuscitaires for babies on the labour ward. We found that they had been checked regularly, were fully stocked and visibly clean with "I am clean" green stickers.
- We saw a cot on the birthing unit which had a label showing it needed repair. The date on the sticker was 16 June 2016. During our unannounced inspection on 7 July 2016, we saw the same cot still unrepaired.
- **We examined cardiotocography** (CTG) equipment (a machine that records the **fetal** heartbeat and the uterine contractions), blood pressure machines, blood glucose machines and electronic weighing scales had been tested for electrical safety. There was a record of calibration and servicing for each item.
- We examined the resuscitation equipment in antenatal clinical, maternity fetal assessment unit and labour ward. The trust policy is for checks to be undertaken daily with a full stock audit to be undertaken weekly.
- The resuscitation trolleys across maternity service had been checked weekly along with the grab bag found in the maternity and foetal assessment unit.
- Room signage was not clear, an example was a room signed as the "milk room" but which was being used for the storage of paperwork.

Medicines

- We examined the controlled drugs records for the maternity service. Records confirmed that medicines which are known as "controlled drugs" were checked regularly. Medicines for resuscitation were checked at the same time as the emergency equipment.
- Medicines were securely stored in locked cupboards or fridges within secure rooms across the service. We checked fridge temperatures and were assured that they were being monitored daily appropriately with the exception of labour ward. Daily recordings of temperature checks on medicine and blood products fridges were seen and completed except for 15 daily check gaps found for May 2016 for labour ward warming fluids cupboard.
- The fridge temperatures were recorded at or below 8°c with clear actions to evidence steps taken when this temperature was outside the accepted range.
- We examined eight medicines records; all had completed history of medicines. However, in one record the allergy status had not been recorded.

Records

Maternity and gynaecology

- We examined the records of 10 women in maternity and found risk assessments for **venous thromboembolism** (VTE) were completed in nine cases of women being admitted into the maternity service. One record showed the absence of the skin integrity assessment.
- Records examined showed that full medical histories, including previous pregnancies, were undertaken in all 10 maternity records.
- Record keeping champions had been instigated by a supervisor of midwives at the last inspection but during this inspection we found no identified record keeping champions on the ward boards. Senior staff confirmed this would be re-introduced as it is a good practice.
- The "fresh eyes" peer review of CTG interpretation and documentation used at this trust had been reviewed and updated in February 2016. This resulted in an updated sticker for women's notes, and was adapted from the Intrapartum National Institute for Health and Care Excellence (NICE) guidance (2014).
- We reviewed the records of 18 women who had been in the care of gynaecology outpatient service between April and June 2016. The records were well organised, clear, and easy to navigate and written in detail which provided a clear view of the person's care plan. Not all staff signatures were legible or had a name stamp with a job title.
- Although we were informed about the service caring for service users with high obesity, diabetes, mental health, substance and domestic abuse and multiple pregnancies, we saw no preventative health care plans to support this group of service users.
- The recording and documentation regarding the termination of pregnancy in six notes examined was excellent. The service was easily able to demonstrate how they met the requirements of the Abortion Act 1967 and associated guidelines through the recording of care.

Safeguarding

- Within maternity and gynaecology services 92% of staff had received training in safeguarding adults which was lower than the trust's target of 95%. Safeguarding children level one had been completed by 92% of staff which is better than the trust target of 90%. Safeguarding children level two was completed by 88% of staff, which is better than the trust target of 85% and safeguarding children level three was completed by 64% of staff which is lower than the trust target of 82%.
- There were up-to-date safeguarding policies and procedures for adults and children, which incorporated relevant guidance and legislation. Staff demonstrated that they could access these via the hospital intranet. All staff were knowledgeable about safeguarding concerns and knew how to raise matters appropriately. Staff were aware of the specialist midwife for safeguarding.
- A trust wide named safeguarding nurse had been in post since September 2015 who worked well with the safeguarding midwife. Specialist midwives were confirmed as in post for mental health, domestic violence and there was a teenager pregnancy team.
- The service introduced a 'Daisy champion' in maternity services, who supported staff with recognising, reporting and dealing with cases of domestic violence. Within maternity services 92% of staff had received training in domestic violence awareness as part of the safeguarding adults training session.
- In response to a serious case review a new information sharing form (ISF) and process was implemented within the maternity services with the ISF sent to the safeguarding team and triaged by the named midwife. A plan of action was agreed and distributed to the professionals involved in the care of the woman. The safeguard team would add to the high risk maternity database or in universal services for regular review.
- The six staff spoken with in the gynaecology service were knowledgeable about safeguarding concerns and knew how to raise matters appropriately.
- Two staff spoke to us about female genital mutilation (FGM) and were able to easily access the policy ratified in May 2016.

Mandatory training

- The trust had set a target of 95% compliance for mandatory training. Mandatory training subjects included safeguarding adults and children, moving and handling, infection control, health and safety and information governance.
- Areas where the service was not meeting the trust's target for mandatory training included infection control (65%), fire training (70%), safeguarding level 3 (64%), manual handling (70%) and hospital life support (65%).
- The trust was achieving the required training rates for information governance (75%), fire training (70%), safeguarding of vulnerable adults (92%), values awareness (80%), equality and diversity (80%).

Maternity and gynaecology

Assessing and responding to patient risk

- The trust has a critical care outreach service to enhance the care of acutely ill patients in hospital. The team were available Monday to Friday between 9am and 5pm and staff were aware of the team and knew how to contact them.
- The 'World Health Organisation (WHO) Surgical Checklist, Five Steps to Safer Surgery' was in place in maternity and gynaecology outpatients where procedures were undertaken. There were four gynaecology and three maternity safer surgery checklists examined which were fully completed.
- In maternity services the Maternal Early Warning Score (MEWS) and Paediatric Early Warning Score (PEWS) system were in place for women and babies. We examined the MEWS of 10 women through their records and found that the scores had been correctly calculated in all cases.
- There was one obstetric theatre that staff described as not fit for purpose and women were transferred to the main theatres, which took approximately 15 minutes to transfer the women to. Staff had not received skills and drills training on the transfer in the event of an emergency. However, speaking with staff they were aware of what would need to happen to ensure the safety of the woman.

Midwifery staffing

- The midwife to birth ratio was assessed monthly and reported to the board. The trust used a nationally recognised matrix for assessing the ratio based on the numbers of births expected in the unit, as well as the number of multiple or high-risk births expected.
- The midwife to birth ratio at 1:33 was higher than the nationally recommended workforce figure 1:29. The Royal College of Obstetricians "Safer Childbirth; Minimum Standards for Organisation and Delivery of Care in Labour, 2007" standards state that, 'The minimum midwife-to-woman ratio is 1:29 for safe level of service to ensure the capacity to achieve one-to-one care in labour.'
- The midwife to birth ratio had not impacted on the delivery of one to one care during labour, for the months of May and June 2016 the service had achieved 100% of deliveries with one to one care.
- At the time of our inspection there were 18 whole time equivalent midwife vacancies across the maternity service. The trust had over recruited to the vacant positions following open days and a rolling advertisement programme to continue recruitment to maintain a stable establishment level.
- The service had recruited 23 new midwives who were due to start in September 2016, which would reduce their current ratio to within the recommended range.
- The ratio of midwives to supervisor of midwives (SoMs) was 1:17, which was lower than the recommended guideline of 1:15, there was adequate provision of supervision for midwives within the unit.
- A midwifery risk meeting occurred at 8:30am each day. Participants at this meeting discussed the previous day's events, incidents, learning, and any potential risks for the day ahead.
- We observed two midwife handovers during the course of the inspection. These were led by the coordinator and were detailed and comprehensive about all women on the unit. This meant the whole team had a greater understanding of the complexities of women in their care.
- Where agency staff were used to cover vacant shifts, this group of staff were provided with a comprehensive induction by the shift coordinator which included contact details, policies, escalation plans, reporting any concerns and documentation requirements. This was documented and agency staff were signed off by the co-ordinator as suitable to work on the unit. The majority of agency midwives had undertaken regular work on the unit and were familiar with the environment and procedures.
- The staff sickness ratio for maternity and gynaecology services was 4.0%, which was better than the trust average (4.4%).
- Electronic staff rostering was reviewed for four weeks and identified staff skill mix and cover requirements had been achieved. This system was directly linked to the bank staffing department which was good.
- We saw the staff roster for the gynaecology outpatient services and noted that all shifts were covered over a four week period. Senior staff confirmed that there were no concerns with this area.
- The gynaecology service staff sickness ratio was 1.2% for June 2016, which was better than the trust's average at 4.4%.

Maternity and gynaecology

- There was one current staff vacancy within the gynaecology service. The service had recruited to this post and the person was due to commence their role in July 2016.

Medical staffing

- The healthcare group employed 34 whole time equivalent medical staff and there was a good skill mix on duty at all times.
- The service was meeting the guideline issued by The Royal College of Obstetricians: "Safer Childbirth; Minimum Standards for Organisation and Delivery of Care in Labour, 2007" standards which state that units with between 2500 and 6000 births a year or classed as high risk should provide at least 40 hours a week of consultant presence. On average The Princess Alexandra Hospital had 4,200 to 4,400 deliveries per year with 60 hours of consultant presence provided per week.
- Between April 2015 and May 2016, the average consultant hours per week had maintained 60 hours. The service had not provided less than 44 hours of consultant cover since October 2013. Therefore, the trust was exceeding the standard recommended.
- We spoke with the lead consultant about the hours covered by consultants who confirmed this was achieved with supporting professional activities (SPAs).
- Consultant medical and anaesthetic cover was available 24 hours a day seven days a week for both maternity and gynaecology services.
- There was an allocated consultant and anaesthetist for elective caesarean sections, which took place weekly.
- There were two dedicated consultants who provided gynaecology services each day. They supported the delivery of the early pregnancy unit, termination of pregnancy and the emergency gynaecology unit. The two consultants undertook daily dedicated ward rounds for women admitted to the hospital with gynaecology concerns.
- There was an allocated consultant for termination of pregnancies, which took place weekly for both medical and surgical procedures. This was supported by trainees and a senior registrar grade.
- We observed a patient ward round with the consultant gynaecologist and junior medical staff, which was detailed and identified the needs of the women in their care.

Major incident awareness, training and child abduction

- Maternity and gynaecology services followed the trust's major incident and escalation policy and the hospital linked with the local Emergency Planning and Resilience groups. Business continuity plans were also in place.
- The major incident information was available for all staff to access on the trust's intranet and three staff members spoken with were familiar with the protocols.
- Three staff confirmed that they were aware of the action cards associated with a major incident and accessed them. They had not been involved with a recent table top or practical exercise. Training figures submitted by the trust did not include this data.
- The trust's policy on child abduction was dated 2015 and was seen on the hospital intranet during the inspection. There had been a recent training exercise around baby abductions from the trust, and improvements made to the security of the service as a result. Training figures submitted by the trust did not include this data.
- We found that the security of babies on the maternity unit, in particular in the birthing unit, was safe as the unit was secure. This was an improvement from the inspection in 2015.

Are maternity and gynaecology services effective?

Good 

The maternity service was rated as good for being effective because:

- Outcomes for women who used services were generally better than expected when compared with other similar sized services. However caesarean section rates were higher than the national average. Staff encouraged and supported women to deliver naturally and start breast feeding post birth. The service had breastfeeding rates of 73%, higher than the England average of 66%.
- The breast feeding and natural vaginal delivery rates at 56% were the best in the East of England and comparable with the national average for England.
- The service had an outstanding process for auditing, learning from national reports and recommendations as well keeping up to date with current guidelines.

- Staff working within the service went through regular supervision, appraisal and personal development with the option to progress within their careers.
- The Maternal Newborn and Infant Clinical Outcome Review Programme (MBRRACE) report for 2015 showed this trust reported a 10% lower than average stillbirth, neonatal and extended perinatal mortality rates.
- Teams across the service worked well together and with other teams including community services. Staff worked well within the multidisciplinary team, particularly in the gynaecology service.
- The termination of pregnancy service was outstanding and followed all elements of national guidelines and legislation.
- Pain relief for women in labour and women having gynaecology procedures was planned and managed well. Feedback from women was all positive in regards to pain relief.
- While the ratio of supervisor of midwives (SoMs) to midwives was 1:17, the midwives reported no concerns with regards to access for SoMs across the service. They were accessible 24 hours per day.
- The caesarean section rate for elective caesareans was lower than expected. While the emergency rates were higher than expected this was monitored and closely managed.

Evidence-based care and treatment

- All policies and procedures used within gynaecology and maternity were in accordance with the National Institute for Health and Care Excellence (NICE) guidelines or those from the Royal College of Obstetrics and Gynaecology. The standards and newly issued guidelines were discussed at monthly audit and governance meetings, which were recorded to demonstrate how the service met the minimum national standards.
- There was a clear process in place for prioritising audit activity. The healthcare group had an audit database, which enabled staff to identify the project lead and progress of the audit. The service undertook more than 25 local audits annually. Topics included stillbirth, antenatal records, postpartum health records, antenatal management of reduced fetal movement, management of multiple pregnancies, management of third and fourth degree perineal tears, and consent in termination of pregnancy.
- After any change in national or local guideline, the service undertook a baseline audit to identify what work was needed to improve the service. All audits were presented by the team to the audit meeting for shared learning and action plan monitoring. The findings from these audits were shared at wards meetings, daily handovers, governance and audit meetings held within the service. The learning and discussion around audit in this service was outstanding. The evidence of shared learning throughout the service was on notice boards.
- The East of England Local Supervising Authority Annual Audit Report: Monitoring the Standards of Supervision & Midwifery Practice from April 2014, showed that the service needed to improve on five standards around ensuring visibility and support from the supervisors of midwives. We checked on the progress with these standards and they could demonstrate through discussion and action plan improvements on all standards identified.
- The trust's **cardiotocography** policy reflected the "The National Institute of Health and Care Excellence; Intrapartum Care 2014" guidelines. Four staff were asked and assured us that their practice was in line with the policy, through risk newsletters and team meetings and that they were familiar with this guidance.
- We reviewed the care records of two women on **cardiotocography** monitors within maternity and fetal assessment care and found that the monitoring was undertaken in line with the trust's policy and NICE guidelines.
- The maternity service was adhering and closely monitoring The National Institute for Health and Care Excellence (NICE) quality standard number 32: caesarean sections. Caesarean sections were discussed at monthly audit and governance meetings and monitored through the maternity dashboard.
- Of the ten records examined, six women were receiving post-natal care. The care received was in accordance with NICE quality standard number 37: post-natal care. Care was monitored through the maternity dashboard.
- We examined the notes of two women receiving antenatal care and specifically looked at the compliance with NICE quality standard number 22: antenatal care.' The service had a clear process for booking women into the antenatal service and checking them at the required phases throughout their pregnancy. In the cases we examined both had been seen in accordance with the standards.

- Within gynaecology, staff assessed patients and provided care and treatment in line with recognised guidance, legislation and best practice standards. In gynaecology, the termination of pregnancy care was delivered in line with the "Abortion Act 1967" and supporting guidance issued by the Department of Health.
- The process for the undertaking of termination of pregnancy at The Princess Alexandra Hospital was outstanding. All aspects of the required guidelines and legislation were being adhered to. Evidence presented to us included audits, policies, and service reviews. The staff's understanding of requirements was also outstanding.
- We examined the records of six women in the termination of pregnancy service. We found that the care provided met the requirements of the national standards set by the Royal College of Obstetricians and Gynaecologists relating to procedure, pre-care, consent and support and advice to women. The evidence in the records was exemplary and we were assured that women using this service received care in line with national standards.

Pain relief

- During the inspection, we spoke with six women about their pain. They told us that staff assessed their pain regularly, offered them choice of pain relief when required and that these medicines were given in a timely way. When we looked at care records, we found that pain scores were being used to assess pain and monitor the effectiveness of any analgesia given.
- All staff confirmed that anaesthetists responded promptly to staff requests for specialist pain relief, such as epidurals. Specialist anaesthetists trained in obstetric care were available 24 hours each day.
- We observed two birthing plans in maternity care records, these included discussion about analgesia in labour.
- Entonox (a pain relieving nitrous oxide and oxygen gas) was available to labouring women who required it once assessed.
- Within gynaecology, pain relief was regularly recorded as being discussed with women. This included women admitted through the emergency gynaecology or early pregnancy route as well as when having a termination of pregnancy.
- Within the hysteroscopy service, pain relief was administered alongside local anaesthetic as required by each individual woman.

Nutrition and hydration

- Four antenatal records seen confirmed that staff discussed infant feeding choices with women prior to birth and supported them after the delivery. There was an infant feeding midwife who supported women when making these choices.
- Three midwives reported that they were very proud of the rates of women who commenced breastfeeding after delivery. In May 2016, the breast feeding rate was 65% and for the year April 2015 to March 2016 the breast feeding rate was 73%, which was better than the England average of 66%.
- We checked the refrigerators for the storage of expressed milk and found that this was stored, labelled appropriately and was in date.
- The post-natal areas of the labour suite and birthing unit provided group sessions for mothers on breastfeeding with the midwives.

Patient outcomes

- There were no outliers relating to maternity and gynaecology care at the time of inspection. An outlier is an indication of care or outcomes that are statistically higher or lower than would be expected. They can provide a useful indicator of concerns regarding the care that people receive.
- The healthcare group participated in local and national clinical audits, which included multiple pregnancy, domestic violence and individualised post-natal care plan audits. The trust scored the same or better than the England average on all audits viewed.
- The Maternal Newborn and Infant Clinical Outcome Review Programme (MBRRACE) report for 2015 had been reviewed by the maternity team. Lessons learnt from the review were shared at the trust audit committee, the quarterly women's division meeting and at local governance meetings.
- The Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE-UK) report used data from 2014 and was published on 17 May 2016.There had been a slight fall in the rates of stillbirths and neonatal deaths across the UK compared with rates in 2013 but preterm deliveries continued to be higher than expected.

Maternity and gynaecology

- This trust reported a 10% lower than average stillbirth, neonatal and extended perinatal mortality rates. In the report, the crude stillbirth and neonatal death rates were suppressed as the numbers were so small. The adjusted stillbirth rate was 2.59 per 1000 births, adjusted neonatal death rate 0.95 per 1000 births and the extended perinatal death rate 3.54 per 1000 births. All of these outcomes were better than the expected averages.
- National Neonatal Audit Programme (2014) shows the trust performed better than the England average on four out of five measures. The one measure not achieving 100% was for a documented consultation with parents by a senior member of the neonatal team within 24 hours of admission and was not linked to the maternity service.
- In May 2016, the maternity service had 337 deliveries, 56% of which were normal vaginal deliveries. The caesarean section rate was 26% and of the twin deliveries two out of seven were planned caesarean section.
- The hospital was higher than the England average rate (25%) on caesarean sections with a rate of 28% for April 2015 and March 2016. Plans to reduce this included changes to VBAC services (vaginal birth after caesarean) to reduce this rate. The service had maintained caesarean section rates of 28% for the last three months (April to June 2016).
- The following information represents the proportion of delivery methods from April 2016 and May 2016. Elective caesarean section (7.7%); emergency caesarean section (18.5%); normal vaginal delivery (56.7%); combined forcep and ventouse (16%), forceps (10.2%); ventouse (5.8%). The trust's total caesarean section (CS) rate for the past year was 28%, which was above the England average of 25%. However, there was a clear plan in place to reduce the number of elective caesareans.
- The trust had made changes to the vaginal birth after caesarean (VBAC) to help in the reduction of planned sections which included all induction of labours agreed by a consultant and all women will have to attend a VBAC active birth class. Successful VBAC rates for the service were 39.7% (141 women who achieved a vaginal birth).
- Consultants spoke of the introduction of the induction of labour cervical dilator balloon technique for vaginal birth after caesarean (VBAC) which aims to reduce caesarean section rate further (Cook's Balloon).This procedure has an inflated balloon that sits just inside the womb in the same way a catheter sits in the bladder. This procedure can then make induction of labour possible for women who would not have been able to have the usual methods of induction.
- The teenage midwifery team supported 69 teenage pregnancies in 2015, with 36 teenage pregnancies between January and June 2016.
- Between April 2015 and March 2016, there were seven stillbirths. This had reduced since 2014. Each stillbirth was reviewed as part of the annual audit on stillbirths. All identified clear reasons for the stillbirth and lessons to be learned. The processes for the review of stillbirths and following delivery bereavement were clear and robust.
- The service predicted approximately 1074 deliveries per quarter to maintain the staff establishment at a safe level. In the quarter from January 2016 to March 2016, the service had 1004, which was within that capacity.
- Between April 2015 and March 2016, there were two admissions of mothers to intensive care. Both cases were audited and reviewed.
- Between April 2015 and March 2016, there were 197 unexpected admissions to the neonatal intensive care unit.
- The colposcopy and hysteroscopy service informed us they were on target with patients seen after referral. The data was requested from the trust but remains outstanding. Colposcopy clinics were held daily from 8am to 4pm Monday and Friday with up to 150 patients seen each month. Women could be seen and treated on their first visit. Hysteroscopy clinics were held every Wednesday and Friday morning with some Tuesday afternoon clinics. The service could be accessed by a telephone service available Monday to Friday between 8am and 4pm.

Competent staff

- Records confirmed that 58% of staff currently working in the service had completed an appraisal against a trust target of 50%. Those staff who had not received an appraisal were either booked for appraisal in the coming month, on long term sickness or maternity leave.

Maternity and gynaecology

- All medical staff within maternity and gynaecology were appraised and had undertaken revalidation with the General Medical Council (GMC). The data was requested but not populated on the spreadsheet submitted by the trust.
- Midwifery and nursing staff were supported by their senior colleagues with completing revalidation. Revalidation authorising staff had been identified within the healthcare group and this had been communicated to staff.
- Supervision time was built into consultant rotas to support more junior medical staff.
- Maternity staff received additional mandatory training which included skills and drills training including obstetric emergencies, domestic abuse, breastfeeding and **cardiotocography** training. This was delivered annually. Records confirmed that 96% of staff had achieved this training for 2015 and 2016.
- Training to meet the service delivery had included two additional midwives trained in third trimester scanning to increase the skills capacity.

Maternity

- The trust had provided data, which confirmed a supervisor of midwives ratio of 1:17 for the past 14 months. All midwifery staff we spoke with felt they could readily access a supervisor of midwives.
- The supervisors of midwives (SoMs) had improved their visibility within the unit with a board displayed in the main area of each unit with photos of the SoMs and information about how supervision can provide help and support.
- We spoke with student midwives who told us they had undergone a local induction including the completion of a competency framework and that they were allocated a mentor and SoM during this period. They told us that they felt well supported. The student midwives had no concerns about their training or supervision.
- Eight staff told us that they were supported to gain additional qualifications to maintain their professional development. Examples given included mentorship, third trimester fetal surveillance scanning, master's degree programmes, leadership and post mortem training.
- While the trust did not have a dedicated gynaecology ward, the gynaecology service had provided dedicated training to the staff nurses on the female surgical ward Penn. This supported staff with meeting the needs of women with a gynaecological condition. However, senior staff informed us that no staff had completed the gynaecology module at university as requested at the last service review.

Multidisciplinary working

- We observed that staff across all disciplines worked effectively together, both internally and in the community. There were detailed multidisciplinary (MDT) team meetings, which supported and developed effective care and treatment plans and handover of patient care.
- Care and treatment plans were documented and communicated to relevant health care professionals, for example general practitioners (GPs) and health visitors, to ensure continuity of care.
- Five staff from the surgical healthcare group informed us that the groups worked well together and that support from maternity was good.
- Staff from children's services all participated in the monthly perinatal mortality meetings and communicated with one another regularly.
- The gynaecology service worked exceptionally well with the rest of the hospital and had established links with all surgical wards, the emergency department and paediatric services. This was supported with the gynaecology team attending ward rounds for their patients.
- Staff from outside this service did inform us that they had been invited to attend the gynaecology briefing sessions held but were not able to attend due to their own ward area patient activity.
- Community midwifery services had provided cover for the wards when they were short staffed or busy. This meant they were able to maintain their skills and knowledge when working within the hospital environment.

Seven-day services

- Medical staff were on call 24 hours per day. Staff we spoke to said the consultants were frequently in at weekends.
- The midwife led birthing unit was open seven days per week 24 hours a day and was located within the main maternity service.

- There was an obstetric trained anaesthetist available on site 24 hours a day, seven days per week with an on call service for out of hours.
- Antenatal services were available 8am to 6pm, Monday to Friday with weekends and out of hours service supported by the on call and community services.
- There was a supervisor of midwives (SOM) available 24 hours a day, seven days a week through an on-call rota system. This ensured that midwives had access to a SOM at all times.
- Gynaecology ambulatory services were only available Monday to Friday 9am to 6pm but we were informed that with the recruitment of additional staff starting in July 2016 the department opening hours would be extended.
- The emergency pregnancy assessment unit was open seven days per week, 9am to 6pm with support from the emergency department.

Access to information

- Records were readily available to staff to refer to during the time of a woman's admission.
- Staff access patient record systems through the use of NHS smart cards. This enabled them access to the pathology results, and radiography imaging results.
- Staff who worked for agency were unable to access this system and were required to speak with a member of trust staff to access the IT systems.
- Information was kept as confidential as possible, given the structure and design of the building, which was old. This meant that the storage of records and protection of patient identity on information boards was not always possible. However, the staff minimised the risks to patient confidentiality concerns where possible.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Consent to care and treatment was obtained in line with national legislation and guidance, including the Mental Capacity Act (2005). The trust had policies in place regarding these subjects and they were accessible to staff via the intranet.
- Training on consent, the Mental Capacity Act, Deprivation of Liberty Safeguards (2009) and learning disability was part of mandatory training and available via an e-learning programme with 91% of midwives,100% of early pregnancy unit and colposcopy staff and 84% of medical staff completing the training from January 2015 to June 2016.
- Four staff spoken with were aware of the assessment criteria needed to assess capacity and also understood that capacity could change. Staff understood the decision making processes for people lacking capacity to be in their best interests and knew who to contact should they need further support in relation to these procedures.
- The trust audit on consent for termination of pregnancy in 2015 achieved 100% compliance with national standards and legislation. Four staff spoken with were aware of the Gillick competence and Fraser guidelines, they knew how to assess whether a patient under the age of 16 was able to consent to their treatment without the permission or knowledge of their parents. Gillick competence is the principle used to judge capacity in children to consent to medical treatment. Fraser guidelines are used specifically for children requesting contraceptive or sexual health advice or treatment.

Are maternity and gynaecology services caring?

Outstanding ☆

The maternity service was rated as outstanding for being caring because:

- Staff providing both maternity and gynaecology care were dedicated, compassionate, caring and they consistently went beyond the call of duty to deliver the best experience possible for the women.
- We spoke with nine women during the inspection. All provided us with positive feedback about the staff who cared for them. Women said that staff protected their privacy and dignity at all times and respectful care was observed in all areas visited.
- The maternity survey results were in line with the England average in all areas.
- The Friends and Family Test was consistently above the England average for scores in all aspects of antenatal, birth and postnatal care. The service consistently received more compliments than complaints.

- Women, their partners and families were active participants in their care and were encouraged through education and support to plan and prepare for their pregnancy, birth and their post birth experience. The services provided outstanding bereavement support to women who experienced miscarriage or the loss of their baby.
- The processes for emotional support to women who terminate pregnancies was also outstanding because staff had carefully considered the experience of women for their pathway of care to place them at ease.
- The gynaecology outpatient service provided outstanding care for women who used the service. Women who used the service, those close to them and stakeholders all gave positive feedback about the way staff treated women.
- Patients' multi-faith spiritual beliefs were catered for and the hospital had a dedicated chaplaincy service who supported women across the service.
- The in-patient feedback relating to the gynaecology service including the women's health unit was good and one patient gave an example of how a consultant had gone beyond what was expected of her role to reassure the patient who had missed a private appointment.
- All gynaecological patients spoken with in the gynaecology ambulatory, early pregnancy and termination of pregnancy service were positive and expressed their confidence in the safety and care offered to them from this service.

Compassionate care

- The Petal counselling service supported staff raising money to soundproof the bereavement room, situated outside of the antenatal ward. Staff placed a "Star" outside of the door when the room was occupied to avoid unnecessary disturbance, which was good.
- The maternity service Friends and Family Test scores demonstrated that the service was consistently performing better than the England average with 100% scored on antenatal care, 98% on post-natal care, 100% on postnatal care in the community and 98% on birth experience.
- The Friends and Family Test results for the service showed that on average the trust received 100 to 150 responses each month and the results, in the majority, were very positive about the service provided.
- The CQC maternity survey results published December 2014 showed that the trust performed about the same on most questions when compared to other trusts in England and better than most trusts on one question.
- Six women spoken with during the course of the inspection were highly complementary about the care that they had received in the maternity service, throughout their antenatal care, birth and post-natal care. Some of the women confirmed that they had been recommended to this service and that it was their preferred choice to attend this service. Three gynaecology women commended the team for the care they had received.
- To deliver a compassionate gynaecology service, the surgical nursing team had requested to complete the specialist module in gynaecological training.
- All patient feedback was extremely positive, "Staff are friendly, kind and passionate about the excellent care they provide", "The staff went out of her way to reduce my anxiety by explaining what was going to happen and make sure I understood", "All staff looked after me and I felt my dignity and respect were met throughout my stay".

Understanding and involvement of patients and those close to them

- We spoke with six women within the service who were able to identify their named midwife and confirmed they had been accessible throughout their pregnancy.
- Three sets of birth plans were reviewed and documentation showed that women had discussed with the staff their plans of care.
- Women were able to be actively involved in the development and preparation of their birth plans and were encouraged and educated to explore all their options for the birth plan. This included tours of the units and discussions with the teams in the community, labour ward and in the midwife led birth unit.
- Women and their families said they had been fully involved and included in the care given.
- Maternity staff were heard talking with the women and discussing the options available for feeding following the birth.

- The maternity service put classes on throughout the service to cover ante natal birthing and post- natal classes including breast feeding classes and what to expect in the first eight weeks after the mother goes home.
- All observations charts seen were completed correctly, including neonatal observations.
- There was a lead nurse and midwife for safeguarding and a specialist midwife for learning disabilities, to support vulnerable women and staff who cared for these women.
- All women were complimentary about the way in which staff had provided care and spoken to them.
- Doctors, midwives and nursing staff were seen introducing themselves to patients using the "my name is" approach.

Emotional support

- We observed many examples of kind, caring compassionate interactions by the midwives who were dedicated to delivering the care the women needed before, during and after their birth.
- The services within maternity had dedicated staff who could provide emotional and counselling support to women who go through the loss of a baby before or after birth. The service provision available to support the emotional wellbeing of women was impressive, with a dedicated bereavement midwife.
- Within gynaecology and the termination of pregnancy service, staff had thought and considered all aspects of emotional care and support that would be required to women following the loss of a baby. The staff showed us the pathways they set up to support women's emotional wellbeing, which was an outstanding element of care.
- After any termination procedure either through the women's choice or for medical reasons, the women attended an initial appointment with the consultant who provided their care to discuss any questions that they may have. We were told by one consultant that they hold the sessions to give the woman the opportunity to speak freely as it can help them in the long term.
- The same service was provided to any woman who loses a baby at any gestational stage. There was a clear focus to holistically provide emotional support to women to understand what happened to them.
- Two women spoken to had attended the early pregnancy unit (EPU) and the gynaecology ambulatory medical unit (GAMU) they gave us an example where staff had gone beyond what they had expected in supporting the women. One example was from a woman who was distressed in missing another private appointment and the consultant had contacted that area and downloaded a leaflet with options available to avoid her disappointment, this was good.

Are maternity and gynaecology services responsive?

Good

The maternity service was good for responsive because:

- The service had actively planned how to manage the fluctuating and increasing demand on service capacity.
- The services were delivered working in partnership with commissioning teams and community services within Essex and across the Hertfordshire borders. Access to the service was through a simple route, which enabled women to be seen by the medical teams soon after arrival.
- The waiting times for emergency and elective gynaecology were good and meant that patient's pathways were generally delivered within 18 weeks.
- The service had a robust process for recognising investigating and learning from complaints. The service monitored its complaints and offered a personalised approach to investigating women's concerns to find a suitable resolution. The service consistently received more compliments than complaints.
- The service had developed the gynaecology outpatient provision into a standalone service working within the women's healthcare group which was outstanding. This had a significant benefit to the care and pathway experienced by women using this service.

However, we also found:

- No gynaecology ward meant that we found 1,522 in-patients had been admitted in the last six months and were cared for on seven different wards. The lack of a gynaecology in-patient ward meant that women did not always receive timely care while accommodated in various wards across the trust.

Service planning and delivery to meet the needs of local people

Maternity and gynaecology

- The service was working with local health groups and commissioners regarding the delivery of the service. The Daisy project saw increasing numbers of women reporting domestic abuse within the emergency and maternity services. This service was designed and delivered to meet the needs of local people within the Harlow area.
- The service had calculated a maximum limit of 1125 births per quarter. In the quarter ending in June 2016 had 1009 births, which is within the limits for capacity.
- Plans were in place with local commissioners to look to the future of how maternity services will be delivered when capacity is reached.
- The gynaecology service consisted of a team of dedicated gynaecology doctors and nurses with experience of working in this area. This has had a significant impact on the development and growth of the gynaecology service, which was good.
- The maternity NHS patient survey 2015 showed this trust was the ninth best performing maternity service out of 64 and that they were the second most improved overall maternity service since the last survey was completed in 2013, which was good.

Access and flow

- Both services had access to intensive care facilities should a woman's condition deteriorate.
- Bed occupancy for the service was much higher than the England average since 2013 at 73%; the data for 2015/16 showed a bed occupancy rate of 82%, which is much higher than the England average of 65% for this quarter.
- Between April 2015 and June 2016, the service did not close to new admissions.
- There was no scan service in the early pregnancy unit (EPU) in the afternoon session; this could delay patient treatment or diagnosis. Staff told us of the appointment of a registered general nurse who would support this service.
- There was no family planning service provided within the trust, which meant women did not have a complete service.
- Since April 2015, the referral to treatment time (RTT) for both admitted and non-admitted gynaecological patients had been around 93%. RTTs mean that patients have the right to start their NHS consultant-led treatment within a maximum of 18 weeks from referral.
- With no dedicated gynaecology ward capacity demands in the hospital, this meant gynaecological patients were admitted to any available bed. While the trust tried to place gynaecology women on one ward (Penn ward) this was not achieved. Inpatient oncology care has been reported on within the surgery service of this report.
- A recent improvement involved the on call matrons identifying on the white board in the patient placement office, all women admitted out of hours by speciality. This meant that the gynaecology matron should be able to follow up those patients and ensure they received an appropriate and safe patient experience outside of this service. We observed a white board within the patient placement site office, with details of where gynaecology women were placed.
- On reviewing gynaecology inpatient placement between January and June 2016, we found that women were admitted across seven different wards and specialties where staff did not have specialist gynaecology training.

Meeting people's individual needs

- The trust had 24 hour access to a translation service. Further support services were available for those who were visually impaired, blind, or deaf. Staff were aware of how to access these services if needed.
- The service had a range of patient information literature available to read in the maternity and gynaecology waiting areas and for them to take home to read as well. Information, which provided links to websites and groups outside of the trust were also made available.
- Staff spoke of the future introduction of applications or apps to support women from antenatal care to post delivery. This would help to engage them more in the processes of birth.
- One of the birthing unit rooms was known as the Daisy room, which was used by women not associated with domestic violence, which could cause confusion or distress.
- We saw a system that allocated protected scan slots to women attending accident and emergency over the weekend or out of hours when the ambulatory service was closed. However, a woman shared her experience where she had to wait between four and five hours in the accident and emergency department when gynaecology ambulatory and early pregnancy service was closed at the weekend. This pathway concern should be addressed by the service.

- Across the gynaecology service there were no identified champions for end of life care, domestic violence or female genital mutilation (FGM).
- There was a low bed for patients with mobility or disability restrictions with an attached cot to the side of the bed for patient ease with caring for her new born.
- The service was able to offer a range of birthing options to meet the needs of women. Home births were available and the service undertook 44 between April 2015 and March 2016. This was 1.28% compared to the national average rate of 2%.
- Water births were available and between April 2015 and March 2016, the service delivered 321 babies during water births.
- The maternity medical and midwifery staff offered a range of specialist obstetric-led clinics for women. This included a diabetic, hypertension, vaginal birth after caesarean section (VBAC), sickle cell, fetal abnormality and drug and alcohol clinics.
- Women were further supported by specialist midwives such as the safeguarding, teenage pregnancy, substance misuse, and a diabetic specialist midwife. The learning and disability team worked closely to support women across the trust.
- The perinatal mental health team were not known across the whole service and although we were informed there was no dedicated midwife, evidence submitted from the service confirmed there was a specialist midwife to support the two consultants who led this team. The trust reported high rates of women attending with a mental health concern.
- There was a bereavement room for women that would meet their needs and offered further privacy. The room was big enough that it allowed the partner or member of the family to stay with the woman should she choose. Staff described how they supported local charities in raising funds to facilitate this room in being soundproofed.
- The lack of protected beds or an identified gynaecology ward meant that women's individual needs as in-patients were not always addressed in a timely manner.
- The termination of pregnancy service was medically offered up to 10 weeks gestation and then surgically up to 14 weeks. Terminations post 14 weeks were outsourced to a private healthcare service in the area.
- The waiting rooms for the emergency gynaecology, emergency pregnancy and termination service were in the same area. However, staff described how they supported patient confidentiality and checked women into the service. This involved an assessment of emotional wellbeing. This meant that they account for the women's emotional state and anyone identified as being 'at risk' or concerned by this arrangement would be taken to another waiting area. This was very responsive to their needs.

Learning from complaints and concerns

- There were no open Parliamentary Health Service Ombudsman (PHSO) complaints at the time of our inspection.
- Lessons learned from complaints were shared at the daily risk meetings, monthly governance and audit meetings and at local team meetings and supervision meetings. We saw minutes of a selection of these meetings which assured us that learning from complaints was a regular item of discussion for the service.
- Between April 2015 and March 2016, the service received 10 complaints in maternity and 20 in gynaecology, with 354 compliments also received. Each complaint was investigated locally between the midwife and a doctor where appropriate.
- For each complaint, the person was invited in to discuss their concerns in detail and to try and find a resolution to the concerns being raised.
- We reviewed two complaint responses sent to the women who complained and each one had a clear and detailed investigation. The complainant was offered an apology, where appropriate, and answers to their questions provided.

Are maternity and gynaecology services well-led?

Outstanding ☆

The maternity service leadership locally was rated as outstanding for being well-led because:

- Staff were aware of the trust's vision and values, which were displayed on posters in prominent areas throughout the hospital, in corridors, ward areas and on notice boards during this inspection.

Maternity and gynaecology

- Both the medical midwifery and operational leadership team were respected and staff spoke highly of the clinical leads for the service and how involved and approachable they were, which created an open culture.
- It was evident that staff worked well together within the service. Staff described how their objective was to be an outstanding service and how they continually looked to improve the experience for women.
- Governance and risk management systems within maternity and gynaecology services were robust and well established. Staff knew how to escalate concerns relating to risk and clinical governance. Risks were added to the risk register, monitored, managed with clear actions in place to minimise risk.
- The service worked well with engaging with the women who used this service, linking with local mother and baby groups to seek feedback on services provided by the hospital.
- Governance and risk management systems within maternity and gynaecology services were robust and well established, which provided a level of assurance to the trust on the provision of maternity and gynaecology.

Vision and strategy for this service

- There was a vision and strategy for the trust, which was displayed throughout the hospital during our inspection. When we spoke with staff they were all aware of the trust's vision, strategy and values. The vision aimed for staff to provide the highest standard of care and support within this service and the community team**.**
- The trust vision and values were displayed on posters in prominent areas of the trust and were seen in corridors, ward areas and on notice boards**.**
- Locally there was a clear vision for the service, which was their journey to outstanding. The service was continually looking for ways to learn from women's experiences, guidance, reports and improve the service they provided.
- There was also a vision to expand the service and improve facilities. However, there were no confirmed plans established for the move of the maternity service.

Governance, risk management and quality measurement

- The service held monthly governance meetings where quality issues such as complaints, incidents, audit activity and research were discussed. Staff were able to feedback learning from incidents and how they were shared with staff.
- The policies and procedures which related to The National Institute of Health and Care Excellence or Royal College guidelines were regularly updated.
- The risk register dated April 2016 for maternity was reviewed and clearly identified the risks currently affecting maternity and gynaecology. All the risks identified in the service, including the one emergency theatre, HDU support and gynaecology inpatient care were identified during the inspection. The risk register detailed the risks and what measures were being taken to mitigate risks where possible. There was a clear escalation process for high graded risks.
- The service held quarterly governance and audit meetings where incidents, serious incidents, the maternity dashboards, complaints and audit presentations were discussed. We reviewed the last meeting minutes which evidenced that the meetings were well attended.
- Staff knew how to escalate concerns relating to risk and clinical governance.
- Governance was focused on the ward to board approach with strong communication channels through the quality and safety meetings.

Leadership of service

- The service was led by a clinical director, a head of midwifery and a director of operations. This team were supported by senior clinical and operations staff on the day to day running of the service. There was a clinical lead for obstetrics and a clinical lead for gynaecology.
- The leadership team were respected amongst their peers and worked well together. Staff working within the units recognised who the leads for the service and clinical leads for specialties were. All staff we spoke with were positive about all of the service leaders and how they ran the service.
- The matrons within the maternity service were known by staff and felt confident to raise any concerns with them, which would be addressed.
- Although not all staff could name the chief executive officer (CEO), they agreed that they and the Chief Nurse were visible and approachable.

- The leadership across the service worked well, with effective multidisciplinary communication to provide a good service.
- A student nurse told us that she found all the senior staff supportive and approachable.
- Staff spoke highly of the consultants who they said went beyond their expectations and above and beyond the call of duty to provide a good service.
- When we spoke with the executive team about their understanding of risks within women's services, they were aware of the concerns with the placement of gynaecology patients. However, they explained that the priority of incoming patients was to find them a bed as soon as possible, and that they had not achieved delivery of an inpatient women's' service. They recognised that this was not responsive to the needs of women. However, they had no formal plan to address this. This was not supportive to the women's health service.

Culture within the service

- There was a very open culture within the service and staff were very willing to speak freely about what worked well in their service and about what did not work well. There was a culture of willingness to listen to staff concerns within the healthcare group.
- Staff confirmed they are aware how to escalate concerns and felt able to speak out.
- The CEO had introduced an 'Open Conversation' where staff can speak freely regarding their concerns directly with him.
- The hospital executive team completed walk arounds to engage with staff.
- There was an anonymous feedback email system provided by the trust for staff to log their concerns. Those themes and actions were reported back to the staff on the hospital intranet.
- All staff informed us that they were supported when raising concerns and there was a whistleblowing policy for the trust which all were aware of and knew how to escalate a concern.
- Staff had attended equality and diversity training as part of mandatory training which included workforce racial equality training.
- The gynaecology leadership team were not supported in getting their voice heard about the importance of having dedicated beds for women admitted for gynaecological reasons. The spread of women throughout the hospital meant that the team spent time walking between wards where the women had been admitted.

Public engagement

- The service worked with local mother and baby groups to establish post birth support streams for women who used the service. The trust also utilised these groups to seek feedback about their experiences and how the service could be improved.
- Women, their partners, their families and carers were encouraged to engage with the service. There were posters displaying how to do this and suggestion boxes were observed throughout the units. People were also encouraged to complete the Friends and Family Test with points to do this displayed throughout the service where coin style tokens were put into the appropriate response box, for example highly recommend.
- The service worked with women to seek feedback for improvements. An example of where this feedback had gone on to improve the service was the extended opening hours for the gynaecology ambulatory service. This was changed based on the feedback of women.

Staff engagement

- Long service in the trust was acknowledged, and awards were given to staff in recognition of their contribution and dedication.
- Staff had been encouraged to contribute to the service by engaging in projects and learning opportunities, which would benefit the service and their long term development. An example was the care of the women with multiple pregnancies.
- Senior staff encouraged staff to attend the morning risk meetings, monthly governance, audit and team meetings as well where information would be shared.
- All staff were sent a maternity newsletter with up to date information to engage them in what was going on within the service.

Innovation, improvement and sustainability

- There was a review of the maternity software application for women to download. This would support them and reduce anxiety during pregnancy.

Maternity and gynaecology

- Staff looked at ways to support and improve the service received by women, an example was soundproofing the bereavement room to reduce noise levels further within this area.
- The set up and establishment of the standalone outpatient gynaecology ambulatory service was innovative and completely responsive to the needs of women who self- referred.
- The trust's operational meeting now identifies in-patients admitted overnight following gynaecological referral by ward.

Services for children and young people

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

Information about the service

The Princess Alexandra Hospital provides services for children and young people, comprising of a children's ward named Dolphin ward, a neonatal unit, a day surgery service and a children's outpatient service.

Dolphin ward has 20 beds across seven cubicles and two bays, and includes a four bedded ambulatory care bay. The neonatal unit has 16 cots inclusive of 10 level special care cots and six cots for intensive therapy or high dependency care. The neonatal unit provides level two care and supports transfer of babies requiring level three care to specialist units in neighbouring trusts.

Children requiring day surgery are cared for in any of the five dedicated children's beds in the day surgery unit.

There were 2259 inpatient admissions for the period August 2015 to May 2016. Elective admissions were lower than the England average of 9%, at 7%. Emergency admissions were higher than the England average of 67%, at 93%.

During our inspection we spoke with 12 nursing staff, five medical staff, and seven staff in senior managerial roles. We spoke with nine sets of parents and their children, and we reviewed 17 sets of medical records and 15 separate prescription cards. We visited Dolphin ward, the neonatal unit, theatres and recovery, the day surgery unit and the children's outpatients department.

Summary of findings

Children and young people's services were rated as requires improvement overall, with the safe domain rated as inadequate, well-led rated as requires improvement, and the remaining domains rated as good.

- The service was rated as inadequate for safety because root cause analysis investigations and three day investigation reports were not always complete to a good standard.
- We were concerned that there was a lack of grip from the leaders of this service in regards to management monitoring and actions regarding the safeguarding of children. There were significant risks for safeguarding children that were thematic and were similar to themes from the last inspection that had not been addressed.
- Daily safety checks for emergency trolleys, controlled drugs and drug fridge temperatures were not consistently completed. This was reflective of a poor culture on Dolphin ward and the neonatal unit around daily checks.
- An audit into antibiotics usage on the neonatal unit showed that babies waited over double the time recommended to receive antibiotics when required.
- Processes for safeguarding children were not robust, as reflected by five serious safeguarding incidents. This was a long standing issue from our previous inspection.

Services for children and young people

- Mandatory training levels were below the trust target across the service, and were at their lowest for medical staff.
- The service was not in line with Royal College of Nursing guidelines relating to staff training levels for life support training.
- The transition service was disjointed for long term conditions and the service did not have a transition nurse, with provision in place for diabetic children but not epileptic children.
- Staff were not trained in supporting children with mental health problems despite mentally unwell children regularly being admitted to the ward.
- Response rates for the Friends and Family Test were very low and did not give any context to the results of the survey. Parents and carers on the neonatal unit felt that communication was lacking.
- Arrangement of the environment in the day surgery unit and recovery areas meant that children had to walk past adult areas to get to the anaesthetic room, and adults in recovery would often directly face the children's bay.

However;

- The service was active in managing medicines related incidents and had created a pathway in response to a high number of incidents, with the approval of the board.
- Staff knew how and when to report incidents. Mortality and morbidity were regularly presented at meetings, where learning was discussed and shared.
- Whilst vacancy rates were high for nursing staff, the service was actively filling shifts with bank and agency staff to ensure there were enough staff.
- A comprehensive audit plan was in place for the service, which included participation in national audits. The service had worked with the local neonatal network to create a first hour of care pathway for neonates. The children's diabetes service was in receipt of the best practice tariff for diabetes, indicating that a good standard of care were being delivered.
- There was a 24 hour a day, seven days a week pain team accessible to the service as required. Staff development was evident when talking to individual staff, and staff were supported in both appraisal and revalidation.
- There was established multidisciplinary working throughout the service, which was consistently recorded in patients' notes. A seven day service was established and pharmacy, physiotherapy and radiological support were available through an on call rota out of hours.
- Parents consistently fed back to us that staff had caring natures and respected the privacy of their children and themselves. Parents felt informed and involved in their children's care on Dolphin ward.
- Referral to treatment times had improved greatly from our past inspection.
- The neonatal unit used the support of the neonatal network to help with capacity in times of high demand by transferring clinically appropriate babies to other neonatal units.
- Child friendly play spaces, adolescent designed relaxation space and games room, separate bays in theatre recovery for children and provision of parents' facilities on Dolphin ward and the neonatal unit were all ways that the service responded to individual need.
- There was a good understanding of complaints and learning at local level.
- Clinical governance issues were presented and discussed at monthly meetings, where learning was shared.
- The local leadership of Dolphin ward and the neonatal unit was strong and supportive of staff. The matron and head of children's nursing provided supportive leadership to the ward managers. Both Dolphin ward and the neonatal unit had a nominated employee of the month scheme in place.

Services for children and young people

Are services for children and young people safe?

Inadequate

Safe was rated as inadequate in the children and young people's services because;

- The recording of investigations into serious incidents was not of a good quality.
- Processes for safeguarding children were not robust, as reflected by five serious safeguarding incidents in the last year, which had not been appropriately acted upon. This was a long standing issue from our previous inspection.
- Daily safety checks for emergency trolleys, controlled drugs and drug fridge temperatures were not consistently completed on Dolphin ward and the neonatal unit.
- There were high numbers of medicines related incidents on both Dolphin ward and the neonatal unit.
- Neonates were waiting over double the time recommended to receive antibiotics when required.
- There were insufficient levels of training across nursing and medical staff in life support and awareness training with 59% of nursing staff trained in basic life support (BLS), and 3% were trained in European paediatric life support (EPLS). No staff were trained in paediatric immediate life support (PILS). Sixty-one per cent of medical staff had advanced paediatric life support (APLS) training. However, no medical staff were trained in PILS, BLS, or EPLS.
- Mandatory training levels were below the trust target of 95% across the service. Nursing staff across Dolphin ward and the neonatal unit achieved 83% compliance and medical staff achieved 62% compliance.

However;

- Staff had a good understanding of how and when to report incidents. However, there was a concern with staff reporting safeguarding children events where required.
- Mortality and morbidity for the service was presented and discussed regularly with shared learning well recorded.
- Nursing staff vacancies were high across the service. However, the service was actively managing this with the use of bank and agency staff so that safe care could be provided.
- A pathway had been implemented for the management of medicines related incidents and the staff responsible for them.
- Oxygen therapy and intravenous flushes were prescribed on the neonatal unit in line with the British National Formulary for Children 2016.

Incidents

- Staff working on both Dolphin ward and the neonatal unit understood how and when to report incidents. There was a good understanding of incident trends and evidence of action taken, and learning from these trends. This was an improvement from our previous inspection where staff were not always clear about what incidents had occurred or what lessons had been learnt.
- For the period March 2015 to June 2016 there had been no reported never events. Never Events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.There were six reported serious incidents (SI's), one regarding a delay in treatment on the neonatal unit, and five safeguarding incidents. Whilst there was a process in place for the reporting and investigation of SI's, we were not assured of the quality of the recording of these. Out of the six SI's, three reports were poorly completed. One three-day report contained sparse detail of a serious incident and was completed six and a half months after the incident date, and one root case analysis (RCA) had conflicting information regarding at what gestation a baby was born, and one three-day report 18 days after the incident date
- Actions and learning were in place for the SI's. For example, one SI had led to the development of a trigger list on the neonatal unit (NNU) that helped staff to be clear on how and when to escalate concerns to a consultant. Senior nurses had also been supported through leadership competencies to know how to manage escalation.
- For the period March 2015 to February 2016 two falls and one pressure ulcer were reported to the NHS safety thermometer. The safety thermometer is a tool to measure and monitor harm in care and looks at falls,

pressure ulcers, urinary tract infections (UTI's) in people with catheters in place, and venous thromboembolisms (VTE). The falls were both incidences of children running in the service's environment and falling over, sustaining minor upper limb injuries.

- The pressure ulcer was on the ear of a 3 year old child who had not been turned regularly. Learning included the improvement of communication and explanation of care to parents. The aim was to improve their understanding of why turning patients was important for their skin integrity. There were no incidences of UTI's with indwelling catheters, and no incidences of VTE in the service.
- Mortality and morbidity cases were shared and discussed at regular monthly meetings. We reviewed the minutes for the January and March 2016 meetings and noted that cases were presented by medical staff for discussion and learning. Minutes of the monthly patient safety and quality meetings showed that mortality and morbidity meeting minutes were also shared in this forum.
- The hospital has reported that there have been no deaths, either expected or unexpected, of any child on the children's ward or on the neonatal unit between April 2015 to March 2016.
- Duty of candour was understood. In four medicines related incidents on the NNU, duty of candour had been completed in each case.

Cleanliness, infection control and hygiene

- Both Dolphin ward and the neonatal unit (NNU) had an infection prevention and control (IPC) link nurse in post. Their role was to coordinate the IPC audits in the environment, link to and communicate with the IPC team and attend IPC meetings along with the matron.
- The service achieved 100% compliance to MRSA screening in January 2016. The trust did not provide us with screening data for the children's service after February 2016.
- For the period April 2015 to March 2016 there was one case of MRSA on Dolphin ward in January 2016. However, this was not apportioned to the trust. There were no cases of Clostridium difficile (C Diff) in the same time period.
- Dolphin ward and the NNU consistently achieved between 98 and 100% compliance in monthly hand hygiene self-assessment audits for the period April 2015 to March 2016. The compliance target was set at 98%.
- 'Cross over' audits took place throughout the year where clinical areas audited their peers. In September 2015 and March 2016 NNU achieved 100% in the peer audits. However, Dolphin achieved 83% in September 2015 and 78% in March 2016 and 86% in another audit in May 2016. The IPC team supported the ward with putting actions into place and assessed improvements in the re-audit cycle.
- We observed nursing staff using hand hygiene techniques and wearing personal and protective equipment such as aprons and gloves throughout our inspection.
- In the period from February 2016 to May 2016, the NNU consistently achieved a score of 100% in the prevention of peripheral line infections audit. Dolphin ward only submitted data in May 2016 and achieved 90% compliance against a set target of 100%.
- For the period March 2016 to May 2016, there was an improvement in compliance for environmental cleaning audits. The compliance targets was set at 95% for Dolphin ward, and the ward achieved 94%, 98% and 98% for those three months respectively. The compliance target was set at 98% for the NNU, and the unit achieved 96%, 94% and 97%.
- For the period January 2016 to May 2016, Dolphin ward achieved between 94% and 99% in its facilities cleaning audit. NNU achieved between 92% and 97%.

Environment and equipment

- Emergency resuscitation trolleys were not consistently checked throughout the service. This meant that the service could not always be sure that emergency equipment was available and in working order if it was required.
- The intubation trolley on the neonatal unit (NNU) was supposed to receive twice daily checks. For the period 23rd May to 23rd June 2016, there were 19 omissions, which meant that the trolley had approximately 70% of the scheduled checks.
- The resuscitation trolley on Dolphin ward was not checked for four days between 23rd May to 23rd June 2016.
- The resuscitation trolley in the children's outpatients department was missing one check on a clinic day, although an arterial syringe was noted as being out of date and in need of replacement on 6th May 2016. Confirmation of its replacement was not documented until 28th June 2016.

- Logs of equipment servicing and repairs were kept on wards. These included detail of identification and location of the equipment being serviced or repaired, the work done on that equipment, the technician who did the work and the date. This was in line with the trust's own policy for the management of medical devices and equipment. Five pieces of equipment were checked on NNU, four were within date of their last service and electrical safety tests. One glucometer was out of date and this was raised with the ward manager who removed it from use.
- There was a locked fridge for expressed breast milk on the NNU. Daily checks of the fridge temperature were missed for two weeks in May 2016. A second milk fridge on the unit had no omissions in its daily checks. Daily checks of the fridge for expressed breast milk on Dolphin ward were consistently done for the period February 2016 to June 2016.
- Equipment in theatre and DSU for suction and the delivery of oxygen was the appropriate size for children. This meant that in an emergency, children could be treated with equipment that was the right size for their bodies.
- In the Care Quality Commission's 2014 children and young people's survey, parents and carers felt that the ward had appropriate equipment and adaptations for their children. This was in line with other trusts.
- There was secured access to and from both Dolphin ward and the neonatal unit. This meant that there was less risk of children absconding from the inpatient areas, and less chance of child abduction occurring.

Medicines

- For the period April 2015 to March 2016, there were 70 medicines related incidents in the service. Forty-six of these occurred on Dolphin ward and 24 occurred on the neonatal unit (NNU). This had been put onto the service's risk register. An action plan was created and presented to the patient safety and quality meeting.
- Actions to improve this trend on Dolphin ward included relevant nurses undertaking supervised practice. Supervised practice included the completion of a supervision booklet with a reflective piece to write. Red tabards with 'please do not disturb' written on them were also introduced for nurses working with medicines. However, we were not assured that data provided by the trust was accurate, and we could not corroborate whether medicines related incidents had decreased on Dolphin ward.
- A pathway was in place for managing medication errors made by nurses. A flow chart was established for the escalation of incidents and how to manage them. A first occurrence would be reported onto the electronic incident reporting system with duty of candour to be considered. A reflective piece of writing was also required. Second occurrences led to a competency review by the practice development nurse. Third occurrences led to supervised practice with an action plan, a letter, and a meeting with the human resources department.
- An amendment in the guidelines for the use of a specific antibiotic had led to an increase in medicines related incidents on the NNU. There had been four cases of omissions in the two weeks prior to our inspection. A plan was due to be rolled out to explore staff knowledge and educate them of the new guidelines at the next team meeting. Auditing of the checklists for this specific antibiotic was due to commence too. This meant that there was fast recognition of medicines related incident trends and this was managed in a timely manner.
- The use of antibiotics was audited on NNU, which showed that babies were waiting an average of two hours and four minutes for antibiotics to be prescribed and administered, which does not achieve the one hour recommendation in the National Institute for Health and Care Excellence (NICE) clinical guideline 'Neonatal infection: antibiotics for prevention and treatment'. Recommendations were set out in the audit report with the plan to re-audit to assess improvement.
- Controlled drugs, which are drugs that have their supply and storage controlled under the misuse of drugs legislation, were not consistently checked on Dolphin ward. For the period 23rd May to 23rd June 2016, twice daily checks were only achieved on eight days. The remaining days only had one check. Twice daily checks of controlled drugs on the neonatal unit were consistently achieved.
- Checks of the drugs fridge temperature were not consistently done. For the period 23rd May to 23rd June 2016, temperature checks were not recorded for seven days.

- Medicines were stored securely throughout the service. Medicines and controlled drugs were stored in locked cupboards with access to the medicines limited to one registered nurse key holder on each shift.
- Drugs cupboards, with the exception of controlled drugs cupboards, were locked with a padlock on Dolphin ward. However, the padlock did not provide tight and robust security, with space to reach behind the cupboard doors with a hand. This was reported to the estates department and placed on the risk register.
- We reviewed 15 sets of prescription cards, five on the NNU and 10 on Dolphin ward. All cards were completed appropriately and included signatures and dates for entries, allergies documented, reasons documented for any omissions, legible recordings, weights recorded and age/gestations recorded.
- There was recorded evidence of the pharmacist checking prescription cards on a daily basis, sometimes more frequently, on the NNU. This meant that the NNU were less likely to have prescribing errors due to frequent checks.
- There was good practice of oxygen and intravenous flushes being prescribed on the NNU in line with the British National Formulary for Children 2016.

Records

- Records were consistently well completed throughout the service. We reviewed 17 sets in total. Of those 17, seven records had no bleep number recorded for the doctor who wrote an entry.
- All records had diagnosis and management plans documented; evidence of daily ward rounds; and evidence of multidisciplinary team involvement documented.
- The neonatal unit (NNU) records were audited and showed that communication with parents and responses to nurses' requests were not well documented.
- Recommendations were put in place with a plan to re-audit for effectiveness of the actions. A re-audit in October 2015 showed an improvement in recording responses to nurses' requests but that recording communication with parents still required improvement.
- Ten of the 17 records we reviewed were on the NNU. Of those 10 we saw evidence of communication with parents recorded in eight sets. This indicated that improvements had taken place since the re-audit.
- There was a patient journey whiteboard on Dolphin ward. The whiteboard was supposed to give a picture of each patient's progress through their discharge planning. However, the whiteboard was missing information at the time of our inspection. This meant that staff may not have immediate access to the information around a patient's progress towards their discharge.

Safeguarding

- The processes for the safeguarding of children were not robust. Whilst the processes were in place for the escalation and reporting of safeguarding concerns, five safeguarding serious incidents (SI's) had occurred in the period March 2015 to June 2016. This indicates that the concerns around safeguarding children process noted at our last inspection had not been addressed effectively.
- Safeguarding incidents was on the risk register for the service and actions were taken to address each safeguarding SI, although we were not assured that these actions were effective. For example, out of the five SI's, three were related to processes not being followed. Despite actions taken in response to SI's of this nature, three had occurred in total.
- In March 2016 it was noted on the risk register that the main issue was that locum staff were not aware of the safeguarding policy, so the policy was included in locum orientation packs as mitigation. However, three of the safeguarding SI's occurred after this date.
- One SI related to an allegation of abuse and was still under investigation at the time of our inspection. This was a concern that the parent tried to report on several occasions through a variety of sources, including to a trust source. However, no appropriate action was taken despite the concerns being raised. This resulted in a delay of months before the incident and investigation was raised and could have potentially compromised any police or trust action.
- A safeguarding committee was established and provided scrutiny of all safeguarding incidents. Actions such as the introduction of safeguarding huddles in clinical environments were embedded, with staff confirming they occurred daily. Safeguarding training had been changed from being an online course once every three years to being a face-to-face session annually.

- The set target for compliance to safeguarding children training was 95%. Ninety-two per cent of nursing staff were trained and 62% of medical staff were trained. The service had placed compliance to safeguarding level three training on its risk register. Medical staff who had not completed the training were booked on to attend. The leadership of the service explained that the change to the frequency and set up of the training was the reason the medical staff were below the compliance target.
- Staff in theatres and recovery told us that staff looking after children and young people having surgery had safeguarding level two training but not level three. Training data provided by the trust showed that no staff in surgery had level three training and 51% of staff had level two training. The remaining staff had level one training. This meant that those staff may not fully understand how to recognise and escalate signs of possible abuse.
- A named safeguarding nurse had been in post since September 2015. The nurse reported that the safeguarding team attended morning handovers and strategy and discharge planning meetings on Dolphin ward.
- Twelve champions across the trust had received training on child sex exploitation and were available as a source of knowledge and support to staff.
- Nursing staff understood safeguarding processes. In the children's outpatients department staff understood the process in the event of children not attending appointments. Flowcharts were seen on Dolphin ward and the NNU for how to follow the safeguarding process and access the safeguarding team.

Mandatory training

- The trust had set a high target of 95% compliance to mandatory training. Nursing staff achieved 78% on Dolphin ward, 100% in the children's outpatients department and 88% on the neonatal unit (NNU). Medical staff achieved 62%.
- Ward managers were addressing the low compliance of nursing staff by building in time to the nurses' rotas so that they were released on shift to do their e-learning. Senior nurses were covering their staff when they were released. The practice development nurses were providing oversight of this arrangement although it was too early to tell how effective this would be.
- The clinical lead and the service manager were working with the medical staff to encourage a drive towards completion of mandatory training.

Assessing and responding to patient risk

- We saw evidence in two of the seven sets of notes we reviewed on Dolphin ward of action being taken when a child's early warning score was raised. However, in one of those sets of notes, the recording of the escalation was inconsistent. The notes stated that no action was taken to escalate although there was evidence of medical staff reviewing the child.
- There were 182 Paediatric Early Warning Score (PEWS) audits conducted between April 2015 and March 2016. Common themes from these audits were inconsistency in obtaining an initial blood pressure reading when patients were admitted to the ward; and the lack of documentation of triggered pain scores on the front of the charts.
- The PEWS audits represent that the staff were completing all the patients' details on the charts; observations (with the exception of blood pressure) were recorded on initial assessment; observations were documented correctly; and nausea and vomiting recording was always completed on the charts.
- Escalation charts were visible on the walls on the neonatal unit (NNU) so staff had clarity about when to contact the consultant in the event of babies deteriorating. This was an action as a result of a serious incident.
- On Dolphin ward 59% of nursing staff were trained in basic life support (BLS), and 3% were trained in European paediatric life support (EPLS). However, no staff were trained in paediatric immediate life support (PILS). The ward manager and the high dependency nurse were due to attend advanced paediatric life support training (APLS). This meant that the Royal College of Nursing guidelines were not met that state that at least one nurse on each shift ought to be trained in APLS or EPLS.
- Across the service 61% of medical staff covering both Dolphin ward and the NNU had APLS and no medical staff were trained in PILS, BLS, or EPLS. This was recorded on the service's risk register, which stated that staff would be sent on the appropriate level of training as places became available. In the meantime, extra BLS training was being given.

Services for children and young people

Nursing staffing

- Staffing was determined by using an acuity scoring tool. On the neonatal unit (NNU), British Association of Perinatal Medicine (BAPM) standards were used to determine how many nurses were required to provide the levels of care on the unit. On Dolphin ward, Royal College of Nursing guidance was used to determine staff numbers to provide care.
- On the NNU the vacancy rate was 26% which meant that the unit was short of seven whole time equivalent (WTE) staff. The vacancies mostly were in the band six, or sister level, nursing group. The unit covered these shortages with the use of bank staff and did not use any agency staff. A longer term plan to increase the number of sister level nurses on the unit was to support staff nurses in their training to become 'qualified in service' for caring for neonates.
- On Dolphin ward the vacancy rate was 30% which meant that the ward was short of 7.9 WTE staff. The ward manager was mitigating the risk of not having enough staff by having three senior nurses on shifts from Mondays to Fridays between the hours of 9am and 5pm, and reorganising substantive staff to cover weekday day shifts.
- Bank and agency staff were supported by one or two substantive staff to cover shortages at nights and weekends. For the period September 2015 to March 2016, agency use on Dolphin ward averaged 0.8% a month of all shifts, which was approximately three to four shifts per week.
- Agency staff received an orientation to Dolphin ward. This included paperwork detailing important information such as the number for the crash team bleep with important information.
- Sickness rates for the period April 2015 to March 2016 were 2.76% on Dolphin ward and 1.48% on the neonatal unit.

Medical staffing

- The service was supported by 10 consultants from 8:30am to 9:30pm Monday to Friday, 8:30am to 2:30pm and 7pm to 10pm at weekends.
- Two hot week consultants a week provided cover on weekdays between 8.30am and 5pm. One consultant covered Dolphin ward and second consultant covered the neonatal unit. There was an on-call consultant available on week nights between 5pm and 8.30am. The weekend consultant remained onsite between 8:30am and 2.30pm, and 7pm and 10pm.
- Three middle grade doctors supported the service on weekdays between 8.30am and 5.15pm. One doctor covered Dolphin ward, one covered the neonatal unit and one covered the children's emergency department. One middle grade doctor on each shift would provide cover on a long shift finishing at 9:30pm. Cover was provided on weekend days between 8:30am and 9:30pm, and night cover was provided between 8:30pm and 9:30am. One middle grade doctor supported the children's outpatients department between 9am and 5pm.
- There was long day and night shift cover provided by senior house officers to both Dolphin ward and the neonatal unit.
- Morning medical handovers took place at 8:30am and included representation from medical staff, nursing staff and the safeguarding team. Teaching ward rounds took place weekly. Afternoon handover was between the nurse in charge and the on call consultant, with a final handover at 8.30pm.
- For the period September 2015 to March 2016, the use of locum doctors had increased each month. Usage was 7.05% in September 2016 and was 16.65% in March 2016. The clinical leads for the service told us that this due to the service having 60% of their middle grade doctors in post. The senior house officer rota was being filled and was expected to be fully staffed from September 2016. The use of locum medical staff had been put onto the service's risk register.
- Locums received an information pack on orientation containing log in information for trust computers and systems, the information governance code, the safeguarding children policy (requiring a signature to confirm it had been read), and details of how to access e-learning.
- Out of the 17 records we reviewed, a consultant reviewed the child or baby within 24 hours in 16 cases. The remaining case was seen by a specialist registrar.

Major incident awareness and training

Services for children and young people

- The trust had a major and critical incident plan in place although the plan was out of date by seven months. The plan clearly set out prompts and guidance for a senior nurse and consultant from the service who would be on call on any day that an emergency took place.
- The service had a child abduction policy in place that had been reviewed and was in date. Training had been rolled out to staff and a simulation exercise had been completed to test the policy which the trust felt was successful. This was an improvement from our last inspection, where the policy was out of date and not tested.

Are services for children and young people effective?

Good

Effectiveness was rated as good for the children and young people's service because;

- The service had a comprehensive audit plan and was also participating in national audits.
- A first hour of care pathway had been created in partnership with the local neonatal network and was audited for improvement.
- The children's diabetes service was in receipt of the best practice tariff for diabetes. This meant that the service was achieving set criteria for the delivery of high quality diabetes care for children.
- An established pain team was available to the service 24 hours a day, seven days a week.
- Patient outcomes were good in the National Neonatal Audit, the National Epilepsy 12 Audit, and the National Paediatric Asthma Audit, and the service was active in improving its results.
- Staff were able to develop in their skill sets and were supported in both appraisal and revalidation.
- Multidisciplinary working was established and consistently recorded in patient records.
- A seven day service was established and pharmacy, allied health professional and radiological support was available through an on call rota out of hours.

However;

- The transition service and arrangements for transition from child to adult care was disjointed for long term conditions and the service did not have a transition nurse.
- Staff were not trained in supporting children with mental health problems despite mentally unwell children regularly being admitted to the ward.

Evidence-based care and treatment

- The service had a comprehensive audit programme in place for the period April 2015 to March 2016. This contained 23 audits, including participation in five national audits. Local audits focused on the effectiveness of care pathways such as the newly diagnosed diabetic admission pathway audit and the first hour of care pathway audit. Local audit focus was also on practices such as record keeping and prescribing standards. This was an improvement since our previous inspection, when audit participation and benchmarking was limited.
- Audits were presented to a monthly audit meeting where outcomes and learning were also shared.
- The practice development nurses took a lead role in making the clinical guidelines available and accessible to all staff. We saw a folder on the neonatal unit for staff to access that had all evidence based-guidelines organised for staff to access quickly. The guidelines were also available to all staff electronically on the staff intranet.
- The neonatal unit had applied for and were working towards Bliss Family Friendly Accreditation Scheme, which sets out care standards for babies born too small, too sick and too soon.
- First hour of care pathway for babies requiring high dependency care was created in partnership with the local neonatal network. The pathway was audited and presented to network. Audit outcomes had led to a change in SIPAP (or non-invasive positive pressure ventilation) practice.
- The service was in receipt of the best practice tariff for diabetes. The best practice tariff incentivises the provision of high quality care to diabetic children.

Pain relief

- In the Care Quality Commission's 2014 children and young people's survey, parents and carers reported that they felt staff did everything they could to ease their child's pain. This score was similar to those achieved by other trusts.
- There was an established pain team. Children requiring pain relief that was not already prescribed could receive prescriptions quickly. There was an out of hours provision from the pain team who were supported by an anaesthetist.
- In theatres, staff provided a local anaesthetic cream, which was used on children. This was used to ensure that children did not feel any pain when they were cannulated.

Nutrition and hydration

- A double checking process was in place on the neonatal unit to ensure that babies received the correct expressed breast milk.
- There was clear fasting guidance for children requiring surgery. Children on the morning operating lists were required to fast from 6am and have water until 7am. Children on the afternoon operating lists were allowed their breakfast at 7am then water only until 11am. This meant that children were not left hungry for unnecessary periods of time before their operations.
- Malnutrition assessments were undertaken for all children admitted to the service. However, children's heights were not being included which reduced the efficiency of the assessment.

Patient outcomes

- The trust performed well in the 2015 National Neonatal Audit Programme. Eighty-one per cent of babies born under 32 weeks gestation had their temperatures checked within an hour of birth, which was below average of 91%. The percentage of mothers receiving steroids who delivered their babies between 24 and 34 weeks of gestation was 84%, which was the same as the national average. One-hundred per cent of babies born under 32 weeks, or weighing less than 1501 grams had retinopathy of prematurity screening compared to the average of 90%. Fourty-six per cent of babies born under 33 weeks were receiving their mother's milk on discharge from the unit, which was below the average of 59%. Ninety-one per cent of parents had a consultation with a senior team member within 24 hours, which was better than the average of 86%; only 4% of the data was submitted for the normal survival at two years so this measure was not assessed.
- Action plans were in place for the two areas where improvement was required. A nutritional pathway was in development at the time of our inspection to support the low breastfeeding on discharge numbers. Breast pumps had been purchased for the unit for mums to take home and express. A two year developmental assessment clinic had been set up and was due to commence in July 2016.
- The trust performed well in the 2014 to 2015 National Epilepsy 12 Audit. There were negative outliers in the following four (out of 12 in total) clinical indicators assessed as part of the Epilepsy 12 Audit: The provision of a paediatrician with expertise in epilepsy; the provision of an epilepsy specialist nurse; an appropriate first clinical assessment; and seizure classification. An action plan had been implemented and at the time of our inspection the trust had achieved the improvements of having a paediatrician with a specialist interest in epilepsy (who had been in post for one year), and weekly epilepsy clinics had been set up. The service was still lacking a clinical specialist nurse. However, the other indicators were in line with or better than expected compared to the national averages.
- The 2013/14 National Paediatric Diabetes Audit was the most recent data available at the time of our inspection. The audit showed that the trust was performing 10% below the England average for the percentage of children and young people having controlled diabetes.
- The trust performed below the England average for the mean average glycated haemoglobin (HbA1C) level at 76.6 mmol/mol compared to England average of 71.7 mmol/mol.
- Emergency readmission rates were lower than the England average for the period November 2014 to October 2015 which was the most recent data available at the time of our inspection.
- Fifteen records were audited for the 2015 National Paediatric Asthma Audit by the British Thoracic Society. The results were in line with or better than the national data set results. The trust had set some recommendations to improve elements of the discharge process for children with asthma and/or wheeze, such as arranging follow up appointments with primary care within 48 hours and checking inhaler techniques.

- Multiple admission rates within 12 months of discharge for children with epilepsy were below the England multiple admission rate, as were the rates for diabetic children. Multiple admissions for children with asthma were higher than the England average rate by 1.2% at 17.7%. An action plan was created that included a proforma for patients going home as indicated in the recommendations from the National Paediatric Asthma Audit.

Competent staff

- Staff appraisals on Dolphin ward and the neonatal unit (NNU) had improved since our previous inspection. For the period April 2015 to March 2016, 88% of nursing staff on Dolphin ward had received their annual appraisals, which was an improvement from the previous year's (April 2014 to March 2015) completed appraisal rates of 17%.
- At the last inspection, 59% of nursing staff on the neonatal unit had received their annual appraisal. However, the ward manager for the neonatal unit had achieved an improvement in appraisal rates for the six months they had been in post, with 100% of nursing staff receiving appraisals at the time of our inspection.
- Nurses were supported in their revalidation. Staff were supported by their senior colleagues. Revalidation was led by the associate director of nursing. Supervision time was built into consultant rotas to support more junior medical staff.
- Nursing and healthcare assistant staff on both Dolphin ward and the NNU stated that they had had the opportunity develop professionally. One HCA stated they had been on a study day for bereavement and was due to attend study day on observations.
- Eight nurses on Dolphin ward had completed oncology study days in support of the shared care that oncology patients had with the children and young people's service and the oncology team.
- Both Dolphin ward and the NNU had a practice development nurse in post. The role of these nurses was to improve patient care by incorporating a range of evidence based approaches in the clinical setting. The work of the practice development nurses was underpinned by the development and engagement of the nurses providing the care in those environments.
- A high dependency specialist nurse was in post on Dolphin ward. The role was developed with a tertiary centre and supported staff in: the provision of high dependency care; responding to crash calls, recognising and responding to raised early warning scores; and the provision of high dependency training. The high dependency nurse networked with a tertiary paediatric intensive care unit provider and was supported staff with simulation training, debrief sessions and arterial blood gas training.
- One healthcare assistant on Dolphin ward stated that they took a caseload of one to two patients on their shift. Patients were only allocated to their case load if they required observations only and/or they were awaiting discharge home. No entries could be made in the patient's records without a counter signature of registered nurse, and the healthcare assistant was not allowed to administer any medication. This meant that staff skillset was being used appropriately and safely to allocate workloads.
- Of the nurses on Dolphin ward between January and June 2016 there were between 20 and 26 nurse positions on the rota, which was budgeted for 27.71 WTE nurses. Of these nurses on duty between 87% and 100% of nurses were registered children's nurses.
- Of the nurses on NNU the service was budgeted for 31.71 WTE, with 17 in post between January and June 2016. Of these there were between 81% and 85% of registered children's nurses on duty.
- Local child and adolescent mental health services provided support to Dolphin ward within four hours of request. However, staff were not trained in supporting children in mental health crises despite admitting children and young people who had self-harmed and/or had suicidal thoughts on to Dolphin ward.

Multidisciplinary working

- The service had established external multidisciplinary team (MDT) working for several specialities such as the East of England neonatal network, tertiary centres for specialities such as neurology, rheumatology, cardiology, oncology and respiratory medicine, and the local emotional and wellbeing mental health service (EWMHS).
- CAMHS teams for the two counties served by the trust supported the service for children in mental health crisis. Discharges did not take place until CAMHS had reviewed the patient. The trust was working with the CAMHS providers to improve the timeliness and effectiveness of their assessments.

Services for children and young people

- Discharge planning was a multidisciplinary approach and involved the local community care and social care providers where appropriate.
- A psychologist from a neighbouring tertiary centre provided the service with two days a week of cover specifically in support of diabetic patients.
- The high dependency nurse based on Dolphin ward was involved in providing care to children in recovery from surgery, this enabled a more smooth and succinct handover back to the ward post-operatively.
- MDT working was recorded in all 17 sets of notes we looked at. This indicates that MDT working is embedded in the service.
- On both the neonatal unit (NNU) and Dolphin ward, the named nurse and consultant information was on display above cots and beds in line with The Academy of Royal Colleges Guidance for Taking Responsibility: Accountable Clinicians and Informed Patients. Although this was observed to be consistently completed on the NNU, we observed that the information was not updated during the days of our inspection.
- The transition policy for children moving from the children's service to an adult service for their long term conditions such as diabetes, epilepsy and asthma, was in the process of being developed at the time of our inspection.
- Although there was no transition nurse or policy in place, transition pathways for diabetic and asthmatic children were in place. Diabetic children attended a joint MDT clinic with the paediatrician and the endocrinologist for the adult service where a joint handover took place, with the support of the diabetes specialist nurse for the adult service. Asthmatic children would be referred to the adult respiratory physician by the paediatrician and a consultant to consultant handover would take place.
- The transition pathway for children with epilepsy was not in place. Epileptic children would be referred to the local tertiary centre as there was no substantive neurologist at this trust.
- There was a lack of clarity around when the transition process was supposed to start for young people. The leads of the service stated that transition started from the age of 13 years. However, in the children's outpatient clinic staff felt that transition started from the age of 16 years. This was likely to be related to the policy for transition not being in place.

Seven-day services

- There was consultant presence to Dolphin ward and the neonatal unit at night and the weekends. The consultant was supported by middle grade and senior house officers during these hours.
- Pharmacy support was available 24 hours a day seven days a week to Dolphin ward and the neonatal unit through an on call rota.
- Radiological investigations were available to children and young people out of hours with the support of an on call radiologist.
- There was an on call physiotherapy rota that ensured physiotherapy support was available to Dolphin ward and the neonatal unit if required out of hours.

Access to information

- Staff had access to the computer systems used for ordering investigations and reviewing test results.
- A communications book was observed being used on the neonatal unit. This book was used by staff to ensure that relevant information was handed over such as anticipated admissions. The communications book was used to compliment the nursing handovers.

Consent

- Staff understood the Gillick competence. This meant that staff were able to assess whether a child under the age of 16 was competent to consent to their own treatment without the permission or knowledge of their parents.
- Consent forms for young people were a different colour to the parental consent forms in records on Dolphin ward. This enabled staff to quickly ascertain when a young person had consented to their own care.
- Out of the 17 sets of records we looked at, consent for treatment was required in 10 sets. Out of those 10 sets, there was one record of parental consent missing.

Are services for children and young people caring?

Good

Caring was rated as good for the children and young people's service because;

- We spoke with nine sets of parents and their children. Parents we spoke with on our inspection gave positive feedback about the caring nature and respect of privacy from staff.
- Parents felt informed and involved in their children's care on Dolphin ward.
- We observed the staff on the neonatal unit provide kind and compassionate care to babies.
- Screens were used to protect the privacy of babies and their parents on the neonatal unit.

However;

- Although Friends and Family Test data was submitted to NHS England, response rates were very low which did not give context to the results.
- Small numbers of parents and carers on the neonatal unit felt that communication was lacking. Examples include information that the parents felt important not being included in handovers, and not being kept informed on updates relating to test results.

Compassionate care

- Parents felt confident that staff respected and genuinely cared for their children. Four sets of parents on the neonatal unit (NNU) stated that they believed the nurses really did care about their babies. The parents of a child on Dolphin ward told us that staff spoke to their child and not just them.
- We observed two nurses on the NNU providing very gentle and slow interventions to a baby.
- Screens were used to protect the privacy of babies and their parents on the neonatal unit. For example, screens were provided for mothers to express milk and/or breastfeed their babies at the cot side. Screens were also used when performing procedures on the NNU.
- Parents stated in the Care Quality Commission's 2014 children and young people's survey, which is the most up to date data available, that their children were given enough privacy when receiving care and treatment, that staff looking after their children were friendly and that their children were well looked after by hospital staff.
- Data from the NHS England Friends and Family Test for February to April 2016 showed that whilst Dolphin ward consistently achieved 100% for patients who would recommend the service, their response rates were very low at 21% in April compared to the England average that month of 24.5%, 11.9% in March compared to the England average that month of 23.2%, and 1.5% in February compared to the England average that month of 24.1%.

Understanding and involvement of patients and those close to them

- Five set of parents on Dolphin ward felt that they were well informed of their child's care and that medical staff had explained the care plans to them clearly.
- We observed one medical staff member on the neonatal unit (NNU) ensuring that a parent understood what had happened on the ward round. The staff member was observed using a kind and respectful tone and body language.
- Three sets of parents on the NNU stated that they felt they were not always communicated with well. Examples include information that the parents felt important not being included in handovers, parents not receiving updates on when investigations were expected to happen, parents not receiving clear information about discharge and parents not having their specific questions answered around their baby's condition.
- Out of the 10 sets of notes we reviewed on the NNU, eight sets of notes had parent communications documented.
- Communication problems with parents and carers had been identified in the May 2016 NNU patient survey. The feedback was largely positive, but identified the need to improve communications between medical staff and women whose babies were admitted to the NNU as an emergency where no prior visit could be arranged. An action plan had been created and included a named person to be responsible for actions.

Emotional support

- Psychological support was available to diabetic children from the psychologist attached to the paediatric diabetes service. Two local child and adolescent mental health services supported the service for children requiring mental health care, treatment and support.
- Pastoral care was available to children and their families from the chaplaincy team.
- Children's oncology survey showed that four out of five respondents felt their children were supported emotionally by staff.

Services for children and young people

- There were clinical nurse specialists for learning disabilities and oncology available to support children and their families.
- Two play specialists provided cover to the children's emergency department, the NNU, Dolphin ward and the children's outpatient department 9am to 5pm Monday to Friday and on Saturdays. The play specialists were able to use distraction techniques to help reduce anxiety in children throughout their stay and whilst receiving treatment.

Are services for children and young people responsive?

Good

Responsive was rated as good for the children and young people's service because;

- Referral to treatment times had improved greatly from our past inspection. The service had improved from 34.8% to 82%.
- Children were not inappropriately admitted or transferred to adult wards.
- The neonatal unit utilised the neonatal network to help with capacity in times of high demand by transferring clinically appropriate babies to other neonatal units.
- The service was focused on the individual needs of children and families, such as creating child friendly play spaces, separate bays in theatre recovery for children and provision of parents' facilities on Dolphin ward and the neonatal unit.
- There was a good understanding of complaints and learning at local level.

However;

- The arrangement of the environment in the day surgery unit and recovery areas meant that the service could not be sure to keep children and adults separated.

Service planning and delivery to meet the needs of local people

- In periods of high demand Dolphin ward had the physical capacity to increase its bed numbers from 16 to 18 depending on the ability to staff the ward.
- In the event of children and young people being retrieved by specialist tertiary providers, service planned and performed intubations in theatre and cared for the children in recovery until the retrieval team arrived.

Access and flow

- All patients have the right to receive treatment within 18 weeks of being referred. The service had improved since our previous inspection in the amount of children being seen within 18 weeks.
- For the period October 2015 to May 2016, eight out of nine (89%) children requiring planned treatment as an inpatient were treated within 18 weeks.
- For the period April 2015 to May 2016, an average of 82% of children were treated as an outpatient within 18 weeks of referral. This was an improvement from our previous inspection when the service achieved 38.4%. The introduction of extra clinics and telephone clinics had helped to improve this figure.
- Median length of stay for emergency admissions in babies under one year old was two days which was one more than the England average. This meant that babies less than one year old stayed in hospital on average one day longer than if they were admitted to another trust.
- Median length of stay for children and young people aged between one and 17 years was one day, which was the same as the England average.
- The service did not admit children under the age of 16 to adult based wards unless it was clinically appropriate. Data provided by the trust showed that two children were admitted to an adult ward and in both cases it was clinically appropriate and in line with their specific care pathway.
- Overall bed occupancy for the period July 2015 to June 2016 was 75.8% for Dolphin ward and 85.3% for the NNU. The ward manager on the NNU encouraged staff to report over-capacity times as incidents on the electronic incident reporting system.
- In times where the NNU could not care safely for the amount of babies on the unit, babies with the most appropriate clinical circumstances would be transferred to a neighbouring unit as part of the local neonatal network. Babies would be repatriated to the trust when capacity on the unit had reduced.
- For the period January 2016 to June 2016 there had been 15 children's outpatient clinics cancelled. This equated to 67 children expecting their first appointment and 78 children expecting a follow up appointment.

Thirteen of these clinics were cancelled within two weeks of the clinic's set date. The reasons for the clinics being cancelled varied between industrial action, doctor's staffing issues and doctors taking leave. Data provided by the trust did not assure us that the service had capacity to rebook these children in a timely manner.

Meeting people's individual needs

- There were two isolation rooms available for immunosuppressed children on Dolphin ward.
- Colourful pictures were observed on the ceilings of the Dolphin ward corridors. This provided distraction for children being wheeled in beds whilst on the ward.
- Children requiring surgery were allowed to wear their own nightwear to theatres; this helped the children with a sense of familiarity and comfort.
- Parents could go with their children into the anaesthetic room prior to their child's surgery; leaving at the point their child was anaesthetised. Parents were called to be with their children after the child had been extubated. This helped the children feel secure and have the comfort of a parent as they were anaesthetised.
- Children requiring surgery were placed on theatre lists with adults, although the children were prioritised at the start each list. There was a dedicated bay in theatre recovery for children. However, post-operative adults were wheeled past the children's bay in recovery to where the adults were recovered. During our inspection we observed one adult male patient opposite the children's bay receiving a blood transfusion whilst bare chested. This meant that the environment was not suitable for children.
- The day surgery unit had six beds for children and young people, including a playroom and a pre-assessment space. Children requiring day surgery were placed on separate lists to adults. However, in the unit children were required to walk from the children's area through the adult bay to the anaesthetic room.
- Dolphin ward was logistically planned so that younger children were placed in a bay together (where clinically appropriate), and adolescents were placed in a bay together. Both young children and adolescents had dedicated area to play and relax.
- There was a summer house located in the outdoor play area with games consoles for adolescents. An outdoor play area for younger children had been created on a converted roof.
- Dolphin ward had a school room with two visiting teachers from the local authority to support children who were at risk of missing their education whilst in hospital. There were toys and a space for siblings to play on the neonatal unit.
- Breastfeeding mothers were offered food and drink when their children were admitted to the service. Breastfeeding and expressing advice was displayed by the handwashing sinks on the neonatal unit.
- Parents were able to stay overnight with their children on Dolphin ward. Foldaway beds were available that were located next to patient beds. The ward also had a parent's room for parents to relax, along with a kitchen area with hot drink facilities, a fridge and a microwave. A shower, bathrooms and toilets were available for parents including a supply of emergency toiletries if required.
- There was a parent and visitor's room on the neonatal unit including parent lockers. Parents had access to their own kitchen with hot drink facilities and a fridge and microwave. There were two parent rooms for parents to stay overnight with their babies when discharge from the service was imminent. This meant that parents had the opportunity to spend the night with their babies and have the support of staff if required. The parent rooms had double beds, a shower and toilet.
- There was a trust-wide learning disabilities nurse accessible to the service, who was supported by children's service matron. Support from the learning disabilities nurse was planned for implementation in the transition policy which was still under review at the time of our inspection.
- In the Care Quality Commission's 2014 children and young people's survey, parents and carers felt that staff knew how to care for their children's' individual needs, that their children liked the food available and that there were appropriate things for their children to play with on the ward.
- Staff had access to translation services when required.

Learning from complaints and concerns

- For the period July 2015 to May 2016 there were 18 recorded complaints against the service, two of which were not upheld.

- Complaints were discussed at the monthly patient safety and quality meetings where any trends were identified and action plans were reviewed. This was evident in the meeting minutes for March and June 2016.
- A complaint trend had been identified on Dolphin ward around the patient journey, specifically awaiting discharge paperwork. The action taken was for daily ward rounds to be undertaken using a computer-on-wheels, so that medical staff could complete any discharge medication immediately after seeing each child. This action was being implemented at the time of our inspection so we could not assess its efficacy.

Are services for children and young people well-led?

Requires improvement 

Well-led was rated as requires improvement in the children and young people's service because;

- We were concerned that there was a lack of grip from the leaders of this service in regards to management monitoring and actions regarding the safeguarding of children. There were significant risks for safeguarding children that were thematic and were similar to themes from the last inspection that had not been addressed.
- There was a poor culture of quality on Dolphin ward and the neonatal unit around daily checks of emergency trolleys, drug fridge temperature and controlled drugs. The importance and need for this was not well accepted by all staff.

However;

- The service had an established vision and strategic priorities in place for 2016 to 2017.
- There was a comprehensive risk register that reflected status of the service.
- Clinical governance issues were presented and discussed at a monthly dedicated meeting, where learning was shared.
- The local leadership of Dolphin ward and the neonatal unit was strong and supportive of staff. The matron and head of children's nursing provided supportive leadership to the ward managers.
- Both Dolphin ward and the neonatal unit had a nominated employee of the month scheme in place.

Vision and strategy for this service

- The children and young people's service had a vision to create a better start in life for children and deliver an evidence-based compassionate service that met the needs of children and young people. Five strategic priorities had been developed to achieve this vision throughout 2016 to 2017.
- The five strategic priorities were to develop a children's assessment unit, introduce a seven day consultant presence, reduce admissions by joint working with the community service, increase care and treatment provision for babies and children requiring high dependency or intensive care, and to improve the transition service for children crossing over into the adult services for their conditions.
- Progress against some of these strategic priorities was evident, such as having a seven day consultant presence and having a level two neonatal unit that can provide high dependency and intensive care to babies.
- The vision for the service, with the five strategic priorities, was an improvement from our previous inspection, when there was no vision set. However, no staff nurses or healthcare assistants we spoke to knew what the vision for the service was. However, the ward manager for Dolphin ward had created their own vision and objectives for the ward and staff were familiar with these.

Governance, risk management and quality measurement

- The service had a comprehensive risk register in place that included risk descriptions, controls, assurances, risk scoring and risk appetite. The risk register reflected issues identified during our inspection including safeguarding incidents, medicines related incidents, life support training provision and medicines security. This meant that there was oversight of the areas requiring focus in the service.
- The minutes of the monthly patient safety and quality meetings were reviewed for January to March 2016. There was evidence that the service risk register had been discussed in the February meeting only. The clinical lead of the service told us that although the risk register was discussed at the patient safety and quality

meetings, scrutiny of the risk register took place at the executive performance reviews. Data provided by the trust for these meetings indicates that service risks are presented and actions discussed.

- The management of the service risk register was an improvement from our previous inspection. With the exception of safeguarding, the risk register now in use reflected the risks within the service at the time of our inspection.
- We were concerned that there was a lack of grip from the leaders of this service in regards to management monitoring and actions regarding the safeguarding of children. There were significant risks for safeguarding children that were thematic and were similar to themes from the last inspection that had not been addressed.
- The issue of safeguarding children, despite the thematic trend, was also not clearly listed as a risk on the risk register.
- Whilst structural elements of governance had improved, there were issues within the quality assurance systems, which meant that elements such as fridge temperatures, resuscitation trolley checks and medicines issues were not being identified or addressed in a timely way.
- Clinical governance of staff appraisals and training, clinical indicators, infection control, audit and incidents and complaints for the service took place at the monthly patient safety and quality meetings. Minutes of these meetings for January, February and March 2016 evidence that these issues received presentation and discussion.
- A clinical governance newsletter was seen for the service. This was a transparent and open document that shared learning from complaints and incidents for the service with a no blame approach.
- Monthly ward team meetings were set up for both Dolphin ward and the neonatal unit. However, out of three months meetings between January and march 2016, two were cancelled due to service demand and capacity.

Leadership of service

- The children and young people's service was led by a clinical lead, an associate director of nursing and head of midwifery, and an associate director of operations. These senior leaders were supported by the head of children's nursing and the paediatric matron who in turn supported the Dolphin ward and neonatal unit managers.
- The leadership structure of the service was established. From ward level, both Dolphin ward and the neonatal unit had ward managers. Ward managers received leadership from the paediatric matron.
- The paediatric matron received leadership from the head of children's nursing, who in turn received leadership from the associate director of nursing and head of midwifery. Medical leadership came from the clinical lead for paediatrics who was a practicing consultant at the trust.
- Both Dolphin ward and the neonatal unit had new managers in post since our previous inspection. The previous acting manager for Dolphin ward was now substantive and had driven improvements on the ward in her time in post. The ward manager for the neonatal unit had been in post for approximately six months at the time of our inspection and had also introduced some positive changes to the unit.
- The neonatal ward manager had given four of the unit's six senior nurses a team of nurses to lead each. These senior nurses helped to achieve the appraisal rates for the unit and allocate tasks for their teams.
- The matron and head of children's nursing were visible and supportive of the clinical areas and supported the ward managers in their roles.
- All of the healthcare assistants and registered nurses we spoke to felt supported by the ward manager.

Culture within the service

- Although improvements had been achieved throughout the service in staff culture, led by the ward managers, there was still a poor culture around safety issues such as daily checks for resuscitation and intubation trolleys and controlled drugs and fridge temperatures, and the safeguarding of children from a recognising a concern perspective.
- The consultant body had met with the chief executive to discuss heavy locum use although one consultant told us that they felt uncertain of the outcome of that meeting.

Public engagement

- The neonatal unit had invited a parent to present their experience of care to help with staff understanding and development of caring for babies requiring intensive care.

Staff engagement

- Team away days had taken place for the neonatal staff. The team performed role play and looked at extracts of complaints for learning.
- Both the neonatal unit and Dolphin ward managers held an employee of the month scheme. On Dolphin ward, the ward manager bought prizes and badges for each employee of the month.

Innovation, improvement and sustainability

- The neonatal community outreach team was developing training for parents to be competent in tube feeding their babies at home.

End of life care

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

Information about the service

The Princess Alexandra Hospital provides end of life care to patients across all its clinical areas and treats a variety of conditions including cancer, cardiac and respiratory diseases, dementia and orthopaedic conditions. The specialist palliative care team (SPCT) consists of three whole time equivalent (WTE) clinical nurse specialists and two palliative care consultants providing 0.4 WTE hours between them, equalling two full days, per week.

The Princess Alexandra Hospital does not have a dedicated ward for end of life care. There are no palliative care champions within the trust. There were 1,017 in-hospital deaths reported between September 2014 and August 2015. The SPCT received 476 referrals from April 2014 to March 2015, with 70% of these being for patients with a diagnosis of cancer. Referrals increased between April 2015 and March 2016 to 525, with 66% of these being for patients with a diagnosis of cancer.

The Chief Medical Officer has responsibility for end of life care within the executive team. The Chief Medical Officer is supported by a non-executive director. In addition, the bereavement office provides support to relatives and the chaplaincy service provides a 24 hour service for patients at the end of life, their relatives and staff.

During the inspection, we spoke with one patient and one relative. The majority of patients that were end of life were not suitable to speak with due to their clinical condition. We spoke with 30 members of staff which included medical and nursing staff, allied health professionals, the specialist palliative care team, the Chief Medical Officer, porters, mortuary and chaplaincy staff. We reviewed 23 sets of patient notes and information requested by us and provided from the trust. We visited the following clinical areas during the inspection: Kingsmoor ward, Lister ward, Locke ward, Henry Moore ward, Harold ward, Harvey ward, Williams Day Unit and Saunders ward. We also visited: the mortuary, chaplaincy and bereavement suite.

End of life care

Summary of findings

End of life care at The Princess Alexandra NHS Trust was rated inadequate overall. Safe and effective have been rated requires improvement, with caring rated as good. Well-led and responsive have been rated as inadequate.

- The mortuary environment was not fit for purpose, with damage and inefficiencies in the workings of the fridges and freezers.
- Medical staffing was not in line with national guidance, with the equivalent of 0.4 whole time equivalent palliative care consultants. Medical staffing was being provided on a service level agreement from two local hospices. Safeguarding was not included within the anticipated last days of life care plan.
- There was a risk nursing staff may not consider safeguarding when undertaking care planning.
- Medication was being prescribed and administered without documenting times on medication charts.
- Patient outcomes were not routinely or robustly being monitored. The trust had a decrease in the number of clinical outcomes achieved within the End of Life Care Audit, published in March 2016.
- There were no end of life care champions in clinical areas.
- Multidisciplinary team meetings were attended by palliative care nurses and a palliative care consultant. However, no other professions attended, for example physiotherapy, occupational therapy or social workers.
- There was inconsistent knowledge amongst staff around the Mental Capacity Act.
- No formal counselling or emotional support was available for patients at the end of life or their families. One patient stated they felt no member of staff was taking the lead on their care.
- The trust did not routinely monitor patients preferred place of care or preferred place of death. The fast track discharge process was not being monitored or audited for patients at the end of life.
- The trust had a four hour target in place for completion of the rapid discharge process,however this was not audited to show how long patients waited for discharge.
- There was no vision or strategy in place for end of life care. A non-executive director had been appointed to lead end of life care. However, this was in May 2016 and they were not yet fully established in post.
- There was a disconnect between clinical staff and the executive lead for end of life care. The executive and non-executive leads showed limited oversight of the service.
- There was no specific risk register for end of life care. The risks identified by the specialist palliative care team and the executive team did not match the risks that had been documented.
- There was a lack of medical palliative care leadership at the trust. Two consultants covered 0.4WTE in the service.
- There was a decline in compliance with 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR) form completion, despite executive oversight. The trust had limited improvement plans in place at the time of inspection.

However:

- Infection control practices within the mortuary were good. There was a robust system for checking the deceased in and out of the mortuary. Nursing documentation within patient notes was good. Nurse staffing within the specialist palliative care team was above national guidance.
- Pain relief was prescribed appropriately and in line with trust policies on end of life prescribing. Patients were encouraged to eat and drink as they wanted and for as long as they could in the last days of life.
- Staff were seen to provide kind and compassionate care across clinical areas. Patients' dignity was maintained at the end of life. Patients and relatives felt well informed about the care being provided. The specialist palliative care team and chaplaincy service provided emotional support to patients and relatives.
- Thirty-four per cent of referrals to the specialist palliative care team were for patients with a non-cancer diagnosis. This showed ward staff considered referring patients with multiple

End of life care

diagnoses. There was evidence of learning from complaints and concerns raised by patients and their relatives. There were improvements in the response time for the specialist palliative care team.

- Staff across all areas of the hospital acknowledged the importance of end of life care. The executive team and senior nursing team were aware of the concerns with end of life care and were receptive to the need to improve the service for patients throughout the inspection.

Are end of life care services safe?

Requires improvement

Safe was rated as requires improvement because:

- The mortuary fridges and freezers were not functioning properly due to significant amounts of rust around the hinges, bowed doors and inefficient cooling units.
- The mortuary was using a trailer type unit to store an additional 20 deceased patients. The trailer was not securely stored and was accessible from outside the mortuary.
- There were low reported rates of incidents related to end of life care.
- Outcomes and learning from incidents was not documented, however, was discussed at the end of life steering group.
- Medical staffing within the specialist palliative care team (SPCT) was below national guidance at 0.4 whole time equivalent (WTE), with no improvement since September 2015.
- Safeguarding assessments had been removed from the last days of life care plan and 'COMPASSION' tool (the hospitals documentation method), resulting in the potential for staff to not consider safeguarding when assessing patient at the end of life.
- Medications were being prescribed without timings, meaning that staff did not know when patients had received medication.
- No evidence of escalation plans or ceilings of care were seen in patients' notes. Daily plans were documented during ward rounds. However, these did not include a ceiling for treatment.
- There was a risk of inappropriate pathways or treatments being implemented without medical challenge due to the lack of oversight by a specialist palliative care consultant.

However:

- Decontamination practices and the use of personal protective equipment in the mortuary were in line with trust policies.
- Staff documented regularly within patients notes. Documentation followed the 'COMPASSION' tool and was detailed from the specialist palliative care team.

End of life care

- There was a robust system in place for checking the deceased into and out of the mortuary.
- Nurse staffing within the SPCT was above national guidance at three WTE.
- Improvements had been made within the mortuary in the two weeks following the inspection.

Incidents

- The trust electronic incident reporting system recorded incidents relating to end of life care. We reviewed incident data between July 2015 and June 2016 and found that eight incidents mentioned 'end of life care'; four of these were related to the mortuary. This meant that we were not assured that all incidents related to end of life care were being captured across the hospital.
- The specialist palliative care team, visiting palliative care consultant, mortuary staff, and the chaplaincy staff knew how to report incidents, and had an understanding of what should be reported.
- Poor recording of outcomes onto the electronic incident reporting system meant that we were not assured that incidents were managed appropriately. Of the four incidents not relating to the mortuary, one did not have any outcome information documented and the remaining three incidents had actions from meetings documented but no outcomes from the agreed actions.
- Regional clinical incident analysis meetings were held six times per year jointly with St Clare Hospice and the Community Services in West Essex. The service discussed the trust's incidents at these meetings.
- There were no never events or serious incidents in relation to end of life care between July 2015 and June 2016. Never Events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- The specialist palliative care team were aware of recent incidents and the shared learning from them at end of life steering group meetings.

Cleanliness, infection control and hygiene

- Two of the three SPCT nurses had completed the trust's infection control training, with the third nurse due to undertake the training later in June 2016.
- Of the staff in the mortuary, 100% had completed the trust's infection control training.
- The mortuary manager explained the process for decontamination following autopsies, and the process for decontamination following the autopsy of a patient with an infectious disease. The process used in both cases was appropriate and the decontamination of the mortuary room was seen during the inspection.
- The mortuary cleaning and decontamination policy was seen following the inspection. The policy was brief and lacked credible references. However, it was appropriate and in line with the Health and Safety Executive safe working and prevention of infection in the mortuary and post-mortem room guidance.
- Personal protective equipment (PPE), such as aprons and gloves, was readily available throughout the mortuary setting for use by staff and visitors, including funeral directors. Appropriate PPE was being used when disposing of waste and during autopsy within the mortuary, and good hand hygiene practices were seen throughout. The standard infection prevention and control precautions policy was seen following the inspection to support the use of PPE within the mortuary.

Mortuary

- During our previous inspection in July 2015, concerns were raised to the board of directors regarding the maintenance of the mortuary, namely the condition of the fridge doors.
- As part of this inspection, the mortuary was re-inspected to establish if improvements had been undertaken. We found that the mortuary was in a worse state of maintenance than in our previous inspection.
- The bank of fridges and freezers between the post mortem room and the main fridge area all had significant amounts of rust on the hinges of the doors. Staff we spoke to confirmed the condition of the hinges had deteriorated since the last inspection and that there had been no maintenance work undertaken.
- Six fridges and one freezer opened directly into the post mortem room. Of these, two fridges had doors that did not close fully. A third fridge door was not secured in place and was hanging at an angle. There was a significant gap of approximately 4cm between the bottom of the door and the wall due to the buckling of the fridge door.
- A further fridge within the main area of the mortuary had a bowed door which meant force was required to ensure a proper closure of the door.

- The mortuary floor had two small drains for water to drain away following decontamination and cleaning. However, the mortuary floor around the fridge doors sloped away from the drains, resulting in puddling of water.
- Staff told us that the freezer unit was inefficient. The chiller unit within the freezer was surrounded by a large amount of ice which had formed a pile on the top tray within the freezer. Staff were unable to remove the top two trays as these had become frozen in place. Staff were continuing to use the bottom four trays as there was no other means of deep freeze storage on site.
- We were not assured that the integrity of the deceased was maintained due to the build-up of ice in the freezer, the door seals not being wholly intact, and staff stating there had been no risk assessment completed for the faulty and damaged fridges and freezer.
- A further concern was raised over the use of an additional 20 fridge spaces which were housed in a trailer unit outside the mortuary. The trailer was parked up to the shutters of the loading bay to reduce the access to the door, was locked and CCTV was in use. However, the trailer unit was still accessible by anyone from outside the mortuary.
- When the Chief Medical Officer, who leads for end of life care, was asked about improvements within the mortuary he stated that funding for improvements had been ring fenced. However, the Chief Medical Officer was unable to give any details on timeframes for improvements and was unaware of the current condition of the mortuary environment.

Medicines

- There was no permanent full time palliative care consultant at The Princess Alexandra Hospital at the time of our inspection. This meant that there was a potential of an increased risk of errors in the prescribing of end of life medication due to the lack of senior specialist medical oversight. The SPCT clinical nurse specialists (CNSs) were regularly recommending treatment and medication pathways. However, they were leaving the final decision on implementation of these to a non-palliative care specialist consultant. This could have a potential for delays in the administration of end of life medication.
- We found evidence of prescriptions appropriately written in line with the anticipatory medication policy at the trust.
- Regular medications were being stopped in a time appropriate manner for patients at the end of life where it was no longer required. This was in line with the trust's last days of life care plan.

· Medication was being prescribed across the trust with no specific times for administration. There was a risk that patients may have received pain relief either with too short a time between doses or a prolonged period between doses. No evidence of this was found as identifying the exact time of administration was not possible.

Records

- The SPCT made detailed entries within the multidisciplinary notes. Documentation was clear and concise and considered all aspects of patient care. SPCT documentation followed the hospitals 'COMPASSION' acronym for assessing and documenting care.
- The 'COMPASSION' acronym stood for: communication, observations, medications, pain, activities of daily living, skin, safeguarding, invasive devices, oral care and nutrition. The acronym had been changed for those patients at the last days of life and safeguarding had been replaced by spirituality.
- The hospital had a sticker system in place to show a patient had been seen by the SPCT. Further documentation was then made to support the outcome of the review. The trust also used stickers within patient notes to highlight a patient's preferred place of death (PPD) or care (PPC).
- Nursing staff were using a last days hourly rounding tool to assess patients in the last days and hours of life. The last days rounding tool is a prompt for nursing staff to undertake and monitor a patient for mouth care, comfort, hydration, safety and pain, amongst others, to ensure maximum comfort and dignity at the end of life. We saw the last days rounding tool in use across the trust. However, it was not always completed appropriately. We found an example on Henry Moore ward of a patient with a community acquired pressure sore who had not had pressure area care documented. The ward manager told us that pressure area care was done but the nursing staff did not always have time to document it.
- 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR) orders were signed by a senior doctor, mainly a consultant in all cases we looked at.

End of life care

- The mortuary had a robust system of checking the deceased into and out of the mortuary. On admission to the mortuary, in addition to hospital wrist bands with the deceased name, date of birth and NHS number on, an individual mortuary number was assigned to each patient. The individual number was attached using pre-printed stickers to the deceased wrist band, property and within the mortuary register. This was used as an additional check prior to any procedures or discharge from the mortuary to ensure the correct patient.

Safeguarding

- All SPCT nurses had completed their mandatory training in respect of safeguarding.
- In the chaplaincy 100% of chaplaincy staff had completed level two adult safeguarding. In the mortuary 50% of mortuary staff had completed adult safeguarding level two and 100% of mortuary administration staff had undertaken adult safeguarding level two.
- We found no concerns during the inspection in relation to safeguarding end of life patients. The SPCT and mortuary manager were able to explain how to report and escalate a safeguarding concern.
- The SPCT did not know of any recent safeguarding incidents involving palliative care patients or those at the end of life where a safeguarding alert had been raised.
- The 'COMPASSION' tool used to assess patients on a shift by shift basis had had safeguarding removed and replaced by spirituality. The SPCT relied on the assumption that ward staff took safeguarding into account in their assessments of patients. This meant that there was a risk of safeguarding being overlooked as it did not appear in the COMPASSION tool for end of life patients or in the last days of life care plan.

Mandatory training

- End of life care training was part of the trust's induction training. The SPCT delivered a three hour session during the staff induction training program.
- The SPCT had completed an average of 84% of the required mandatory training for their role, with three outstanding modules. However, one SPCT nurse was on long term leave at the time of the inspection, which equated to two modules not undertaken, which was understandable. The trust had a target of 95% compliance with mandatory training.
- Chaplaincy staff had completed 93% of mandatory training required for their role.
- Mortuary staff had completed 71% of mandatory training required for their role. However, administration staff within the mortuary department had completed 79% of mandatory training.

Assessing and responding to patient risk

- Within clinical areas, there was no system to identify those patients who were in the last days of life or had an active DoNot Attempt Cardiopulmonary Resuscitation (DNACPR) order in place. There was a risk patients may be inappropriately resuscitated, or not resuscitated when appropriate.
- No evidence of escalation plans or ceilings of care were seen in patients' notes. Daily plans were documented during ward rounds. However, these did not include a ceiling for treatment. This posed a risk of inappropriate escalation of patients or continuity of treatment which is likely to be unsuccessful.
- A patient's ceiling of care is the point that further medical intervention would not be in their best interests, for example escalation to intensive care.
- Physiological observations were stopped when patients were at the end of their life in line with the care plan for last days of life, ratified May 2016. Although no national guidance on stopping physiological observations exists, in patients at the end of life it is generally considered good practice to stop observations in the last hours of life. Physiological observations monitor patients for deterioration and supports decisions to intervene with further medical treatment. In the last days or hours of life, this would be considered inappropriate. The last days rounding tool should be implemented when the decision is made to cease physiological observations, this was observed during the inspection.

Nursing staffing

- The SPCT provided a nursing service Monday to Saturday between 8am and 4pm.
- The Association of Palliative Medicine for Great Britain and Ireland, and the National Council for Palliative Care recommends there should be a minimum of one specialist palliative care nurse per 250 beds. The trust

currently has around 540 beds. Based on national recommendations, to provide a seven-day service the trust would require two WTE specialist palliative care nurses. The SPCT consisted of three whole time equivalent (WTE) clinical nurse specialists (CNS), therefore nurse staffing was sufficient and appropriate for the current workload.

- The SPCT did not use any bank or agency nurses from July 2015 to June 2016.
- The SPCT stated that there were no palliative care champions on any wards across the hospital.

Medical staffing

- Two palliative care consultants were providing 0.4 WTE hours between them, in the form of four half days a week, as part of a service level agreement with two separate hospices. The trust's palliative care consultant WTE had not changed since the previous inspection in July 2015.
- The trust did not have a substantive palliative care consultant in post until September 2015 when they left the trust.
- The National Institute for Health and Care Excellence (NICE) guidelines for end of life care in adults (QS13) recommends between 1.56 and 2.0 WTE palliative care consultants per 250,000 population. The Princess Alexandra Hospital serves a population of around 350,000, meaning around 1.4 WTE consultants were required to meet QS13 guidance.
- A palliative care consultant was available 24 hours a day, seven days a week, contactable via switchboard for advice and guidance. This was provided by the two hospices. The contact details for these were kept in the ward resource files. Ward staff needed to contact the hospice within the patient's clinical commissioning group (CCG) catchment area to seek additional advice.
- The trust had advertised for a WTE palliative care consultant in May 2016 with the closing date for applications the end of July 2016.

Major Incidents

- The trust had a major and critical incident plan in place. The mortuary had a contingency plan for major incidents and business contingency, and a mortuary service contingency and capacity plan in place. These detailed the response from the mortuary in the event of a major incident or incident resulting in an interruption to service provision.
- Both plans were published in 2014. However, neither contained a review date and therefore we could not be assured that these were being reviewed on a regular basis to ensure continued suitability.

Are end of life care services effective?

Requires improvement

End of life care services were rated as requires improvement for effective because:

- Patient outcomes were not being routinely monitored.
- There was a decrease in the percentage of clinical outcomes achieved in the End of Life Care Audit, published March 2016.
- There were no end of life care champions across clinical areas.
- Staff had inconsistent knowledge of the Mental Capacity Act and how it should be used.
- 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR) forms were not completed in line with trust policy or national best practice guidelines. The forms completed lacked detail and some contained inappropriate reasons for DNACPR. For example 'age' or 'frailty'.
- There was no on site seven day specialist palliative care service in place at the time of the inspection.

However;

- Pain relief was prescribed appropriately and in line with trust policies.
- Patients were encouraged to eat and drink for as long as they felt able to.

Evidence-based care and treatment

- The last days rounding forms and care plan had been introduced in May 2016 and therefore not fully embedded within the trust.
- The lack of a defined plan was raised as concern in the July 2015 inspection, which meant that there was a substantial period of time between our inspection and a plan being introduced throughout the trust.
- The last days rounding tool used across the trust had no direct reference to a supporting evidence base.

However, the tool, along with the provision of pain relief and hydration, meets the recommendations set out in NICE guidelines from December 2015, care of dying adults in the last days of life.

- The trust's policies concerning the provision of pain relief and the use of the Mental Capacity Act were evidence based against well respected research and bodies. The trust's DNACPR forms were the recognised East of England forms which met relevant Resuscitation Council guidance.
- The trust undertook audits across a variety of areas. We reviewed audits of mental capacity, Deprivation of Liberty Safeguards, anticipatory medication, preferred place of care, DNACPR completion and advanced care planning. Auditing was sporadic and no audit plan was in place. All of the audits, except one, had a re-audit date included within the actions. Therefore we could not be assured that continued review and improvements were being made.
- The trust did not submit evidence of monitoring of rapid discharge target time achievement.
- No audit for the last days of life pathway had been undertaken as this was introduced in May 2016 and is yet to become established.

Pain relief

- Prescribing of pain relief was in line with the care plan for last days of life: symptom control algorithm. We reviewed five medication charts where patients had been prescribed end of life anticipatory medication. All pain relief had been prescribed in accordance with the symptom control algorithm.
- We found evidence of prompt administration of pain relief following pain assessments. However, reassessments of pain following the administration of pain relief were not always documented.
- Pain was assessed as part of the last days of life hourly comfort rounding. Evidence of pain assessments was seen and appropriate actions taken. 'Pain' formed part of the 'COMPASSION' daily assessment tool used by nursing staff and was part of the last days of life care plan. Evidence of consideration of patients' pain and pain relief was seen during the inspection.
- Anticipatory medication was prescribed in accordance with the trust's care plan for last days of life: symptom control algorithm.

Equipment

- The SPCT stated they had no concerns over accessing equipment, such as syringe drivers, for patients who require them. There were 35 syringe drivers within the hospital at the time of inspection.
- Mortuary fridge temperatures were continuously monitored via switchboard. The fridges were 'banked', meaning not all fridges were running from the same system. This helped mitigate the risk of equipment failure across all fridges within the mortuary at the same time. Mortuary staff were knowledgeable about the procedure in the event of failure of the fridges.

Nutrition and hydration

- Patients we spoke to during our inspection were happy with the food on offer at the trust.
- Patients had drinks within easy reach and were routinely offered fluids throughout the day.
- In clinical areas inspected there was documented evidence on the last days rounding forms of nursing staff offering regular nutrition and hydration. This was also observed in clinical areas.
- Nutrition and hydration were part of the 'COMPASSION' documentation tool and the last days of life care plan as areas for consideration. Patients are encouraged to eat and drink as and when they are able to and for as long as they are able to in their last days of life.

Patient outcomes

- In the latest End of Life Care Audit: Dying in Hospital (formally the National Care of the Dying Audit (NCDA)), published March 2016 by the Royal College of Physicians, the trust met one of the five clinical outcomes, assessing a patient's individual needs in the last 24 hours of life. This is a decrease in the number of clinical key performance indicators (KPI's) achieved in the NCDA published March 2015, where five of the 10 clinical KPI's were met.
- We reviewed 23 sets of multidisciplinary notes from patients who were at the end of their lives or receiving palliative care. Of the 23 notes, 11 had clearly documented that the patient was palliative or near the end of life.
- The trust participated in the National Care of the Dying Audit.

Competent staff

End of life care

- Appraisal data for the SPCT showed that of the three staff members, one had completed their appraisal, one was yet to complete their appraisal and one had not yet completed it due to only being in post for a short amount of time.
- All staff were provided with three hours of training on end of life care during corporate induction.
- End of life care champions were not in place across the trust. The SPCT stated this was something they would like to implement.
- Porters that transported deceased patients to the mortuary had a set of competencies completed by the mortuary manager. These competencies included: the booking in process, infection control and the safe movement of the deceased.

Multidisciplinary working

- We saw evidence of multidisciplinary working on Henry Moore ward for a palliative care patient requiring a fast track discharge. Multiple professionals had contributed to the discharge process including the patients' medical team, tissue viability nurse specialists and the SPCT.
- Multidisciplinary team (MDT) meetings were being held weekly. However, these were attended by the SPCT nurses and one of the SPCT consultants as part of the service level agreement. The SPCT stated they would consider the involvement of other professions in specific cases.
- The presence of allied health professionals, for example a physiotherapists or an occupational therapist, at these weekly meetings would provide a more holistic overview when planning care delivery. Due to the trust covering two counties and clinical commissioning group (CCG) areas, the presence of a social worker at the MDT meetings would have been beneficial.
- Referrals to the SPCT came from multiple professionals, including nursing, medical and allied health professionals.
- The mortuary had an agreement with the local undertakers that in the event of capacity issues at the hospital, the deceased could be moved out to refrigeration spaces at local undertakers.

Seven-day services

- The specialist palliative care team (SPCT) currently provided a Monday to Saturday 8am to 4pm service. The provision of the service on a Saturday commenced in May 2016. Staff could access a palliative care consultant out of hours via switchboard.
- The chaplaincy service was available 8am to 4pm Monday to Friday in the hospital. Out of hours, they provided a responsive service for any urgent referrals.
- The bereavement team was available Monday to Friday 8.30am to 4.30pm and provided an out of hours services for urgent enquiries.
- Mortuary staff were on site during the day, Monday to Friday between 8am and 4pm. Mortuary staff provided a responsive service out of hours, contactable via switchboard, for urgent referrals.
- Porters had access to the mortuary 24 hours a day, seven days a week, which enabled prompt transfer of deceased patients from clinical areas to the mortuary.

Access to information

- Medical notes and nursing notes were easily accessible within clinical areas when required. Ward based nursing staff were able to locate specific information within patient records. All members of the multidisciplinary team (MDT) documented in the same place. This meant all members of the MDT had access to all relevant notes.
- The SPCT had a separate area of the staff intranet containing information on end of life care.
- The bereavement officer ensured that all relevant information pertaining to a patient's death was gathered and a written explanation was available for families upon the collection of the death certificate. The bereavement officer was able to contact medical staff to provide a verbal explanation, either on the day or by prior arrangement.
- **Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**
- The trust used the East of England Do Not Attempt Cardio-pulmonary Resuscitation (DNACPR) form. The DNACPR form does not contain an area to document mental capacity or to document the patient's escalation plan or ceilings of care.
- During the inspection we reviewed 23 DNACPR forms from across multiple clinical areas.
- Of the 23 DNACPR forms reviewed, nine had inappropriate explanations of the reason for the implementation of the DNACPR. The inappropriate reasons included: "frailty", "dementia", "age" and

"mobility". All DNACPR forms found to have inappropriate reasons documented were highlighted to the medical teams and the nurse in charge and were reviewed.

- Of the 23 DNACPR forms reviewed, we found five with no clear documentation as to why the DNACPR decision had not been discussed with the patient. We found one DNACPR form on Lister ward with "very confused" documented as the reason for no discussion. However, no supporting mental capacity assessment (MCA) had been completed to support this. Staff on Lister ward were unsure why a formal MCA would need to be undertaken for the purpose of completing the DNACPR.
- An internal audit of DNACPR forms from December 2015 showed that of the 41 forms audited, 15 were completed in line with trust policy. Seventy-one per cent of the 41 forms had fully completed patient details and 49% had a discussion documented within medical notes.
- A further 40 patient notes were audited and 14 should have had a DNACPR form considered. However, no documentation of this was evident.
- A further audit in June 2016 showed that of the 26 DNACPR forms looked at, 58% had fully completed patient details, 69% were discussed with the patient and 46% had evidence of discussions documented in the medical notes. These results show a reduction in compliance compared with December 2015.
- We found one patient on Kingsmoor ward who, on admission, had a DNACPR in place within the community. However, this had not come into hospital with the patient. Although documented within the medical notes, the patient's DNACPR form was not brought into the hospital for 36 hours following admission. The ward medical team did not rewrite the form and no documented evidence was found to show that this had been considered.
- Knowledge and understanding of mental capacity was inconsistent across the trust.On Harold ward, Kingsmoor ward and the stroke unit we found examples of appropriately completed MCA's where patients had been identified as potentially lacking capacity. However, we found two examples, one on Henry Moore ward and one on Lister ward, where an MCA had not been completed for patients who potentially lacked capacity. On both occasions it was documented in the patient's notes that they were confused. However, no supporting capacity assessment was present.
- The trust has provided copies of their Mental Capacity Act (MCA) policy and Deprivation of Liberty Safeguards policy. The trust's MCA policy stated that a full MCA assessment must be carried out when a person's capacity is in doubt and a serious medical decision needs to be made, for example any decision not to continue active treatment. We found two incidents of patients with diagnoses of dementia who had not had an MCA assessment completed. However, a DNACPR had been implemented.
- The trust made 50 Deprivation of Liberty Safeguards applications from April 2015 to March 2016.
- The trust's Deprivation of Liberty Safeguards policy was issued March 2016. The trust's Deprivation of Liberty Safeguards policy stated that staff should consider all other options and a Deprivation of Liberty Safeguard should only be used as a "last resort". A Deprivation of Liberty Safeguard should be applied for whenever a patient has had their liberty deprived, for example if a patient is subject to continuous supervision and control or is not free to leave. A patient must also lack capacity for a Deprivation of Liberty Safeguard to be applied for.
- We saw no patients at the end of life or receiving palliative care that had an active Deprivation of Liberty Safeguard in place at the time of the inspection. However, staff across the hospital had an understanding of Deprivation of Liberty Safeguards and provided rationales for not applying for a Deprivation of Liberty Safeguard when asked. A consultant and two senior nurses on Kingsmoor ward had good knowledge and understanding of Deprivation of Liberty Safeguards. A consultant on Lister ward also had a good understanding of Deprivation of Liberty Safeguards.

Are end of life care services caring?

Good

Compassionate care

- Staff provided compassionate care in all clinical areas. Both nursing and medical staff were observed communicating in a kind and gentle manner with patients and families. Staff took time to assist patients at the end of life to eat and drink in a calm and non-rushed way.

End of life care

- One patient stated they were happy with the care being provided and that staff were kind and friendly. One relative stated they were very happy with the care provided and the staff were caring and considerate.
- There was an appropriate process in place for transporting deceased bariatric patients between clinical areas and the mortuary, to ensure their dignity and privacy was maintained.
- The porters and mortuary staff stated that they did not have any concerns over the care delivered to patients from ward staff and believed that patients were cared for in a dignified manner.

Understanding and involvement of patients and those close to them

- Positive interactions were observed between staff and patients and their family and relatives.
- We observed multiple discussions between patients and nursing, medical and allied health professionals that were caring and considered the wishes of the patient.
- The last days of life pathway was completed in conjunction with the patient, where possible, and their family. Documented evidence of patient and family involvement was seen during the inspection.
- On Kingsmoor ward a patient stated staff kept him informed, however, he felt no one was taking the lead on his care. The patient stated that staff knew a little bit about his care but none appeared to understand everything.
- A family on Locke ward told us that they had been kept informed throughout the care process and were aware of the next stages. The family were very happy with the level of information provided and the discussions that had taken place.

Emotional support

- The clinical nurse specialists (CNS) from the specialist palliative care team (SPCT) spent time with patients and their families to provide reassurance and support and answer any difficult questions that they may have in relation to the treatment being received.
- The SPCT acknowledged the importance of supporting not only the patient but their relatives and friends throughout the dying process.
- Chaplaincy, bereavement and mortuary staff demonstrated empathy for the relatives and friends of the deceased, stating the need for a holistic approach to the emotional needs of those left behind.
- The chaplaincy provided spiritual and non-spiritual support to patients and families regardless of religious beliefs in times of crisis and distress. However, this was difficult to access due to the chaplaincy staff being located in a separate building away from the main hospital.
- The bereavement office was a place for relatives to relax, ask questions and be supported before and after the death of a family member. The bereavement office had the facility to host discussions between families and medical staff to answer any questions about the treatment of the deceased and provide reassurance and support throughout the process.
- The trust had no formal psychological or counselling support available to relatives of patients at the end of life. The trust had no plans to implement a counselling service.

Are end of life care services responsive?

Inadequate 

Responsive was rated as inadequate for end of life care because:

- The trust recorded a patients' preferred place of care or preferred place of death on a database, however there was no recording or monitoring of what percentage of patients achieved their preferred place of care or death.
- The trust provided no data or supporting evidence to show the fast track discharge process for patients at the end of life was being monitored or audited. The trust had a four hour discharge target achievement time.
- The specialist palliative care team had limited insight into the complaints relating to end of life care.
- The process for disseminating learning from complaints was slow. However, evidence of learning from complaints was seen.

However;

- Thirty-four per cent of referrals to the SPCT were for patients with a non-cancer diagnosis, which was an increase from the previous year.
- The specialist palliative care team had made improvements in the time taken to review patients.

Service planning and delivery to meet the needs of local people

End of life care

· There were 476 referrals to the Specialist Palliative Care Team (SPCT) between April 2014 and March 2015. This increased to 525 between April 2015 and March 2016. The SPCT stated that 66% of referrals in 2015/2016 were for patients with a cancer diagnosis and 34% with non-cancer diagnosis.

· The SPCT encouraged referrals from nursing, medical and allied health professional staff from across the trust.

· During the inspection, the notes of a palliative care patient were reviewed who was part of the fast track discharge (FTD) process.

- The trust did not have a specific end of life care ward and patients requiring end of life or palliative care were cared for across all clinical areas. Patients were allocated side rooms wherever possible. However, this was not always possible and patients were prioritised according to need using the trust's side room prioritisation tool.

Meeting people's individual needs

· A last days of life care plan had been introduced in June 2016 to guide staff on individualising end of life care. However, this was not fully embedded at the time of the inspection. A last days of life care plan was seen on Locke ward which was missing details on spirituality. However, this was fully completed in all other areas. A second last days of life care plan was seen on Lister ward which had been fully completed throughout.

· Staff stated they would try wherever possible to move patients at the end of life into side rooms to promote privacy and dignity. However, this was not always possible.

· Carers and family members of palliative patients and those at the end of life were supported and services put in place to achieve this. Relatives had access to reduced car parking charges, food and drink within clinical areas and open visiting.

· Relatives had the opportunity to stay with patients who were receiving palliative or end of life care. One patient on Kingsmoor ward told us their relative was able to stay with them in the side room as they lived a long distance away.

· Data was requested on the target time for rapid discharge and the rapid discharge process. No data or supporting evidence has been submitted by the trust in response to the request. Therefore we could not be assured that patients were being discharged in a timely manner.

· Many religions including Christianity, Roman Catholic, Jehovah witness and Muslim were supported by the chaplaincy team on site. The lead chaplain was in the process of making arrangements with other local religious leaders, for example the local Imam, to facilitate them to come into the hospital should they be required.

· The chaplain was unable to provide examples of weddings, ceremonies or funerals that had taken place at the hospital for patients, though they were aware that they had happened in the past. However, the chaplain did state that he was in a position to be able to undertake funerals at the request of patients or relatives.

· Chaplaincy staff were located in a separate building away from the main hospital. However, the chapel was located within the main hospital building. The chapel was only accessible through a prior arrangement due to the chaplain and other staff not being located within the main hospital. The chapel was locked at all other times.

· There were no specific facilities within the mortuary to accommodate religious needs in terms of end of life rituals, for example allowing a family to wash the deceased. However, the bereavement service was available 24 hours a day seven days a week to facilitate rapid access to death certificates and the release of the deceased back to their families. The accessibility of the bereavement services allowed families to observe religious traditions, for example being buried within a certain length of time, as the process was more streamlined.

Access and flow

- In September 2015, 87% of patients referred to the SPCT were seen either the same day or the following day. One patient waited four days to be seen and another patient waited five days to be reviewed by the SPCT. In February 2016, 93% of patients referred were seen either the same day or the following day. One patient waited three days to be reviewed. Where a delay of more than three days was identified, the reasoning was due to no weekend cover and therefore patients referred on Fridays may have a longer wait.

End of life care

- The fast track discharge of patients was coordinated by the discharge planning team.
- Information was requested from the trust regarding the rapid discharge policy, target times for reviewing patients and achieving rapid discharge, and the monitoring and auditing of rapid discharge compliance and achievement. The trust provided a flow chart with a which detailed the fast track discharge process. The trust target was four hours for the discharge of patients. However this target was not being monitored therefore we could not be assured that patients were being assessed and discharged in a timely manner. Low monitoring demonstrates a lack of desire to improve the discharge process for patients at the end of life.
- One discharge nurse stated that they would like to think patients were discharged within 48 hours of funding being approved. However, was unable to provide any clarity about how this was measured or monitored. We were not assured that rapid discharge was being monitored and patients were reaching their desired outcomes in a timely manner.
- A clinical nurse specialist (CNS) from the rapid discharge team told us that patients were assessed using the Gold Standard Framework (GSF) prognostic indicator. The GSF prognostic indicator is a tool used to identify patients that require palliative or end of life care and their likely life expectancy. A CNS explained that patients were assessed using the GSF and their fast track processes were started in order of life expectancy.
- We reviewed one palliative care patient's notes that were currently being assessed for fast track discharge. The patient had been waiting seven days for a full rapid discharge assessment. Staff stated this was due to family involvement and the need to discuss the needs of the patient with their relatives before undertaking an assessment. This had delayed the fast track process and therefore the possible outcome for the patient.
- The trust did not routinely audit patients' preferred place of care (PPC) or preferred place of death (PPD). One audit was undertaken in March 2016 reviewing PPC / PPD of patients between January 2016 and March 2016. The report showed that out of 110 palliative care patients, none had their PPC / PPD documented prior to a referral to the discharge team. Following referral to the discharge team, 105 patients had their PPC / PPD documented. Of the five patients where PPC / PPD was not documented, four patients were not medically suitable to be moved and one patient was not end of life. The trust was aware of the actual place of death of 77 of the 110 patients, and 52 achieved their PPC / PPD.
- The trust was now recording PPD / PPC on a system, however monitoring of this outcome was still limited.
- The mortuary capacity was 74 fridge spaces, with two suitable for bariatric patients, and six deep freeze spaces. However, two of the freezer spaces were not usable due to the broken freezer unit. The mortuary has access to a further 20 fridge spaces in an external unit. However, its use was due to end in July 2016. There was no specialist refrigeration for children or babies. However, specific storage was available for non-viable foetuses.
- Portering staff had access 24 hours a day to the mortuary. This ensured the transfer of patients from clinical areas to the mortuary in a timely manner.

Learning from complaints and concerns

- The trust submitted data showing it had received 11 complaints relating to end of life care between July 2015 and March 2016.
- The SPCT stated the most recent complaint was from December 2015. The data submitted by the trust shows two complaints from March 2016 relating to the provision of end of life care.
- The SPCT stated that learning had not been disseminated to staff following a complaint in December 2015 as this was done at 'sharing the learning group', which met every four to six weeks. However, no explanation was given for the delay in disseminating learning from December 2015 to July 2016. Delays in disseminating learning from complaints could result in staff providing poor care unnecessarily.
- Complaints relating to end of life care were not specifically highlighted on the trust's complaints database. Complaints were logged under the speciality that the patient was being treated within, for example surgery or outpatients.
- Learning was seen following a complaint in July 2015 relating to the mortuary. Changes had been made to reduce future risk following a biopsy being taken from the wrong deceased patient.

End of life care

- Staff on Harvey ward gave an example where, following a complaint from a relative, concerns were discussed at the patient safety and quality group. Findings were disseminated to the staff concerned and changes made at a local level.

Are end of life care services well-led?

Inadequate

End of life care services were rated as inadequate for well-led because:

- There was no vision or strategy in place for end of life care. This had been highlighted as a concern at the previous inspection in July 2015.
- A non-executive lead had been appointed for end of life care. However, this lead was only established six weeks prior to the inspection.
- There was a lack of understanding and oversight of the service from the executive and non-executive team.
- There was no risk assessment undertaken for the mortuary with regards to the deteriorating condition of the fridges and freezers.
- There was no risk register for end of life care. However, risks were incorporated into the cancer and specialist services healthcare group risk register.
- The risk highlighted on the cancer and specialist services risk register and the risks on the mortuary risk register did not correlate with the risks found during inspection. The risk register for cancer and specialist services was out of date and did not reflect the current function of the SPCT.
- Individual speciality consultants making medical decisions around end of life care could result in inconsistencies across the trust. However, the specialist palliative care team (SPCT) did not consider it a risk to have no substantive medical leadership.
- The senior management team were not active in mitigating risks and challenges facing the service, for example the need for maintenance work within the mortuary.
- Compliance with the completion of DoNot Attempt Cardiopulmonary Resuscitation (DNACPR) forms had decreased, despite additional training and director level oversight.

However:

- Nursing staff across all clinical areas acknowledged the importance of end of life care.
- Medical and nursing staff were open and receptive to challenge throughout the inspection.

Vision and strategy for this service

- The Chief Medical Officer stated that a vision and strategy for the service was not yet ratified.
- The draft vision was brief, lacked detail and had no strategy for achievement. It consisted of six ambitions, which had been taken from the National Palliative and End of Life Partnership, and eight brief bullet pointed mechanisms for achievement. However, these did not constitute the start of a viable strategy.
- The document stated the trust aspired to achieve the vision by 2020. Although a long term view of end of life care was required, there was no short term plan, ratified vision or strategy.
- This demonstrated that there was little improvement from the last inspection in July 2015, when the trust was found to have no vision or strategy for end of life and palliative care services.

Governance, risk management and quality measurement

- The More Care, Less Pathway report, published July 2013 by the Department of Health (DH), recommended that all healthcare organisations appoint a non-executive member of the board to oversee end of life care. The trust adopted this recommendation and had appointed a non-executive director (NED) to oversee end of life care.
- The trust did not have a specific risk register for end of life care. Identified risks were incorporated into the trust's cancer and specialist services risk register.
- At the time of inspection there were two risks identified for end of life care: the lack of a seven day service and non-compliance with NICE guidance NG31 care of dying adults in last days of life. However, these risks were not current to the service.
- The risk concerning a lack of a seven day services stated that the SPCT were providing a Monday to Friday service and were awaiting a third clinical nurse specialist (CNS) to commence employment. However, a Monday to Saturday service was provided and the third CNS commenced employment in February 2016.
- The second risk concerned the trust's compliance with NICE NG31 was a result of not providing a seven day

service and had been cross referenced to the first risk. The risk register identified a plan to increase to a six day service. At the time of our inspection, a six day service had been implemented.

- The SPCT told us there were two risks on the risk register: the lack of a consultant and no care plan to replace the Liverpool Care Pathway. This does not correlate with the information supplied by the trust prior to the inspection.
- The mortuary risk register included three risks. However, this did not include the faulty fridge doors, faulty freezer unit, the outside storage unit or the potential risk to the integrity of bodies through the broken fridges and freezers. There was a lack of oversight into the risks within the mortuary. Staff had not considered the risk to the deceased through inefficient cooling units and were not actively monitoring bodies for degradation.
- The Chief Medical Officer and NED did not demonstrate an understanding of the service risks as reported on the risk register. The Chief Medical Offcer stated the main risk areas were imperfectly filled in DNACPR forms and inappropriate resuscitation attempts.
- We could not be assured that the SPCT, mortuary staff and executive team were fully aware of the risk within the service. The SPCT, mortuary staff and executive team gave differing risks and these were not in line with the risks identified on the risk registers as submitted by the trust at the CQC's request.
- More Care, Less Pathway recommended that a yearly report be submitted to the board to establish the state of end of life care within the trust. This was completed through the submission of an annual report on specialist palliative care.
- Following the audit of DNACPR forms in November 2015, additional training was provided to staff, exemplar DNACPR forms were distributed to clinical areas and the results discussed during grand round. However, the latest audit of DNACPR forms from June 2016 showed a decrease in the compliance surrounding their completion. Interventions made following the November 2015 audit had been ineffective in improving compliance. As the June 2016 results were not fully ratified at the time of inspection, no action plan was in place to improve the results. The Chief Medical Officer and NED were unable to provide further detail on how improvements in DNACPR compliance were going to be achieved.
- The trust had published a 'Guideline to Implement the Care Plan for the Anticipated Last Days of Life' in May 2016. However, the guidelines stated the Chief Nurse was the executive lead and accountable officer for end of life care. During the inspection, the Chief Medical Officer was identified by the trust as the executive lead for end of life care. The guideline stated that ward based champions were "a resource for the multidisciplinary team" and acted as a link between ward areas and specialist teams. Ward champions were not in place at the time of the inspection and the SPCT told us there were no plans to implement ward champions in the near future.
- Publishing conflicting and inaccurate information shows a lack of senior oversight and scrutiny of end of life services. The guidance was ratified by the trust policy group which shows a lack of trust wide understanding and knowledge of end of life care services, as inaccuracies have not been highlighted and challenged.
- Palliative care was discussed during quality and safety committee meetings. A member of the SPCT was present at the November 2015 and March 2016 meetings. During the June 2015 meeting, it was noted that funding had been approved by the board for a further two sessions from a palliative care consultant, making six sessions in total. At the time of inspection, two consultants were providing four sessions a week. Although funding had been approved, the trust had not implemented the recommendations and recruited a consultant to provide the additional hours, or increased the hours provided by the two current consultants.
- The trust held an end of life steering group, led by the SPCT. The end of life steering group was attended by clinicians from across multiple clinical specialties and patient representatives. The minutes from the steering group showed detailed discussions and actions set.

Leadership of service

- End of life care was led at an executive level by the Chief medical Officer and supported by a non-executive director (NED). However, the NED commenced the end of life role in May 2016 as was not fully established within the role.
- The Chief Medical Officer evidenced past experience of delivering end of life care at a strategic level. The NED evidenced current and past experience of providing palliative care at a strategic level.

End of life care

- There was a lack of medical palliative care leadership at the trust. Two consultants covered 0.4WTE in the service. Consultant support was being provided through a service level agreement (SLA) with two local hospices.
- The SPCT stated that medical consultants took the lead on patients' palliative care.
- Leadership of end of life care was not effective due to the Chief Medical Officer and NED evidencing little oversight of concerns and problems.
- The SPCT and executive team were open and accepting of challenge during the inspection. In the two weeks following the inspection, changes had been made following feedback, particularly in reference to the mortuary.

Culture within the service

- There was recognition of the importance of end of life care across all staff groups throughout the hospital. Medical staff on Kingsmoor ward and nursing staff on Lister demonstrated a particular enthusiasm for high quality end of life care.
- Mortuary and bereavement staff showed a strong team ethic and a structured working relationship. The mortuary and bereavement teams demonstrated a willingness to improve the care and experience of both the deceased and their relatives.
- End of life care had been highlighted as a priority for change following the previous inspection in July 2015. Implementation of change, review of services and the appointment or advertisement of an appropriate NED and palliative care consultant had been slow. Many of the changes that had been made were implemented within the two months leading up to our inspection; for example the appointment of a NED, advertising for a palliative care consultant, moving to six day working and the roll out of the replacement for the Liverpool Care Pathway (LCP).

Public and staff engagement

- Patient and relative feedback was gathered informally with no structured approach to feedback.
- Patient representatives were invited to the end of life care steering group. Minutes from the end of life steering group from March, May and June 2016 show patient representation at the group.
- Staff were encouraged to provide feedback on the last days rounding tool. However, this was done informally and without structure.

Innovation, improvement and sustainability

- A NED had been appointed in May 2016 and was beginning to take oversight of the service.
- A six day palliative care service had commenced and was working well.
- A substantive palliative care consultant post was being advertised at the time of the inspection.
- Improvement plans had been implemented for the mortuary in the two weeks following the inspection.

Outpatients and diagnostic imaging

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

Information about the service

The outpatient service at The Princess Alexandra Hospital covered a wide range of specialities including dermatology, orthopaedic, ophthalmology, respiratory and oncology. The diagnostic and imaging department carried out routine x-rays as well as more complex tests such as magnetic-resonance imaging (MRI) and computerised tomography (CT) scans. We inspected services that were solely delivered from The Princess Alexandra Hospital during this inspection. Services at the hospital saw adults and children and there was a separate children's outpatient area. The children's outpatients' service has been reported on separately within our children and young person's report.

Outpatient and diagnostic imaging services were available seven days a week. Outpatients operated between 8am and 6pm on weekdays and held clinics, aimed at reducing appointment waiting times, during weekends. Diagnostic services operated 8am to 8pm Monday through Friday and 9am until 5pm Saturday and Sunday.

There were 210,017 outpatient attendances between April 2015 and March 2016. The services most in demand were midwifery, ophthalmology and trauma and orthopaedics.

Outpatient and diagnostic services sat within the cardiology, cancer and clinical support (CCCS) division, which is led by an associate medical director, associate director of operations and an associate director of nursing and therapies.

During our inspection we visited the main outpatient and diagnostic imaging departments, cardiology, ears nose and throat (ENT), and ophthalmology areas. We spoke with 14 members of staff including diagnostic and imaging staff, clinicians, managers, nurses and support staff. We observed care, looked at 11 patient records and spoke to 10 patients and four relatives.

Outpatients and diagnostic imaging

Summary of findings

Outpatient and diagnostic imaging services at The Princess Alexandra Hospital have been rated as good overall. Safe, caring and well-led have been rated as good with responsiveness requiring improvement. We do not rate effective in outpatient and diagnostic services due to there being an inconsistent data set for services of these types.

- During this inspection we followed up on a number of areas which we found to be inadequate or requiring improvement during our last inspection in July 2015. The previous issues related mainly to patients having to wait unsafe amounts of time before being offered an appointment. We found that the service had taken action and improvements were seen.
- Staff were aware of how to report incidents and when this should be done. There was a clear escalation pathway for safeguarding concerns and medication was stored appropriately, in line with manufacturer's guidance.
- Mandatory training compliance was good and staff were competent in their roles.
- Policies and procedures were developed using relevant national best practice guidance and patient outcomes were monitored via national audit arrangements. However, the limited audit activity within the division meant that there was limited opportunity to improve patient outcomes locally.
- There was patient choice about how and where they accessed services and people's individual needs, such as physical and mental disabilities, were catered for.
- Staff provided compassionate and respectful care to patients. We observed that staff were understanding and maintained patient dignity. The majority of patient feedback that we received during our inspection was positive, and the latest Friends and Family Test (FFT) results demonstrated 96% of patients would recommend the service.
- There was a cohesive leadership team and staff felt managers were approachable and that there was a strong open culture. Patients and staff were engaged in the running of the service and staff were enabled to be innovative. Since our previous inspection, governance systems had been reviewed and a clear structure had been put in place.

However:

- However, the main outpatient department was dated and in need of repair and refurbishment, and 10 out of the 11 patient records we reviewed did not contain up to date patient information.
- The service was not being responsive to ensure patients received timely access to services.
- The majority of specialities within the outpatients service were not meeting the 18 week referral to treatment (RTT) indicator and there was a high number of avoidable clinic cancellations.
- Data demonstrated that there was a high rate of patients not attending appointments and we found that appointment bookings were not being managed effectively as there was not a complete central booking system.
- Systems for governance quality and assurance were not yet embedded and required continuous monitoring to assess its effectiveness.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services safe?

Good

We rated safe as good because:

- There was a good incident reporting, investigation and feedback system.
- Appropriate infection control procedures were in place and the environment was clean.
- There were robust medicine management procedures.
- Staff recognised how to respond to patient risk and there were arrangements to identify and care for patients who became unwell whilst attending the outpatient and diagnostic services.
- Staffing levels were appropriate and were planned around clinics.
- Staff received mandatory training and there was a good level of completion.

However:

- The main outpatient department was dated and in need of repair and refurbishment.
- Of the records reviewed 10 out of the 11 patient records did not contain up to date patient information.
- Records management was not robust. There were 116 record incidents across the outpatient department between Aug 2015 and July 2016.
- There were long periods between safety checks on defibrillators.

Incidents

- We spoke to staff who were aware of their responsibilities to report incidents through the hospitals electronic reporting system. Each member of staff gave appropriate examples of the types of incident which they would report. These included medication errors, falls or issues with patient's records.
- Between April 2015 and March 2016 the service reported 556 adverse incidents or near misses. The hospital as a whole was a higher than average incident reporter. This suggested an open culture. We saw that incidents had been collated and analysed and key areas for improvement were identified, such as, to see a reduction in laboratory test errors and appointment errors. Actions included providing additional training to staff, amending paperwork and the highlighting of relevant policies and procedures. However, it was not clear from information we reviewed how the monitoring of these improvements would take place.
- During the same period the service reported one serious incident. This was in relation to a delayed outpatient appointment. This delay in medical intervention led to avoidable harm for the patient. We reviewed the root cause analyses (RCA) for this incident and saw that a thorough investigation had been carried out with lessons learnt identified.
- There had been no incidents reportable under the Ionising Radiation (Medical Exposure) Regulations 2000 (IR(ME)R) in the year preceding our inspection.
- Staff were provided with feedback on incidents and an example was given in relation to a maintenance incident raised within the cardiology team. The incident reporter had been kept up to date with action being taken and was informed of the outcomes.
- We spoke with staff who confirmed that learning took place following incidents. We were given an example whereby a patient had received sub-optimal care due to being nursed on a non-specialist cardiology ward. Processes had been put in place which ensured these patients were identified to cardiology staff so that regular review and monitoring could take place.
- Learning was also evident from the services' patient safety and quality forum, which was held monthly. We reviewed minutes from the January 2016 meeting, where we saw that incidents had been analysed and the top theme identified was in relation to cancelled clinics. After a review it was established there was a problem with the hospital's electronic patient information system and action was taken to address this.
- The hospital had regard to duty of candour. This is the duty on healthcare providers to act in an open and transparent way with patients when a notifiable safety incident occurs in relation to their care or treatment. We saw, from a selection of RCAs, that patients were contacted when things went wrong and provided with appropriate information and support.

Cleanliness, infection control and hygiene

- All the outpatient and diagnostic imaging areas we visited were visibly clean. However, on three occasions,

we saw unclean public toilet areas. We reviewed documents provided by the trust which showed that the cleaning of public areas had been reduced to support cleaning of inpatient areas.

- We saw staff in clinical areas observed 'bare below the elbow' guidance and practiced appropriate hand hygiene techniques. This included the use of alcohol gel dispensers, which were in ample supply, and hand washing.
- We reviewed hand hygiene audits for January, February and March 2016 for the outpatient and diagnostic service departments and noted between 99% and 100% compliance.
- Infection prevention and control policies were accessible to all staff on the intranet. We reviewed a copy of the hospital's infection prevention and controls precaution policy dated 2014 and saw that it made reference to best practice guidance.
- 84% of staff had completed infection control training.
- Appropriate waste management systems were in place with the use of clinical and non-clinical waste bins and separate sharps disposal boxes.

Environment and equipment

- We reviewed four resuscitation trolleys during our inspection and found that daily and weekly checks had been marked as complete on all days clinics were running in the month of June 2016. However, we were concerned at the adequacy of defibrillator checks because on two occasions there were long periods of time between checks. For example, in the cardiology department we saw that the defibrillator was last checked on 26 May 2016 and before that on 2 November 2015. We escalated this to the management team during our inspection.
- Other equipment we checked such as electrocardiogram (ECG) machines, patient monitoring equipment, blood glucose machines and eye refractors were up to date to with servicing and safety testing. This was supported by the hospitals equipment log sent to us prior to our inspection which confirmed all equipment had been serviced as required.
- At our previous inspection in 2015 we found that the minor operations room at St Margaret's Hospital was not fit for purpose. This was because procedures had been being carried out in an environment which was not safe. We were told by the outpatient manager for St Margret's Hospital that a full review of services had been carried out and improvements to the procedure room undertaken. This resulted in an agreed list of procedures being developed which were suitable for this area. We reviewed the updated guidance and procedures. These demonstrated only suitably risk assessed and supported procedures were undertaken.
- The outpatient manager also told us about improvements being made to the environment at St Margaret's Hospital which involved the local community. For example, the local secondary school had been asked to paint pictures which could be displayed and a local charity called Epping in Bloom was involved in making the outside areas more appealing.
- All areas visited, with the exception of the main outpatient department, were in a good state of repair. Whilst we noted new windows had been installed in some of the main outpatient clinic rooms, the general condition of the department was worn. We saw paint chipping off walls, skirting frames coming away from walls, stained ceiling tiles and unfilled holes covering the walls.

Medicines

- We checked the storage and management of medicines and found effective systems in place. We reviewed checklist for the month of June 2016 and found that refrigerator temperatures were monitored on a daily basis and remained within an optimal temperature range.
- Drugs and lotions were stored safely. All medicine cupboards we checked were locked.
- We checked five medicines in the department and all were within their expiry date.
- We saw copies of monthly audits from July 2015 to May 2016 which demonstrated the medicine arrangements in the department were monitored regularly. All audits seen showed that procedures were adhered to.
- The process for ensuring the safe storage and appropriate use of FP10 prescriptions (prescriptions used in outpatient departments) was well understood by staff. We saw these being signed out by medical staff during our inspection and saw that appropriate logging took place on their return.

Records

- We reviewed 11 sets of patient records and in 10 sets we noted the patient's last clinic letter or GP referral was not present in the record. This meant that clinicians and

nursing staff often had to spend additional time tracking information down on the electronic record system or from secretaries. In order to ensure correct patient care we were told that should information not be found patient appointments would have to be cancelled.

- However, data demonstrated that only 0.2% (16 patients) of patient appointments had been cancelled because records were not present between Aug 2015 and July 2016.
- Records management remained an issue for the trust in general. We reviewed incident data between August 2015 and July 2016 and noted 116 records related incidents. These ranged from notes not being present in patient's records, patient records not being available for clinics; therefore temporary notes were having to be compiled and incidents of patient notes being found in other patient records.
- Nursing staff told us that records were often disorganised which meant that on occasion information could not be found.
- Nursing assessments were completed in full as necessary and consultant notes were present and legible within the patient record.

Safeguarding

- Policies and procedures were in place for staff to access in relation to safeguarding both adults and children. However, the hospital's safeguarding vulnerable adults policy was overdue review since May 2016.
- The hospital's procedures linked in to the local Southend, Essex and Thurrock Safeguarding board. This enabled information sharing and learning from wider safeguarding issues to be considered.
- All staff were provided training on safeguarding vulnerable adults and safeguarding children level one. At the time of our inspection in June 2016, 97% of staff were up to date with both these training modules.
- 84% of staff required to undertake safeguarding children level two training had completed this.
- Senior management and some registered nurses had been identified to undertake level three safeguarding training and compliance stood at 92%.
- There was a dedicated staff champion at local level to support staff with safeguarding queries or concerns.
- We spoke with three members of staff who were confident in providing examples of when a safeguarding concern would need to be raised. They spoke at ease about the internal reporting and escalation arrangements including contacting the hospitals safeguarding lead and completing an incident report.

Mandatory training

- There was a good level of compliance with mandatory training across the service.
- Mandatory training consisted of health and safety (87% compliance), dementia training (100% compliance), equality and diversity (96% compliance), fire safety (84% compliance) and manual handling (88% compliance).
- Infection control and safeguarding training was also classified as mandatory training. Compliance figures have been reported earlier in this report.

Assessing and responding to patient risk

- During our previous inspection carried out in 2015 we found that the service had a very high number of patients on clinic waiting lists. Some patients had been waiting over 52 weeks for appointments.
- The service had undertaken a review of all these patients and ensured that patients were seen according to clinical priority.
- To reduce the backlog of patients on waiting lists and ensure patients were assessed in a timely way, the service had been holding clinics at weekends. At the time of our inspection 1200 additional clinics had been provided.
- In order to provide a sustainable service and not see clinics build up such long waiting lists, we heard that a service review and redesign had taken place. This review led to changes in staffing and clinic utilisation. Managers were aware of the need for continuous monitoring to assess the impact of this change.
- Should a patient become unwell whilst attending their outpatient appointment, processes were in place which meant that they would be transferred to the emergency department (ED). During our inspection we saw an example of this in practice. A patient became faint and nursing staff took immediate action to assess their condition and made arrangements for them to be transferred to the ED.
- The matron of the outpatient service had recently introduced safety huddles to the team. These huddles were carried out during the morning and offered staff an opportunity to raise concerns, get an understanding of

how the clinic was running and offer or request support. This practice was implemented following learning gained from another hospital and staff we spoke with felt it had made a positive impact.
- The hospital's electronic patient records system allowed vulnerable patients to be highlighted. We heard that when a vulnerable patient was known to be accessing the service, reasonable adjustments would be made. This included lengthening appointment times, arranging appointments at the beginning or end of the day or increasing staff support.
- There was an outsourcing arrangement for the reporting on diagnostic imaging for patients who required emergency out of hours scans.
- The diagnostics department used the 'Five Steps to Safer Surgery' World Health Organisation (WHO) checklist, for interventional radiology.

Nursing staffing

- There were two nursing vacancies in the outpatient department at the time of our inspection. Active recruitment was taking place with one vacancy due to be filled in July 2016.
- There were also seven members of staff off sick at the time of inspection which was impacting staff morale due to extra workloads and shifts.
- However, the existing workforce, together with bank staff, were maintaining safe staffing for clinics which was for one or two trained nurses per clinic with a support worker to aid with chaperoning.
- Rotas were generally planned four weeks in advance to ensure appropriate cover. However, we heard that on two occasions recently business services had announced two short notice clinics. Staffing for these clinics had not been prearranged and staff were asked to work additional hours.

Medical staffing

- Clinicians and managers in the outpatient department assessed the medical staffing needs for clinics and flexed these to meet the needs of individual clinics.
- There were a minimum of eight consultants on-site between 8am and 5pm Monday to Friday and one consultant on site between 5pm and 9pm.
- One consultant was then on call from home between 9pm and 8am. This was rotated between 11 different consultants.
- There were three radiographer vacancies at the time of our inspection. These posts were due to be filled by students.

Major incident awareness and training

- There was an internal major incident policy in place and the hospital linked with the local emergency planning and resilience groups. We saw these plans were accessible and staff members spoken with were familiar with the protocols.
- Business continuity plans were also in place. These contained plans to assist staff in dealing with circumstances such as loss of staff, loss of information technology or data, loss of utilities or acute pressures in capacity.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

We do not rate effective for outpatient and diagnostic imaging services. However, our findings demonstrated:

- Policies and procedures were developed using relevant national best practice guidance.
- Patient outcomes were monitored via national audit arrangements.
- Staff were supported with learning and development to ensure they were competent in their role.
- There were good procedures in place to gain people's consent and staff were aware of their responsibilities in relation to the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.

However:

- The local audit plan was limited in content meaning that there was limited opportunity to improve patient outcomes locally.
- Appraisal rates were low with only 74% of staff having received an appraisal between April 2015 and March 2016 within outpatient staff.

Evidence-based care and treatment

- Diagnostics and imaging services conducted patient dose assessments and audits to ensure that patients received the correct level of radiation dose when

receiving x-rays. Part of this work used national guidelines to inform their practice such as the NHS Breast Screening Programme and Public Health England.

- We saw reviews against the Ionising Radiation (Medical Exposure) Regulations 2000 (IR(ME)R) were undertaken and that learning was disseminated to staff through team meetings and training. This included auditing xray services and the breast unit. Outcomes were reported to the radiation protection committee.
- The trust had nine radiation protection supervisors (RPS) to lead on the development, implementation, monitoring and review of policies and procedures to comply with IR(ME)R regulations.
- Policies and procedures for the hospital were based on best practice guidance issued by bodies such at the National Institute for Health and Care Excellence, the Nursing and Midwifery Council, Royal College of Physicians and the Department of Health.

Pain relief

- The outpatient department ran specialist pain management clinics.
- We asked the trusts to provide us with audits which demonstrate the standards of the Royal College of Anaesthetics (RCOAs) Faculty of Pain Medicine's Core Standards for Pain Management have been reviewed at the hospital. However, no audits were provided.

Patient outcomes

- The outpatient service had been allocated a Commissioning for Quality and Innovation (CQUIN) target for the 2016/17 year. This was in relation to shared decision making. The service was implementing an "Ask 3 questions" approach to encourage people to play an active role in decisions about their care and treatment.
- A number of Healthcare Quality Improvement Partnership (HQIP) audits were taking place within the service to look at patient outcomes and subsequent improvements. This included an audit on Prescribing Observatory for Mental Health (POMH) Congenital Heart Disease run by the Royal College of Psychiatrists, and audit on Cardiac Rhythm Management (CRM) conducted by the National Institute for Cardiovascular Outcomes Research. Outcome data was not available at the time of our inspection.
- However, there was a lack of local auditing taking place. There had only been 15 audits identified for the 2016/17 year for the whole of the cardiology, cancer and clinical support (CCCS) division. This meant there was little opportunity for the services to assess its performance and make improvements to benefit patients.

Competent staff

- The outpatient matron monitored nursing revalidation to ensure that staff renewed their professional registration every three years and demonstrated effective and safe practice.
- Staff had good access to learning and development courses such as domestic violence training and clinical study days to support them in their roles. We spoke to a healthcare assistant who was being supported to undertake their nursing qualification and attending a foundation degree course.
- Staff were regularly competency assessed in areas such as record keeping, vital signs, aseptic non-touch technique and blood glucose monitoring. We checked five staff files and saw completed checks had taken place throughout the past year.
- Nursing staff rotated between clinics and locations in order to build and maintain an appropriate skill-mix of staff.
- This method of building up a skill-mix had also been applied to administrative staff. We heard that this staff group were also rotating through clinics in order to gain experience and knowledge. This meant that covering sickness and absence in the team would become less troublesome because there would be a cohort of staff who had multiple areas of expertise.
- Leadership training had been provided to the managers of this service in order for them to become more effective in their roles.
- However, appraisal rates were low with only 74% of staff having received an appraisal between April 2015 and March 2016 within outpatients.

Multidisciplinary working

- Good internal team working was reported between services, for example, between clinics and diagnostic imaging services and the pathology department.
- We heard that there had been an emphasis on building relationships between nursing and administrative staff. Staff we spoke with felt that this relationship had much improved and there was a wider understanding from all staff on how they impacted and supported each other in their roles.

Outpatients and diagnostic imaging

- The diagnostic imaging service worked with community nursing teams and provided a dedicated community referral service.

Seven-day services

- Outpatient services were not routinely available seven days a week. However, in order to deal with appointment backlogs, some outpatient services were being made available during the evenings and weekends.
- Diagnostic imaging services were available seven days a week. Services operated Monday to Friday between 8am and 8pm and between 9am and 5pm on Saturday and Sunday. On call out of hours arrangements were also in place to deal with emergencies.

Access to information

- All staff had access to the hospital's electronic records system where patient letters, blood results and diagnostic reports were stored and accessible. This system was protected with username and password security.
- In order to track and maintain information on cancer patients, the hospital had implemented the Infoflex System (an integrated IT system to share information and workflow across departments).
- The diagnostic and imaging services used an electronic reporting system which was accessible to a variety of healthcare professionals such as consultants and GPs. This system was also accessible to the Border Agency to access information on suspected smugglers who had been brought to the hospital for scans.

Consent, Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards

- Nursing staff we spoke with had a good understanding of consent and when consent was required.
- We reviewed five consent forms and saw these were completed in full and were legible. Risks and benefits were discussed with patients and clearly documented on the consent forms.
- MCA and Deprivation of Liberty Safeguards training was provided to staff at the time of our inspection. Between 87% and 100% of clinical staff working in outpatients had received safeguarding level one training, which incorporated training on the Mental Capacity Act 2005.
- We spoke with three members of staff who all demonstrated a good understanding of the requirements of the MCA and Deprivation of Liberty Safeguards. They were aware of the assessment criteria needed to assess capacity and also understood that capacity could be fluctuating. Staff understood the decision making processes for people lacking capacity to be in their best interests and knew who to contact should they need further support in relation to these procedures.

Are outpatient and diagnostic imaging services caring?

Good

We rated caring as good because:

- Patients reported positive experiences and felt the care received met their expectations.
- People had their privacy and dignity maintained at all times.
- Patients were listened to and actively involved in their care and treatment.
- People's emotional needs were recognised by staff and we were given examples of how these needs would be met.

Compassionate Care

- Throughout our inspection we observed care being provided by nursing, medical and other clinical staff. We saw examples of staff being friendly, approachable and professional. For example, when people became lost, staff would accompany people to the area in which they should be.
- We witnessed people being spoken to with respect at all times.
- Patients reported a positive experience. One patient told us "My treatment has always been of a high standard, I cannot fault the care" and another patient who had attended for multiple appointments told us that the staff made them feel "relaxed."
- We were provided with Friends and Family Test data for February 2016.It was reported that 96% of people would recommend the service to their friends or family
- We reviewed 12 comment cards which had been completed by patients and saw these contained positive

feedback. For example, one person stated "You did everything well, my Dr was lovely, pleasant and helpful and explained everything, another person said about their time in diagnostic imaging "X-ray was pleasant and helpful, the nurses were lovely."
- Areas that had been suggested for improvement included more disabled parking, better parking facilities in general and shortening clinic waiting times.

Understanding and involvement of patients and those close to them

- All patients we spoke with felt well informed and included in the entire decision making process in relation to their care and treatment. For example, one patient told us "I can ask questions [of my Doctor] and they go out of their way to explain everything." Another person stated "Staff are professional and explain everything well."
- We observed patients being greeted and booked into the department. Staff greeted patients in a warm and welcoming manner and were given clear instructions by the receptionist regarding which waiting area to sit in and any delays there were in the clinics.
- We observed staff interactions with patients and saw that they explained what was happening and ensured that the person and their relative, where appropriate, understood the care or treatment being provided to them.
- We reviewed the radiology department's patient feedback from March 2016 and saw that all patients had responded that the communication of their diagnostic results were either good or excellent.
- We did, however, receive negative feedback from one patient who informed us that staff had not, on two occasions, reported back information in relation to their condition and who could not get through on the telephone which had led them to come to the hospital with no appointment. We advised this patient to contact the patient advice and liaison service (PALS) and access the hospital's complaints system if necessary.

Emotional support

- Patients we spoke with told us staff were kind and considerate to them during their visit to the outpatients department. For example, one patient stated that the staff had come over to check on them because they were waiting on their own.
- Information was available to patients regarding support groups they could contact for specific conditions, for example, diabetes and epilepsy.

Are outpatient and diagnostic imaging services responsive?

Requires improvement

We rated responsive as requiring improvement because:

- The majority of specialities were not meeting the 18 week referral to treatment indicator. The trust was not meeting the 92% referral to treatment (RTT) indicator for patients waiting more than 18 weeks for an appointment in 11 out of 16 specialities.
- There was a high number of avoidable clinic cancellations. In April 2016, 601 patients were affected by these cancellations. Out of 62 clinic cancellations, 57 were noted to be avoidable.
- There was a high rate at patients not attending appointments. On average, 10% of patients did not attend for their appointments each month.
- Appointment bookings were not being managed effectively as there was not a complete central booking system. This meant that on occasion patients would not turn up for appointments because they had not received notification of their appointment.
- The trust averaged a 31.6% deferral of appointment ratio, which is higher than what would be expected for a service of this size.
- There was limited evidence to demonstrate that learning from complaints took place.

However:

- There was patient choice about how and where they accessed the service.
- The service was set up to ensure people's individual needs, such as physical and mental disabilities, were catered for.
- The service was meeting national targets for cancer patients.

Service planning and delivery to meet the needs of local people

Outpatients and diagnostic imaging

- Patients we spoke with confirmed there had been a choice of appointment and clinic location offered to them. The service was delivered at a variety of locations to meet the needs of the public.
- The hospital had recently updated the signage system within the hospital. It had designed a zone system and areas were labelled and signposted in relation to which zone the fell into. For example, the main outpatient department was located in Zone B. This system was still confusing to patients and visitors. We witnessed people who had become lost and required direction and five patients we spoke with commented the new signage was unclear.

Access and flow

- Staff working within the outpatient department told us patients could use the 'choose and book' system to enable them to choose an appointment in a hospital location close to their home. Patients we spoke with confirmed this also.
- A booking team was available at the hospital to assist patients with booking appointments or making rearrangements. Letters were sent to patients to inform them of their appointment date and time.
- However, not all appointment bookings were managed by the central booking team. We spoke with an external stakeholder who attended the hospital to run respiratory clinics. We were told that on occasion patients would not turn up for appointments because they had not received notification despite the instruction for an appointment to be made having been given well in advance to secretarial teams.
- Between January and May 2016, 5767 patients were unable to book an appointment through the choose and book system due to there being insufficient clinic capacity. On average the provider had a 31.6% defer to provider rate for choose and book appointments.
- April 2016 data demonstrated that the trust was not meeting the 92% referral to treatment (RTT) indicator for patients waiting more than 18 weeks for an appointment in 11 out of 16 specialities. The worst performing speciality was general surgery, where only 74.6% of patients were seen within 18 weeks; this was followed by cardiology, where only 80.2% of patients had been seen.
- An RTT recovery plan was in place which included actions such as holding more clinics, reviewing the access policy and outsourcing services. The recovery plan was due to be fully implemented by the end of August 2016 and review and monitoring was taking place at the trust board and via the local commissioning group.
- There was a high proportion of avoidable short notice clinic cancellations. In April 2016 601 patients were affected by these cancellations. Out of 62 clinic cancellations (which were not strike related) 57 were noted to be avoidable. In May 2016 897 patients were affected with 55 out of 77 cancelled clinics being noted as avoidable. The majority of clinic cancellations were due to annual leave and training or staffing issues.
- There was a high proportion of people not attending for appointments (DNAs). Between December 2015 and February 2016, on average, 10% of patients did not attend for their appointments each month. DNA rates were higher for follow up appointments, with an average of 1419 patients not attending each month, compared to an average of 723 patients for new appointments. At the time of our inspection work was on-going to try and understand the reasons why patients were not attending their appointments. This included telephone calls to a selection of patients who had not attended. The audit results demonstrated that a high proportion of patients (20%) had decided not to attend because of other commitments or that they forgot their appointment time (10.6%). 10% of patients reported that they had not attended because they had not been given an appointment. However, extra clinics were being provided at weekends to meet demand.
- Diagnostic services were seeing 99% of patients within six weeks.
- There had been improvement in the percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment for all cancers with the hospital performing better than the England average. In March 2016 the hospital was meeting the national standard of 85%.
- The trust's performance against the cancer two week wait target has met the standard since 2014/15.
- The trust has met the performance standard against the cancer 31-day targets since 2013/14.
- Fast track access clinics were available for cardiology and transient ischaemic attacks (TIA). These services provided short notice appointments to speed up diagnostic tests and relieve patient anxiety.
- Since our previous inspection, the diagnostic imaging service had implemented an electronic porter system.

This system was displayed on a big screen and identified all patients within the hospital who were waiting for diagnostic tests. It identified at what stage in the process they were, for example, whether they were waiting, whether they were being collected or if they had had their scan and gone back to the wards.

- March 2016 data demonstrated that radiology services were meeting their target of 85% for seeing cancer patients within 7 days of referral for all specialities, with the exception of general surgery, where only 82% of patients had been seen.

Meeting people's individual needs

- The clinics and diagnostic departments we visited met people's individual needs. Services were accessible. Lifts and ramps were available where appropriate to assist with people's physical disabilities.
- There was a chaperone policy in place. This information was clearly on display throughout the service. We heard examples where chaperoning would take place as a matter of course in clinics such as gynaecology.
- Both outpatient and diagnostic imaging services had dedicated staff champions to help support people who had learning difficulties or were living with dementia. There were also dedicated staff champions to help support people who may have suffered domestic violence. The role of these champions extended to providing advice and guidance to other staff members in order to ensure appropriate care and intervention.
- There was no bariatric couch available for use in the main outpatient department. We noted this was on the risk register and that auditing and costing was taking place to support a business case. The trust reported to us that there were a high proportion of bariatric patients attending the hospital, and the demographics support that there was a higher than average rate of obesity in the community.
- Translation services were available in outpatients and diagnostic imaging services. Translators were available via the phone or could be booked for face to face appointments.
- Whilst we noted patients had access to water in many of the clinic areas, hot beverages were not accessible in many of the areas we visited. However, the main outpatients department was situated in close proximity to an area where there were facilities to purchase food and drinks. However, patients risked missing their appointment if they wished to visit the shops for food and drink, as some clinics were situated quite a distance from these facilities.
- Patients were informed of delays in their clinic times. We saw nursing staff regularly visiting clinic waiting areas to inform patients about any delays being encountered.
- In clinics that also saw children, there were designated areas for children to play and wait for appointments. We observed that they were well used by families. There was, however, a lack of facilities to cater for adolescents, such as age appropriate magazines.

Learning from complaints and concerns

- There was an accessible complaints procedure in place at the hospital, accessible to both staff and patients.
- Complaints were reviewed and discussed at the patient safety and quality forum.
- There was, however, a lack of understanding from staff in how complaints had led to service improvement. We noted from the last two sets of patient safety and quality forum minutes we reviewed that learning had not been discussed.

Are outpatient and diagnostic imaging services well-led?

Good

We rated well-led as good because:

- The service had a local vision which was to ensure all patients that used services had a quality and safe experience, that staff were supported and were fit for purpose and that services were delivered effectively and reliably to support all the healthcare groups within the hospital.
- Risk management systems were being used and monitored appropriately.
- There was a cohesive leadership team. Staff felt managers were approachable and that there was a strong open culture.
- Patients and staff were engaged in the running of the service.

- Staff were enabled to be innovative and there were many examples of how individual staff members had sought improvement for their areas and were supported to do so.

However:

- Whilst the governance structure had recently been reviewed, this required further embedding with a clear focus on learning and improvement.

Vision and strategy for this service

- The service had a local vision which was to ensure all patients that used services had a quality and safe experience, that staff were supported and were fit for purpose and that services were delivered effectively and reliably to support all the healthcare groups within the hospital.
- Staff we spoke with were aware of the vision and we saw this displayed in various areas of the service during our inspection.
- We did not see, through minutes or governance papers such as the 2015/16 annual governance review, how this vision was being applied or monitored to ensure it was being worked against.

Governance, risk management and quality measurement

- Since our previous inspection, governance systems had been reviewed and a clear structure had been put in place. However, the system was not yet embedded and required continuous monitoring to assess its effectiveness.
- The local governance arrangements included a health group board which was supported by a local patient safety and quality forum which provided information on incidents, risk management and patient feedback.
- We reviewed minutes of the April and May 2016 local heath group board meetings and the patient safety and quality forum and found these were not comprehensive. This meant we could not be assured that actions were being carried forward or that discussion and challenge on pertinent issues was occurring.
- There was confusion amongst staff in the roles of the governance committees and we noted that work was being undertaken to refine the roles and escalation processes.
- There were appropriate risk management systems in place. The service maintained an up to date risk register and reviewed this monthly.
- The service had recently introduced the Allocate System in order to track and implement relevant National Institute for Health and Care Excellence (NICE) guidance.

Leadership/Culture of service

- The outpatients and diagnostics service sat within the cancer and clinical support services health group. This group was led by an associate director nursing, clinical director and deputy director of operations. The senior team are supported by matron in outpatients and a lead in radiology.
- There was a cohesive, joined up leadership team for both outpatients and diagnostic imaging. The leaders of this service were clear on the priorities and challenges going forward. This included the need to continue and sustain the referral to treatment (RTT) recovery programme and staff recruitment.
- We were told that the hospital management team, including the chief executive and Chief Nurse, often did walk arounds to engage with staff.
- We spoke with members of the cardiology team who had recently moved into the clinical support services healthcare group. They told us that following the move they felt they had a clearer remit and there was a clear emphasis on improvement.
- We spoke with 14 members of staff during the inspection and of these we asked 6 about the culture of the service. All were unanimous in the fact that there was an open, supportive culture within the service. We were told that managers were approachable and took issues forward and there was a sense of positivity and respect.

Public and staff engagement

- Administrative staff within the outpatient department had been engaged with about improvements which could be made within the service. We saw that they had suggested uniforms be sought in order to bring unity to the department. At the time of our inspection, we saw that this had been implemented. Administrative staff we spoke with told us that this had given them a sense of pride, unity and belonging.
- Long service awards had been implemented within the outpatient and diagnostic imaging services. These

acknowledged and recognised staff contribution and dedication. We heard that following positive feedback, this practice was being adopted by other areas of the hospital.

- An "in your shoes" event was held in September 2015. Patients were invited to attended a session and contribute to ways in which the service could make improvements.

Innovation, improvement and sustainability

- There was a clear attitude from all staff we spoke with on the need to improve and be innovative. The outpatient matron had invited an external organisation called "triumph over phobia" to provide a talk to staff on how people with known phobias and mental health conditions, such as obsessive compulsive disorder, could be better supported in the department.
- The cardiology team were developing an enhanced heart failure service because it was recognised that the current service did not meet demand or continuity for patients.
- Six of the Outpatient and radiology band 6 sisters attended a six month leadership development programme run in house. Each of them undertook a local project to enhance practice and experience.
- During October 2015, the nursing staff within outpatients were consulted on being able to provide a six-day, evening and cross site cover service. This was implemented in December 2015.

Outstanding practice and areas for improvement

Outstanding practice

- The ward manager for the Dolphin children's ward had significantly improved the ward and performance of children's services since our last inspection
- The tissue viability nurse in theatres produced models of pressure ulcers to support the education and prevention of pressure ulcer development in theatres. This also helped to increase reporting.
- The improvement and dedication to resolve the backlog and issues within outpatients was outstanding.
- The advanced nurse practitioner groups within the emergency department were an outstanding team, who worked to develop themselves to improve care for their patients.
- The gynaecology early pregnancy unit and termination services was outstanding and provided a very responsive service which met the needs of women.
- The outcomes for women in the maternity service were outstanding and comparable with units in the top quartile of all England trusts.
- MSSA rates reported at the trust placed them in the top quartile of the country.
- The permanent staff who worked within women's services were passionate, dedicated and determined to deliver the best care possible for women and were outstanding individuals.
- The lead nurse for dementia was innovative in their strategy to improve the care for people living with dementia.

Areas for improvement

Action the hospital MUST take to improve

- Ensure that safeguarding children's processes, reporting and investigations for the safeguarding of children are improved.
- Ensure that staff caring for children and young people have appropriate levels of life support training in line with the Royal College of Nursing 'Health care service standards in caring for neonates, children and young people'.
- Ensure that staff are provided with appraisals, that are valuable and benefit staff development.
- Improve mandatory training rates, particularly around (but not exclusive to) safeguarding children level three, moving and handling, and hospital life support.
- Ensure that there are safe and efficient staffing levels at all times.
- Ensure that resuscitation trolleys and difficult airway trolleys are routinely checked, stocked and kept in a safe condition for emergency use.
- Ensure that fridge temperatures are monitored, and acted upon when concerns are identified.
- Ensure that women undergoing elective gynaecology procedures, including but not exclusive to TOP procedures, are cared for by staff trained in the clinical, holistic and social needs of women.
- Ensure that staff caring for children and young people have appropriate levels of life support training in line with the Royal College of Nursing 'Health care service standards in caring for neonates, children and young people'.
- Ensure that rapid discharge of patients at the end of their life is monitored, targeted and managed appropriately.
- Ensure that trust staff are knowledgeable and provide care and treatment that follows the requirements of the Mental Capacity Act 2005.
- Ensure that governance arrangements, including the risk register and board assurance framework are embedded, robust, and actively reflect the risks within the organisation.
- Ensure that the quality of record keeping on critical care improves.
- Reduce the impact or likelihood of mixed sex accommodation breaches on HDU.
- Ensure that complaints are learnt from, and learning is shared throughout the trust.
- Ensure that patients arriving by ambulance into the ED are appropriately assessed and triaged in a timely manner in accordance with Royal College of Emergency Medicine (RCEM) guidelines.

Outstanding practice and areas for improvement

Action the hospital SHOULD take to improve

- Review the timing of ward rounds to ensure that discharges are identified earlier to minimise the chances of late discharges, and increase discharges before 12pm.
- Work to reduce the number of discharges between 10pm and 8am.
- Effectively organise patient records to ensure that staff are able to manage patient pathways.
- Review the provision of maternity services at the trust to ensure that the service provision can be sustained beyond the next twelve months.
- Review the pathway for admission of emergency gynaecology patients through the emergency department to ensure that treatment and care is consistent.
- Review the need for dedicated beds for gynaecology inpatients to ensure that care is provided consistently by trained gynaecology staff.
- Review the appointment booking system and consider using a central booking system for all appointments to the effectiveness of appointment management.
- Embed the processes for ambulance triage in accordance with RCEM guidelines.
- Update all trust policies and guidelines to ensure that the services work in accordance with national guidelines and best practice.
- Reduce the time taken for call bells to be answered in ED and on the wards.
- Improve staffing levels for nursing at night time.
- Improve and sustain staffing levels for the resuscitation area in the emergency department.
- Review capacity of clinical and nursing leads for services to ensure that they have sufficient supernumerary time to complete their lead roles.
- Increase clinical staffing levels within palliative care.
- Review and record complaints and incidents related to end of life care, identify trends and learn from these complaints.
- Complete the refurbishment of the mortuary.
- Review theatre utilisation to reduce the number of cancelled operations.
- Review care pathways to ensure patients at the end of their life have clearly documented ceilings of care in place.
- Review MDT working arrangements and improve MDT work for patients in critical care.
- Work to reduce the number of delayed discharges leaving HDU and critical care.
- Review the continued reliance of using the post anaesthetic care unit (PACU) when capacity is predicted to be high.
- Review the processes for mortality and morbidity meetings to ensure these are accurately recorded to reflect the full discussions of each case.