Hinchingbrooke Health Care NHS Trust

Hinchingbrooke Hospital

Quality Report

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

Ratings

Overall rating for this hospital	Good
Urgent and emergency services	Requires improvement
Medical care (including older people's care)	Good
Surgery	Good
End of life care	Good

Summary of findings

Letter from the Chief Inspector of Hospitals

The Care Quality Commission (CQC) carried out a comprehensive inspection between the 15 and 18 September 2014 at which the trust was rated as inadequate and placed into special measures. The CQC undertook a review of the areas rated as inadequate in January 2015 to ensure the safety of patients. At this inspection we rated most elements as requiring improvement although the urgent and emergency services were rated as inadequate. We undertook a focused inspection to review all areas identified as requiring improvement or inadequate in October 2015 to monitor the trusts progress. We returned on 10 May 2016 to monitor whether the improvements seen at the previous inspection were sustained.

Since 1 April 2015 the trust has a traditional management structure of an NHS trust. The trust has a trust board and with non-executive directors. The chief executive has now been in post for nearly 10 months. The changes that had been put in place were beginning to embed and staff were aware of the process for escalating issues to the senior team. The trust were aware of challenges and had plans in place to address these. We were aware of ongoing talks with a neighbouring trusts about efficient use of resources across the county.

The comprehensive inspections result in a trust being assigned a rating of 'outstanding', 'good', 'requires improvement' or 'inadequate'. Each section of the service receives an individual rating, which, in turn, informs an overall trust rating. The inspection found that overall the trust has a rating of 'Good'.

Our key findings were as follows:

- Most new systems and process were in place and these were embedded. Senior managers could articulate risks both internal and external to the organisation.
- Some new systems in processes in the emergency department such as triaging patients arriving by ambulance were yet to be embedded.
- There was an increased emphasis on incident reporting and disseminating learning to all areas of the trust though there were some delays in reporting incidents in surgery.
- Medicines were well managed across the trust with consistent processes to investigate concerns.
- Staff were caring and compassionate in their care of patients.
- Organisational development work had significantly impacted on the trusts development into a learning organisation.
- The emergency department continued to be under pressure through increasing volumes of attending patients and small numbers of emergency care consultants.
- The care of patients with a mental health condition was improved in the emergency department.
- There was an increased programme of audit including stroke audit though performance against some audits in the emergency department was below the England average.
- Referral to treatment times (RTT) were met for medical and surgical patients.
- There were clear visions for the services and visible leadership within the divisions.
- The trust and individual divisions were working with other providers and stakeholders on sustainability and transformation plans. Staff and managers had plans for improving care pathways though there was some anxiety amongst staff about collaborative working with other providers.
- There was a detailed end of life strategy in place which had received additional resourcing to meet the needs of patient and their relatives.

We saw several areas of outstanding practice including:

- The trust employed an Admiral nurse to support people living with dementia, their relatives and carers as well as staff. This was one of only five Admiral nurses in acute trusts in England.
- Staff worked with a local prison where consultants review patients that are at the end of their lives and work with prison and hospital staff to ensure that patients were safely admitted to the hospital or referred to the local hospice.

Summary of findings

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

Importantly, the trust must:

- Ensure that there are sufficient numbers of suitably qualified, skilled and experienced medical staff on duty in the emergency department. Also ensuring that there are robust contingency plans and which forecast shortages and ensure that sufficient cover is provided.
- Ensure that the time to treatment from a clinician in the emergency department is reviewed and times to treatment are improved.
- Ensure that the triage process for ambulance arrivals is received to ensure that the pathway for patients is safely and times of assessment accurately recorded.
- Ensure that infection control practices within the emergency department are improved.
- Ensure that the processes for the checking of equipment, particularly blood glucose and anaphylaxis boxes, in the emergency department is improved and safe for patients.

In addition, the trust should:

- Review the observation and seating arrangements for the children's area to ensure parents and children only sit in this areas.
- Should ensure that fridge temperatures are routinely checked.
- Should allow staff to attend and receive updated mandatory training.
- Review the need to monitor the culture of staff within the emergency department.
- Review the environment and provision of children's services and where children are treated.
- Ensure that records are used in a consistent way across wards, that they are contemporaneous; reflect patient needs and appropriate actions taken following risk assessment.
- Review the relative risk of readmission for surgery patients as data shows this to be significantly above the England average.
- Review the complaints process and the time taken to provide people who complain with a full response.
- Should ensure that audits are undertaken locally within the emergency department to improve quality measurement and assurance.
- Should ensure a consistent monitoring of preferred place of death for patients receiving end of life care.
- Should ensure that there is a clear target for fast track discharge of patients requiring end of life care and ensure consistent monitoring of the timeliness of these discharges.

Based on the findings of this inspection I would recommend the trust be removed from special measures. However I would recommend that ongoing support continue during this period of transition.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	Requires improvement 	The emergency department was rated as requires improvement for being safe because there remained concerns regarding staff hand hygiene techniques, and use of PPE. The boxes which monitor the blood glucose of a patient, known as a BM box, and the anaphylaxis boxes were not checked daily as required. Time to see a clinical decision maker to receive treatment was consistently above 60 minutes. The process for triage of ambulance patient was not yet fully embedded and therefore this could place patients at risk through a lack of monitoring. However we also found that medicines management was safe, items were stored securely and dispose of appropriately. The care and treatment of patients with a mental health condition had much improved since our previous inspection. This included staff awareness on the importance of care for those with mental health conditions. The environment for the children's waiting area had improved since our last inspection. The service was rated as requires improvement for being effective because the service performed worse than expected on the RCEM Asthma audit, and severe sepsis and septic shock audit. Some of the national audits were from 2013; however there was a lack of local audits being undertaken. The service could not demonstrate if any of their key patient outcomes had improved. Fluid rounds and drinks provision for patients had not increased despite the warm temperatures in the department. However we also found that there was a clear protocol for staff to follow with regards to the management of stroke and sepsis. Pathways were written in line with the national institute for health and care excellence (NICE) and RCEM guidelines. Management of pain and administration of pain relief had improved since our last inspection. The service was rated as good for caring because the feedback received from service users was positive. The friends and family test results were consistently above the England average. We observed positive and caring interactions between staff and patients throughout the inspection. Staff were caring and

Summary of findings

compassionate when they spent time with patients. However we also received comments from three patients and relatives on comment cards where they felt the service was not good.
The service required improvement for being responsive because the trust was not consistently meeting the four hour standard. On review we found that this was not only affected by reduced bed capacity but in addition, delays in decision to admit times. The average time spent in the department was much longer than the England average. However we also found that the service has significantly improved the working relationship and pathways, assessment and treatment for adults and children with mental health conditions. The waiting area had an improved paediatrics waiting area including a separated play zone for children.
The service required improvement for being well led because the risk register, identification or risk and management of risk was not yet embedded within the service. The risk register provided did not detail any emergency department specific risks despite concerns about medical staffing being raised by the trust as a risk. There was a lack of medical leadership within the department due to staffing shortages. However we also found that the nursing staff had been provided with some training in leadership, and the leadership and governance for the children's emergency department had sustained good practice which had further improved the children's service.

Medical care (including older people's care)

Good

We rated medical services as Good overall. Learning from incidents was consistently shared with staff across the division and formal mortality and morbidity meetings had been introduced and we observed good infection control practices in relation to hand hygiene and the use of personal protective equipment. All patients had their allergies recorded on their medicines chart and medicines were stored securely though prescription charts were not completed fully for time critical medications such as paracetamol though the trust informed us they would be using new charts in the near future. Staff had a good understanding of safeguarding principles and how to make safeguarding referrals and mandatory training had

Summary of findings

improved compliance across the division. However, records and risk assessments were mainly correct however they did not always reflect the needs of patients and were not updated to reflect changing care or needs.

Patient outcomes were now measured including the reinstatement of stroke audit data. Local audits plans were comprehensive and had lead clinicians identified. Patient care and pathways followed national guidance and best practice and staff had good knowledge of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. However, several patients had been identified as being at risk of malnutrition but we could not see that steps had been taken to address this.

We observed staff interacting in caring and compassionate ways with patients and relatives. Friends and Family Test (FFT) response rates were higher than the England Average and most wards scored highly on the test. Patients we spoke with told us that staff were caring and had kept them involved and up to date with their care and treatment.

The division was meeting referral to treatment times (RTT) and was actively engaging with sustainability and transformation plans and was working collaboratively with neighbouring trusts around the provision of some care including stroke care. There was now a speech and language therapist for patients suffering stroke and other service level agreements for therapy staff providing stroke care and patients had their individual needs met and we saw good practice in relation to dementia care on one ward. However, complaints and concerns were addressed locally. More staff were aware of learning from complaints but half of those we spoke with were unclear on this.

A number of changes in ward leadership and the introduction of a quality matron had become embedded since our last inspection. Governance and risk had been addressed with the implementation of mortality and morbidity meetings and that the findings of root cause analysis was more widely shared. The division was actively engaging with sustainability and transformation plans and collaborative working with other providers. However, we were concerned about the

sustainability of some services due to a lack of key staff. Whilst locum staff were in place permanent recruitment had been difficult. The division was aware of these concerns and a review of some specialty care was underway.

Surgery

Good

Surgery services were rated as good overall.
Staff had access to an electronic incident reporting system and knew how to report incidents.
Scrutiny of mortality cases was regular and robust, with all cases being presented at dedicated meetings and actions for improvement being set.
There was no increased risk of death for this surgery services at this trust, as the trust performed as expected in the two surgery specific mortality indicators, death in the low-risk diagnosis group and death after surgery. Good hand hygiene techniques and the use of personal and protective equipment such as aprons and gloves was consistent amongst all staff. Surgical site infection rates were low, with two cases being reported for large bowel surgery between April 2015 and December 2015 and zero cases being reported for other surgical specialties.
Equipment was regularly safety tested and all equipment checked on our inspection was within date for the next safety check. Resuscitation trolleys were consistently checked with no omissions noted for the time period we checked (January 2016 to May 2016). Medicines were stored securely across surgical wards and access was limited to nursing staff. Learning from medicine related incidents was evident. For example, an insulin-related incident had led to a ward manager completing a course on insulin safety and cascading that learning to their team.
World Health Organisation (WHO) surgical checklists were consistently used by the service and their use was audited. Overall training compliance for Mental Capacity Act and Deprivation of Liberty Safeguards was 92% for surgical services which was above the trust target of 90%. The service comprehensively audited its performance each year, including both local and national audits. There was an established pain team and provision was in place for this support to be provided out of hours. The trust performed in line with, or better than the England average in the national hip fracture audit, the

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national lung cancer audit, and the patient reported outcomes measures for groin hernia, hip and knee replacement and varicose vein surgeries. With the exception of theatres, staff appraisal rates were better than the trust average across the surgery services.

Friends and family responses were positive for surgery services, indicating that between 93% and 100% of respondents would recommend the service to their family and friends. Patients were involved and informed about their care, with a range of patient information leaflets and a hip and knee club for patient undergoing joint replacement surgery. Emotional support was available from an Admiral nurse (a specialist dementia nurse). The Admiral nurse was observed to provide dedicated care to a person living with dementia, ensuring they were settled and had their privacy and dignity respected.

The service provided care within 18 weeks of referral in the majority of cases (90% of the time or more). Cancer treatment targets were consistently met or exceeded and the trust was amending cancer pathways with a view to bringing cancer targets down.

The service performed better than the England average in rebooking cancelled operations within 28 days. One theatre was available 24 hours a day, seven days a week for emergency or life threatening surgeries, in line with National Confidential Enquiry into Patient Outcome and Death (NCEPOD) guidelines. There was awareness at ward level of complaints and learning, with ward managers able to give examples of improvements made to their ward areas as a result of learning from complaints.

A clear plan was in place for the development of a surgery strategy that was linked directly to the development of the new trust values. The development of the strategy involved staff and was based on the results of the staff survey. There was good ward level understanding of risk; however the recording of scrutiny of risk and other clinical governance issues was inconsistent across surgical specialties. Almost half of incidents were not reported within 14 days of their occurrence. The

acute trauma and surgery unit and Juniper ward consistently performed below trust targets for various infection control and patient safety measures.
The length of stay for elective trauma and orthopaedics was 1.5 days over the national average, and the overall risk of re-admission for elective patients was much higher than the England average at a score of 158 compared to an average score of 100.The service had not appropriately managed an increase in medical outliers. This had led to the displacement of emergency and elective surgical patients and ultimately the cancellation of joint surgeries at the time of our inspection, due to elective and emergency (or patients swabbed for Methicillin resistant staphylococcus aureus (MRSA) and those not swabbed) being placed in bays together.

End of life care

Good

End of life care was good at Hinchingbrooke Hospital as patients received safe, effective, and responsive care that met their individual needs and protected them from avoidable harm.
Infection, prevention, promotion, and control was good and patients benefitted from visibly clean environments that were routinely audited and cleaned. Staff knew how to respond to safeguarding concerns and reported these appropriately. Staff reported incidents using the trust electronic incident reporting system and learning from incidents was shared across the staff teams.
Equipment was appropriate for the patient's needs and the bereavement, mortuary, and chaplaincy team made use of a number of key environments to enable relatives and families to access private areas for reflection and practice their religion or belief. The mortuary team provided a caring and empathetic approach and created a homely and comforting environment for families to see their deceased loved ones.
The trust ensured staff were trained, appraised, and supervised appropriately. Improvements were seen in end of life training for all staff, particularly junior doctors, and the number of staff completing the Quality End of Life Care for All (QUELCA) training had increased. Patients were cared for using best practice guidance, for example, National Institute for

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Health and Care Excellence (NICE), and individual care planning promoted patient nutrition, hydration, and the effective use of pain relief to manage patients' symptoms.

Patient records were of a very high standard, reflected the patient's individual needs and choices, and demonstrated multidisciplinary (MDT) working to support patient outcomes. There had been improvements in the way do not attempt cardiopulmonary resuscitation (DNACPR) was recorded and the trust carried out audit activity to ensure quality was measured in key areas of its services. Patients were referred to the specialist palliative care team in a timely and professional way, this meant that patients accessed last days of life care and treatment that met their individual needs.

Patients and their families were cared for with high levels of dignity, compassion, and respect throughout our inspection. Staff gave examples of good practice that enhanced patients' physical, psychological, and emotional wellbeing. Families were offered a wide range of information to help them deal with death and dying and the trust collaborated effectively with external providers, for example, funeral homes, counselling services and patient advice services.

The trust had a clear strategy and vision in place for end of life care with staff roles and responsibilities clearly set out within it. The culture across the service was one of support and mutual respect amongst the staff team and there was a significant focus on improving staff knowledge and competence in end of life care.

Hinchingbrooke Hospital

Detailed findings

Services we looked at
Urgent and emergency services; Maternity (community services); Medical care (including older people's care); Surgery; End of life care.

Detailed findings

Contents

Background to Hinchingbrooke Hospital

Hinchingbrooke Hospital is an established 289 bed general hospital, which provides healthcare services to North Cambridge and Peterborough. The trust provides a comprehensive range of acute and obstetrics services, but does not provide inpatient paediatric care, as this is provided within the location by a different trust. The trust has the traditional system of governance in NHS. The trust had previously been managed by a private provider. The ethos of empowerment of staff remained at the hospital and the "stop the line" initiative was still in use. This allowed anyone to raise issues immediately with the senior team. We found that this system was now working well within the hospital.

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

Our inspection team

Our inspection team was led by:

Chair: Jane Barrett, Chair Thames Valley Clinical Senate

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

The team included seven CQC inspectors and a pharmacy inspector from CQC. A variety of specialists made up the team including: a nurse specialist in; emergency medicine, medical assessment, surgery an end of life care nurse and an expert by experience. (Experts by experience have personal experience of using or caring for someone who uses the type of service that we were inspecting.)

How we carried out this inspection

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

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

The inspection took place between 10 and 11 May 2016, with unannounced inspection on 20 May 2016.

Detailed findings

Before visiting, we reviewed a range of information we held, and asked other organisations to share what they knew about the hospital.

We did not hold a listening event on this occasion. However some people shared their experiences with us via email or by telephone.

We spoke with staff working in patient care areas and in the management teams. 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.

Facts and data about Hinchingbrooke Hospital

Trust information 2014/ 15

Key figures

• **Beds**: 289

– 237 General and acute

– 42 Maternity

– 10 Critical care

• **Staff**: 1,557 (WTE)

– 188.11 Medical

– 491.40 Nursing

– 876.93 Other

• **Revenue**: £108,966,391

• **Full Cost: £122,737,210**

• **Surplus (deficit): (£13,796,820)**

Activity summary (Acute)

Activity type 2014-15

Inpatient admissions 20, 298

Outpatient (total attendances) 154, 965

Accident & Emergency

(attendances) 43, 353

Our ratings for this hospital

Our ratings for this hospital are:

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

Notes

Urgent and emergency services

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

Information about the service

The emergency department (ED) at Hinchingbrooke Hospital provides a 24 hour, seven day a week service to the local area. Patients present to the department either by walking into the department via the reception area, or arriving by ambulance. The department has facilities for assessment, treatment of minor and major injuries, a resuscitation area, and a children's provision ED service.

There is an acute assessment unit (AAU) within the same directorate, for which patients are admitted for up to 24 hours.

Our inspection included two days in the emergency department as part of an announced inspection, and an unannounced visit on 20 May 2016. During our inspection, we spoke with clinical leads from medical and nursing disciplines for the department. We spoke with four members of the medical team (of various levels of seniority), nine members of the nursing team (of various levels of seniority), and five members of support and operational staff. The emergency department sees, on average, approximately 120 patients per day.

During our inspection, we spoke with six patients and four relatives and undertook general observations within all areas of the department. We reviewed the medication administration and patient records for 12 patients in the emergency department.

On average, the emergency department saw around 43,247 patients a year between 2014 and 2015, which equated to around 832 patients a week.

Summary of findings

At our last inspection the emergency department was rated inadequate in terms of being safe and well led, requires improvement for being effective and responsive and good for being caring. This meant that the service was rated as inadequate overall in 2015. At this inspection we noted that there had been improvement overall at this service and we have now rated the service as requires improvement.

The emergency department was rated as requires improvement for being safe because there remained concerns regarding staff hand hygiene techniques, and use of PPE. The boxes which monitor the blood glucose of a patient, known as a BM box, and the anaphylaxis boxes were not checked daily as required. Time to see a clinical decision maker to receive treatment was consistently above 60 minutes. The process for triage of ambulance patient was not yet fully embedded and therefore this could place patients at risk through a lack of monitoring. However we also found that medicines management was safe, items were stored securely and dispose of appropriately. The care and treatment of patients with a mental health condition had much improved since our previous inspection. This included staff awareness on the importance of care for those with mental health conditions. The environment for the children's waiting area had improved since our last inspection.

The service was rated as requires improvement for being effective because the service performed worse

than expected on the RCEM Asthma audit, and severe sepsis and septic shock audit. Some of the national audits were from 2013; however there was a lack of local audits being undertaken. The service could not demonstrate if any of their key patient outcomes had improved. Fluid rounds and drinks provision for patients had not increased despite the warm temperatures in the department. However we also found that there was a clear protocol for staff to follow with regards to the management of stroke and sepsis. Pathways were written in line with the national institute for health and care excellence (NICE) and RCEM guidelines. Management of pain and administration of pain relief had improved since our last inspection.

The service was rated as good for caring because the feedback received from service users was positive. The friends and family test results were consistently above the England average. We observed positive and caring interactions between staff and patients throughout the inspection. Staff were caring and compassionate when they spent time with patients. However we also received comments from three patients and relatives on comment cards where they felt the service was not good.

The service required improvement for being responsive because the trust was not consistently meeting the four hour standard. On review we found that this was not only affected by reduced bed capacity but in addition, delays in decision to admit times. The average time spent in the department was much longer than the England average. However we also found that the service has significantly improved the working relationship and pathways, assessment and treatment for adults and children with mental health conditions. The waiting area had an improved paediatrics waiting area including a separated play zone for children.

The service required improvement for being well led because the risk register, identification or risk and management of risk was not yet embedded within the service. There were three risk registers in the medicine division and the trust acknowledged there was some confusing language used within the division in relation to the risk registers. There was a lack of medical leadership within the department due to staffing shortages. However we also found that the nursing staff had been provided with some training in leadership, and the leadership and governance for the children's emergency department had sustained good practice which had further improved the children's service.

Urgent and emergency services

Are urgent and emergency services safe?

Requires improvement

Urgent and emergency services were rated as requires improvement for being safe because:

- There remained concerns regarding staff hand hygiene techniques, and use of PPE.
- The boxes with kit which monitors the blood glucose of a patient, known as a BM box was not always monitored as required. The anaphylaxis box was not checked daily as required.
- Time to see a clinical decision maker to receive treatment was consistently above 60 minutes.
- The process for triage of ambulance patient was not yet fully embedded and therefore this could place patients at risk through a lack of monitoring.
- The department was not fully compliant with standards for 'Children and young People in Emergency Care Settings 2012'. However improvements had been made to this area, with further plans for the future.

However we also found:

- There was evidenced learning from incidents with detail shared amongst staff through meetings.
- Staff were knowledgeable about what constitutes a safeguarding concern, how to recognise abuse and how they would escalate such concerns appropriately.
- Medicines management was safe, items were stored securely and dispose of appropriately.
- The care and treatment of patients with a mental health condition had much improved since our previous inspection. This included staff awareness on the importance of care for those with mental health conditions.
- The environment for the children's waiting area had improved since our last inspection.

Incidents

- The service had reported no never events since our last inspection. The definition of a Never Event has changed. Although each Never Event type has the potential to cause serious patient harm or death, harm is not required to have occurred for an incident to be categorised as a Never Event. The service followed the trusts incident reporting policy and has reported 255 incidents between 10 November 2015 and 29 February 2016. This is an improvement and increase in incident reporting since our previous inspection.
- The incidents reported, in the majority, resulted in no or low harm for impact with the top reported incidents being low staffing levels, pressure ulcers, and communication related incidents.
- Two serious incidents were reported for the service between 10 November 2015 and 29 February 2016, which were linked to patient falls.
- There was evidenced learning from incidents with detail shared amongst staff through meetings, handovers and through online forums. We observed information displayed on staff notice boards about incidents and what had been learnt from incidents. We spoke with one doctor and two nurses about the serious incidents. All were able to detail what lessons had been learnt from these events and what they would do differently next time a patient at high risk of falls would be in the department.
- Where serious incidents had occurred we reviewed the reports which had recorded that the families and the patients, where appropriate, where informed about the incident and the investigation in accordance with duty of candour requirements.
- The lead consultant described what mechanisms the service had for reviewing and holding mortality and morbidity reviews. Reviews are done at the monthly meetings to identify any patterns trends or learning which would then be shared with staff through local meetings and the main staff notice board.
- We reviewed the information on mortality. Minutes of meetings held between November to April detailed discussions about individual cases together with key learning from each case for sharing.

Cleanliness, infection control and hygiene

- The department was clean as far as possible. The environment presented challenges for ensuring the department looked clean at all times. There was an established rota in place for cleaning the department regularly throughout the day.
- The policy when patients who attended the department and were at risk of infection were known was that they were to remain isolated in their cubicle and the cubicles would be deep cleaned prior to the next patient being able to use it.

- Equipment was visibly clean upon inspection and had been labelled with 'I am clean' labels.
- We observed poor infection control practice amongst the medical staff working in the department. We saw three doctors go between patients throughout their shift without washing their hands and type notes on the computer without washing their hands, wearing gloves and then removing them and not washing their hands and going between cubicles without using hand gels or washing their hands.
- We noted that there had been an improvement in the hand hygiene practices amongst the nursing staff since our last inspection.
- We also observed two members of medical staffing not adhering to the uniform policy by wearing jewellery with jewels in them. Also wearing more than one ring on their hands at any one time.
- Infection control audits from February 2016 identified a 96% compliance with infection control practices and this had also highlighted hand washing therefore further improvements in this area.
- The infection rates on catheter related UTIs for the department was 0.81% which was displayed as green for a positive result on the A&E dashboard.
- There have been no reported cases of MRSA linked to the emergency department.
- Curtains in the main department on each cubicle were disposable, and there were records in place of when these were to be changed.

Environment and equipment

- The environment design and layout within the major's department area meant that it was not possible to observe all patients closely. This was raised during the previous inspection where we noted that the curtains on all bays were closed. On this inspection the nurse in charge routinely went round and ensured that the curtains were open, where possible, to be able to observe patients.
- We checked the resuscitation equipment in the department and found that all had been checked daily and were stocked in line with resuscitation council guidelines.
- The boxes with kit which monitors the blood glucose of a patient, known as a BM box, were available in three areas of the department. We checked all three and found many gaps in checking of these boxes. Within majors there were 13 dates not checked in January, four not checked in February, nine not checked in March, 11 not checked in April and two out of 10 days not checked in May 2016 up to our inspection.
- The anaphylaxis box within the department was checked and found to be stocked, however there were no records that this had been checked daily as required by national recommendations.
- The gas store was located in an inappropriate area near the ambulance entrance. The oxygen cylinders were stored in a cupboard where there were computer servers and wires and the electronic mechanism for the sliding doors which created a fire risk. The cylinders specifically state to store away from electrical items. The trust were aware of these concerns and had completed a risk assessment to address them as well as a redesign plan for the department.
- The department was not fully compliant with standards for 'Children and young People in Emergency Care Settings 2012'. This was because the children were treated in the same area as adults. However the service had made significant improvements in this area by separating the children's waiting area from the main waiting area. However we noted that adults without children were sat in their waiting to be seen. The service had plans for further improvements in this area over the longer term.

Mental Health Care

- At our last inspection the care of patients with mental health concerns was noted to be a significant risk. At this inspection we found that the policies and procedures for care and treatment of patients with mental health concerns had all been updated.
- Staff had received training on the requirements of care for those with mental health concerns. This was provided through the local mental health trust.
- The service had set up an agreement and trialled the placement of psychiatric liaison in the department during peak attendance periods. The service had noted that patients were seen and assessed more rapidly with this in place. The service was working to try and secure this on a more long term permanent basis to support staff and patient access.

- There is no dedicated room or bay for patients with mental health concerns who present with health anxieties or in crisis. Patients are placed into an available bay, where they could be observed or into the relative's room.
- During we observed the new risk assessment procedure and policy being used for three patients. These patients were assessed and placed in a location within the department, which was suitable based on the level of risk identified. If the patient was low risk they waited in an observed waiting room. If the patients were of a medium or high risk they were placed in a cubicle near the nurse base to allow for close observation.
- The relative's room which was used for low risk patient's, did not meet the minimum standards required for an assessment room. There was only one entrance/exit point still, there were no call bells or alarms in the room which meant that it was not safe to use on high risk patients. We were assured that only low risk patients were now placed in that room.
- We inspected the department for the risk of ligature points and found that the service had undertaken an environmental review to remove all assessed ligature points. There was a risk assessment in place for the department now, which detailed the risks of self-harm or suicide.
- We were assured that the procedures for mental health had significantly improved since out last inspection, however further improvements with the environment were still required.
- Staff had systems to request a specialist mental health assessment such as from the local mental health trust, Crisis Resolution and Home Treatment (CRHT) for adults, the Child and Adolescent Mental Health Services (CAMHS) and from older persons services once they assessed the person was medically fit for discharge and their physical health needs were met. We saw referral forms for CRHT.

Medicines

- Medicines cupboards were all locked and medicines were secure. When the resuscitation area was not in use the cupboards were found to be locked at all times.
- We checked a sample of medicines, including emergency medicines, these were in date and stored at the correct temperature. Controlled drugs stores were also checked and found to be correctly recorded and stored appropriately.
- The main fridge was locked due to containing insulin and tetanus vaccinations. The temperatures for medicines requiring refrigeration were mostly checked to ensure medicines were stored correctly. However we found eight days were not checked in March, and three were not checked in April 2016. All days were checked for May up until the date of our inspection.

Records

- We examined the records of 12 patients during our inspection and identified with the staff that there were challenges on completing the records between paper and electronic systems. The mix between paper and electronic recording on the system led to delays in updates being available for others to review the patient records. The management team of the service informed us that there were longer term plans in place to ensure that the records system was more robust.
- We identified that there were discrepancies in two cases where the records on the medicines administration chart were not legible after being written by the doctor and this was immediately rectified by the team.

Safeguarding

- We saw a current safeguarding policy for adults and children, which was accessible on the intranet. The policies were version controlled and the policies reflected national guidance.
- Staff were knowledgeable about what constitutes a safeguarding concern, how to recognise abuse, and how they would escalate such concerns appropriately. The trust had a safeguarding policy which was accessible to staff.
- Training records for the department showed that 89% of medical and nursing staff have received safeguarding adults training at level 1. 92% of medical staff and 97% of nursing staff have received safeguarding children level one training.
- The department had declared a risk on their risk register that there was not a sufficient number of staff trained with level 3 safeguarding children training at only 74% of all staff trained. Whilst an increase since our last inspection where training rates were 60% further work was needed to improve these rates.
- Staff were clear on the Children's & Adolescent Mental Health Support teams arrangements. They told us that safeguarding training included an over view of the mental capacity act and consent practices for children.

- Staff we spoke with referred to reporting safeguarding vulnerable adults and children concerns to the local authority and the trust safeguarding lead. We saw evidence of staff appropriately reporting concerns for a child.
- Posters were displayed throughout the department for domestic violence support. Leaflets for victims of domestic abuse were available.
- We observed staff openly discuss two cases where there was a potential safeguarding concern. We observed the discussions to be appropriate and result in a referral being made to safeguard the patient, which was good practice.

Mandatory training

- Mandatory training was available to all staff who worked in the service. The emergency department staff compliance was 73% for moving and fire training, 86% equality , diversity and human rights, 88% information governance, 24% were trained on PREVENT. Some of these training rates were lower than at the time of our inspection in 2015.
- We asked staff about this who informed us that it had been challenging for them to attend training during the winter due to the capacity and demand issues for the department. This had resulted in training sessions being cancelled.
- The department dashboard does not record mandatory training for Advanced Life Support, and emergency Paediatric Life Support. Records that were provided to us demonstrated that 80% of medical and nursing staff had received this training.

Assessing and responding to patient risk

- At the point the patient reached four hours in the department the staff would complete the inpatient risk assessment record for their care. If the patient was at risk they would transfer them onto a hospital bed as soon as possible. All patients in the department over six hours were placed onto a trust bed where available to support their comfort and reduce risk.
- The trusts policy on early warning scores (EWS), approved in August 2015, states that all adult patients admitted as an in-patient will have a set of physiological observations and a EWS score calculated at least once in 12 hours. The trust informed us that all patients arriving to the department should have at least one set of observations done within 15 minutes.
- The department has a defined streaming system in place for the patients who arrived into the department on foot through the front door, and once streamed into the appropriate pathway then they will be triaged and then treated. This process worked effectively in the main triage area for patients arriving on foot.
- At our last inspection we identified ECGs were not being acted upon in a timely way. At this inspection we reviewed 9 ECGs and all had been appropriately reviewed and acted upon. However the times of these reviewed were not always recorded on the ECG paper. This meant that we were not sure when the patient was reviewed after the ECG was done.
- The ambulance time to initial handover and assessment reported was consistently better than the England average at around 5 minutes. We observed this to be the case during the course of the inspection; handovers from ambulances were taken by the nurse in charge.
- The average time to first assessment, which should be 15 minutes at triage, was showing that the service was performing better than the England average. However there remained a lack of clarity on the triage process through the ambulance arrival route.
- We examined the arrival times of 10 patients who came in through the ambulance route. Of these six had the same arrival time, assessment time and treatment time. Of these two patients were in the resuscitation area, which meant that the timings were appropriate as treatment was provided immediately. However the other four timings could not be explained. Therefore we were not assured the system for ambulance triage had significantly improved.
- However, data provided by the trust showed that in April 2016 patients were being triaged on average at approximately 7 minutes when entering the department and in May 2016 it was 8 minutes.
- The time to treatment by a clinician within the department remained significantly higher than the England average. Treatment is expected to be provided within 60 minutes of arrival. However the service had consistently been averaging around 150minutes to treatment since January 2014.

Nursing staffing

- The nursing vacancy rate had decreased since our last inspection with a 12% nurse vacancy, however there was a higher turnover rate than expected. The turnover rate was recorded as 15% for nurses and 20% for support staff up to February 2016. This was higher than the trust's trajectory of 5%. We were informed that the reasons for staff leaving were linked to staff going to larger trusts or to retired.
- The department had maintained the majority of their staffing establishment for qualified and registered children's nurses in the emergency department, which was positive.
- The overall level of nursing staff on duty was much improved on last year, and we noted that the nurse in charge role was now supernumerary. This enabled the nurse in charge to have oversight of the department and escalate any concerns sooner when required. This was a positive improvement on the staffing from our inspection in 2015.
- The total vacancy, acuity and dependency and demand of the service meant that there was an 2% average use of agency and bank staff on shifts each month. The use and coverage of bank and agency was monitored and managed locally.
- Nursing handovers were done between staff at the beginning and end of each shift. Handovers occurred with nurses allocated to each area handing over to the nurse taking over their area of responsibility. We observed two handovers and observed that it worked well on a local basis.
- The nurse in charge was present on the board round of the medical staff who were handing over patients in the department.

Medical staffing

- The department was staffed by 3.5 WTE permanent consultant. At the time of our inspection one consultant was on long term sick leave and another had resigned and was due to leave at the end of May 2016. The service filled the rota for consultants with locum doctors.
- The consultant ratio at 21% is lower than the England average of 23%.
- The department currently has 6 WTE middle grade doctors. At 43% the use of middle grade staff at the trust is significantly higher than the England average of 13%.
- The department is putting several middle grade staff through a development scheme linked to the College of Emergency Medicine to obtain consultant positions within the hospital within three years.
- The department has only 7% of specialist trainee posts against the England average of 39%, however to ensure that they have cover they utilise middle grade support.
- The department currently has 10 foundation year trainees from Health Education England, which at a rate of 29% is higher than the England average of 24%.
- The current medical turnover rate within the department was 13.5% in February, which is significantly higher than the trust's target of 5%.
- There were concerns raised prior to our inspection regarding the availability of medical staff and the lack of consultants meaning that there were times where there was no consultant cover for the department. At this inspection we found that the lack of permanent staff cover was a significant risk for the service, and we were assured that the trust were developing plans to try and sustain medical staff coverage for the service. However medical staffing remains a risk for the trust. The trust was actively engaging with other providers and neighbouring trusts to ensure a consultant presence within the emergency department.
- Handovers were led by the doctor in charge of each shift and took place at the beginning and end of each shift. We observed the handover and the discussion of each patient which was comprehensive and clear.

Major incident awareness and training

- The trust had a major incident policy and plan in place for major events.
- 95% of staff working in the emergency department had received major incident awareness training within the last two years.
- The service had received external training in major incidents which included, CBRN, HAZMAT, logistics and command and control training.

Urgent and emergency services

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

Requires improvement

Urgent and emergency services were rated as requires improvement for being effective because:

- Of the 18 indicators in the national RCEM Asthma audit the trust performed worse than the England average in 15 of those indicators.
- The severe sepsis and septic shock audit dated October 2015 showed that the trust's performance had declined in five of the six key indicators. There were no new audits which demonstrated if there had been any improvement in this area.
- There was a lack of local audits being undertaken due to shortages of permanent medical staff. This meant that we were not assured, and the service could not demonstrate if any of their key patient outcomes had improved.
- Fluid rounds and drinks provision for patients had not increased despite the warm temperatures in the department.

However we also found:

- There was a clear protocol for staff to follow with regards to the management of stroke and sepsis.
- Policies and pathways for the admission of stroke, fractures and chest pain and these were written in line with the national institute for health and care excellence (NICE) and RCEM guidelines.
- Food and drink was available to those who were in the department for any length of time.
- Management of pain and administration of pain relief had improved since our last inspection.

Evidence-based care and treatment

- There was a clear protocol for staff to follow with regards to the management of stroke and sepsis. The department had introduced the 'Sepsis Six' interventions to treat patients. Sepsis Six is the name given to a bundle of medical therapies designed to reduce the mortality of patients with sepsis. Bundles were also available for neutropenic sepsis.
- We reviewed the notes of three patients who were admitted with a query of sepsis. All were provided with treatment in line with the sepsis pathway recommendations.
- There was also now a dedicated sepsis trolley with all equipment and items needed for the management of sepsis being stored in one place. This was in line with best practice for the management of sepsis and was a positive improvement on last year. However there were no local audits which supported how effective this trolley being implemented had been.
- We reviewed the policies and pathways for the admission of stroke, fractures and chest pain and these were written in line with the national institute for health and care excellence (NICE) and Royal College of Emergency Medicine RCEM guidelines. NICE and RCEM guidance on sepsis, head injury and fracture neck of femur was not always being followed in the department because the care that was being provided was not being recorded.
- The fracture neck of femur pathway between the emergency department and the orthopaedic service had improved since our previous inspection. We observed one patient be placed onto this pathway and their care followed best practice recommendations.
- The department had not undertaken any new local audits from a medical perspective since our last inspection. This was because of a reduction in the number of medical staff which meant that the one department consultant no longer had capacity to look at audits of the service.
- There was no new learning from audits noted since our last inspection due to no new audits being undertaken.

Pain relief

- The Royal College of Emergency Medicine Pain in Children audit for 2014-15 was not available for this inspection.
- We spoke with five patients about pain relief as part of this inspection. All informed us that they felt that their pain was controlled well and they had no concerns. This was an improvement from our previous inspection.
- We observed the triage process for patients who arrived in the department on foot. We noted that pain relief was offered where it was deemed required.

Nutrition and hydration

- Food and drink was available to those who were in the department for any length of time. There were regular time slots for care rounding which included offering people drinks.
- It was very warm in temperature at the time of this inspection, and we noted that many patients were thirsty. However there had been no increase or changes to the times of care rounds. This we raised to the staff who assured us they would increase rounds for drinks when temperatures increased.
- Food and drink was also available to relatives who were waiting in the department.

Patient outcomes

- The consultant sign off audit showed that about 19% of patients were seen by a consultant and 42% of consultants discussed cases with patients which was better than the England average. Only 39% of patients were seen by a doctor ST4 level and above doctor which is worse than expected compared to the England average. However the overall result showed that the trust was in the upper England quartile for discussions with patients.
- The RCEM sepsis audit showed that of the eleven indicators the trust performed in line with the England average on six of the indicators. The trust scored worse than the England average eon five of the indicators including the administration of antibiotics and monitoring of urine output.
- The severe sepsis and septic shock audit dated October 2015 showed that the trust's performance had declined in five of the six key indicators. There was no plan to re-audit sepsis in the department.
- The RCEM mental health audit showed that of the eight indicators the trust performed similar to expected on six indicators and better than expected on two indicators.
- Of the 18 indicators in the national RCEM Asthma audit the trust performed worse than the England average in 15 of those indicators.
- The Asthma in children audit for 2013/14 showed that the trust scored in the lower England quartile for all but one measure where it scored between the upper and lower England quartiles for Treatment IV hydrocortisone or oral prednisone.
- The trust scored above the standard but below the England average for unplanned re-attendance to A&E for the whole time period January 2014 to January 2016.
- There was no local audit plan for the emergency department. We were told this was due to the lack of consultants within the department.

Competent staff

- All medical staff within the emergency team had gone through the revalidation process with the GMC.
- The appraisal rates for the department was 75%, which was below the trust target of 80%. However this was an improvement from 60% at our last inspection.
- The nursing leaders were aware that the nursing staff were going to be completing their nursing revalidation this year and were implementing support mechanisms for the staff to complete their revalidation process with the NMC (nursing and midwifery council).
- Agency staff working in the department completed a full induction including competency checks prior to being authorised to undertake specific tasks such as the taking of an ECG or administration of medicines.
- Competencies for staff were completed on items of equipment in the resuscitation area including defibrillators and echocardiograms (ECGs), we examined training and competency records for staff that used these items of equipment, which supported what we were told.
- There were opportunities to obtain further education and qualifications for role specific qualifications advanced nurse practitioners, nurse prescribers but their first key priority was the leadership skills development for nursing staff in the department.
- The medical leadership provided us with an example of training their own consultants through the DREAM programme which was linked to the college of Emergency Medicine for middle grade staff. This course which can take up to three years offers middle grade doctors progression opportunities to go to consultant level. The department had four middle grade staff on this scheme for development, which was positive.

Multidisciplinary working

- Nursing and medical staff were observed to work well together and with open lines of communication.
- We noted that there had been an improvement in the working relationship with the surgeons and medics who attended the department for referrals. We also noted a greater presence of surgeons and medics in the department, as well as gynaecology. This was an

improvement from our last inspection. Staff told us that there had been an improvement in the timeliness of reviewing patients by other specialities within the department.
- We spoke with four members of the ambulance service who reported that whilst there remained issues at the service from their perspective, they felt that the service was beginning to improve. However they cited that handover times still needed improvement.
- The team worked closely with the wards and the site management team and ensured that appropriate patients were referred over to the care of this service when needed. We observed this work well during the inspection.

Seven-day services

- The emergency department is open seven days per week and twenty four hours per day.
- Radiology services currently do not operate seven days per week but on call services were available for emergency cases when needed to support the service.

Access to information

- The records system used within the emergency department was disorganised because the service used a combination of paper records and electronic records. Access to all systems was not a concern as all information required to provide the care to patients was accessible at any time however it could be time consuming to locate when it was not all stored in the same place.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The training records showed that 89% of staff had received training on the Mental Capacity Act 2005.
- Medical and nursing staff within the department had a clear understanding of the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.
- Staff explained their systems for assessing people's mental capacity to give consent regarding treatment. Staff also referenced assessing children as 'Gillick competent'.
- All patients who arrive in the department over the age of 65 should have a dementia screening undertaken as part of good practice. The department did not undertake screening for Dementia routinely, though more were being undertaken this year compared to our inspection last year.
- We observed staff explain what they were going to do and asked for the patients consent before they proceeded.

Are urgent and emergency services caring?

Good

Urgent and emergency services were rated as good for caring because:

- The feedback received from service users was positive. We received feedback on site and through comment cards and the majority shared positive experiences of using the service.
- The friends and family test results were consistently above the England average.
- We observed positive and caring interactions between staff and patients throughout the inspection. Staff were caring and compassionate when they spent time with patients.

However there were some areas that could be improved because:

- We received feedback from three patients and relatives on comment cards about staff bedside manner not being appropriate, being too busy and not being kind.

Compassionate care

- Since April 2015 the trust has performed between 92% and 95% on the A&E Friends and Family Test, peaking at 97% with their highest score. The trust currently has a 93% score of patients recommending the service to others which is above the England average of 88%.
- Throughout the inspection we observed examples of care where doctors and nurses were kind and compassionate towards patients and treated them with dignity.
- We observed several examples of staff asking for the persons consent prior to entering their cubicle area, respecting their dignity.

Urgent and emergency services

- We received feedback through comment cards during the inspection, and of the seven cards received four provided us with positive feedback about the service and the staff providing the service. Including that staff were kind, they saw the patients quickly and were supported.
- Of the three comment cards which did not provide positive feedback the feedback related to staff bedside manner not being 'acceptable', patients not feeling listened to, and waiting too long to be seen after x-ray. The majority of the feedback however was positive about the care provided.

Understanding and involvement of patients and those close to them

- We spoke with four relatives regarding the care their family member was receiving. All felt that they were being kept informed and updated by the service on what was happening, and what they should expect regarding their relatives care. However two relatives said that they were waiting for a while before they were told anything.
- The staff working within the department were working to ensure that people did receive regular updates, however they acknowledged when the department was busy that this did not happen in a timely way.

Emotional support

- Clinical nurse specialists were available to provide support to patients in the department and we observed two occasions where the older persons specialist nurse and Parkinson's specialist nurse were consulted to attend the department and speak with patients.
- However there were concerns recorded on the trust's risk register regarding the availability of specialist nurses to attend wards and departments to support patients. Specialist support not being available could impact on the emotional support requirements of the patients.
- Whilst no specific counselling services were available patients and staff had access to the chaplaincy service who offered support to patients and staff seven days per week, and they walked through the department at least once per day, which we observed during our inspection.

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

(for example, to feedback?)

Requires improvement

Urgent and emergency services were rated as requires improvement for being responsive because:

- Whilst there had been a number of improvements in the department since our last inspection, performance in some key indicators had deteriorated.
- The trust was not consistently meeting the four hour standard. On review we found that this was not only affected by reduced bed capacity but in addition, delays in decision to admit times.
- The average total time spent in A&E between December 2014 and November 2015 was 163 minutes, this is longer than the England average 140 minutes.

However we also found:

- The service has significantly improved the working relationship and pathways, assessment and treatment for adults and children with mental health conditions.
- The service has access to both a dementia nurse and language line.
- The waiting area had an improved paediatrics waiting area including a separated play zone with toys and a chair demonstrating the department is responsive to the needs of children.
- A pilot scheme to assess demand on the department was in use with escalation procedures to enable effective dealing with pressure. We observed this utilised well within the department, which helped to improve their responsiveness.
- The trust received 23 complaints between November 2015 and April 2016.

Service planning and delivery to meet the needs of local people

- We saw that the trust had plans to work cohesively with other trusts to ensure responsive care. Links were being established with fellow hospitals and the rotation of staff to ensure demand was being met and that it is therefore responsive to the needs of local people.
- New and improved processes for onsite care of patients with mental health conditions had been established. This meant that the trust was being responsive to patient needs in a timely manner.

Urgent and emergency services

Meeting people's individual needs

- Staff had access to translation services, known as language line, when there is a need to communicate with a patient whose first language is not English.
- Staff had received training in understanding learning disabilities and complex needs. There was a named nurse for learning disabilities available Monday to Friday in addition to available information for staff on the intranet for further support with a patient with complex needs.
- The trust has a named nurse for dementia and the service had access to this person Monday to Friday when needed for advice and guidance. This nurse was an Admiral Dementia nurse and the trust was one of only five in England to have an Admiral Dementia nurse. During the inspection we observed the team in the department refer patients to this nurse, who attended to assess their needs.
- Mental health assessment and pathways had been significantly improved. The psychiatric liaison team now work with the team on a more enhanced basis, with a trial being undertaken where a liaison nurse was placed in the department overnight. The outcome of the trial showed an improved pathway with getting patients with mental health needs to their required place of care as soon as possible.
- We observed the liaison team within the department throughout the time of our inspection, and response times and the working relationship between the two services were much improved since the last inspection.
- Patients had access to leaflets in the waiting area providing information on a variety of health conditions. Further leaflets in alternative languages were also available.
- Whilst there were still notable delays in relation to Child and Adolescent Mental Health service patients (CAMHS), the working relationship between services had been improved since our last inspection.

Access and flow

- The trust has been consistently below the standard of 95% for patients being seen within 4 hours. 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.
- Data provided by the trust states that only between 4% and 11% of patients have a DTA within two hours. For the period of January 2016 to February 2016 the trust failed to meet the 95% target on 50 out of 60 days.
- This represented a deteriorating picture in the 4 hour treatment or decision to admit target.
- Median total time in the ED was consistently higher than the England average for all months. The total time in ED (median) between December 2014 and November 2015 was 163 minutes. This was greater than the England average of 140 minutes.
- Since July 2015 until shortly before our inspection the percentage of emergency admissions waiting four to 12 hours to be admitted from the decision to admit until being admitted has been below the England average. At the time of our inspection it was worse than the England average.
- The percentage of people leaving the department before being seen varied between June 2014 and November 2015. It was above the England average for three months between June 2014 and September 2014, but spent most of the time period below the England average with 10 out of the 18 month period. Most recent data suggests fewer patients are leaving before being seen.
- The department was trialling a new system for escalation at the time of our inspection. This draft process allowed the service to assess their status on a red, amber, green or black scale dependent on demand and capacity requirements four times per day. This process when acted upon regularly should alert the trust to any impending red or black alert status for the department. This would then allow the trust to request for additional support to meet service demands. For example additional surgical or medical support
- We observed that this worked effectively during our inspection, as we saw the department declare their black alert status to the trust twice during our inspection. However the process was not entirely followed at the time of declaring black alert. The draft procedure states that when black alert is declared the nurse in charge should call a 'stop the line'. We observed that this did not take place when one black alert was declared.

Learning from complaints and concerns

Urgent and emergency services

- The department received 23 complaints between November 2015 and April 2016. The most common themes of complaints were staff attitude, poor communication amongst staff and relatives and clinical issues.
- Patient responses to the A&E survey were found to be about the same as other trusts. These questions were in relation to responsiveness and included themes such as waiting times and privacy when in the department.

Are urgent and emergency services well-led?

Requires improvement

Urgent and emergency services were rated as requires improvement for being well led because:

- The risk register, identification or risk and management of risk was not yet embedded within the service.
- The quality of governance meeting minutes, and the undertaking of quality measurement and governance within the service was limited.
- There was 3.5 WTE consultants (with one long term sick leave and another about to leave the department) who, whilst dedicated to the service, was not able to deliver good governance due to the medical staffing concerns.
- There was a vision from the trust about this service and how the sustainability of the service would be delivered in the future. However locally the teams were less sighted or aware of this.
- There was an improvement plan in place for the service following our last inspection. Whilst some of the elements of the improvement plan had been implements and key elements of the service had improved, other areas of the service had deteriorated in terms of governance, quality and being effective or responsive.

However we also found:

- Nursing staff had been provided with some training in leadership, and the role of the nurse in charge was now supernumerary which supported their development.
- The leadership and governance for the children's emergency department had sustained good practice and further improved the children's service.

Vision and strategy for this service

- The trust overall has a vision for the emergency department. There were discussions regarding the future of the service and how a long term partnership with another trust in the region may improve staffing and care deliver. At the time of the inspection these plans were not yet formalised but discussions were taking place with the other trust.
- Locally there was limited understanding of the vision for the service and the future. The staff within the department were aware of the plans for a working partnership with a neighbouring trust but did not know at that time what this meant for their service, and were not seeing any visible benefits of a working partnership being in place at the time of the inspection. However the leaders were positive about the option of working with another service in the future and felt that this could be a positive in terms of learning, sharing and improving the service.

Governance, risk management and quality measurement

- The division had monthly governance meetings to look at risk management, governance and quality issues throughout the service. We examined meeting minutes for the last four meetings which demonstrated that issues around governance in the emergency department were discussed.
- The risk register for the service was a joint register with acute medicine though there were three registers within the division; an overall division register and one for medicine and one for emergency care.. The trust acknowledged that there was some confusing language within the division around the three risk registers.
- There were risks on the corporate board assurance framework, rated at 15 or higher, which was a significant concern that related to the emergency department. These were not listed on the emergency department's own risk register. For example mental health crisis response times were identified as a corporate risk. This showed that governance from ward to board was not yet robust.
- The trust wide risk register for January 2016 did not identify any risks relating to the emergency department, the lack of provision of a separate children's department was not identified or seen as a corporate risk, nor was the risks related to medical staffing levels.
- Local governance arrangements were limited. The governance meeting minutes quality was poor and did

not discuss a wide range of governance related matters. For example they did not discuss no or emerging risks or escalation or the lack of local audits taking place in the department.

- The service was not measuring quality within the service effectively. Whilst staff could verbalise where they had made improvements they were not able to demonstrate this through any definitive outcomes, reviews or audits to show the service had improved. For example the staff proudly spoke of their improvements regarding sepsis, and were planning to undertake an audit, however one had not been done despite the measures they had implemented.
- Following the October 2015 inspection there was a clear improvement plan for the service to make significant improvements. Local meetings were taking place to support improvement. However these were not all minuted, and locally the sense was that they were no longer taking place regularly.
- There was a risk that the service governance in its current format could demonstrate that the service was improving. In some key areas deterioration in the service was noted where as in October 2015 many of these areas were not of concern. We were concerned that the trust was not able to demonstrate sustainability in the service improvement.

Leadership of service

- The emergency department was led by an acting clinical lead, a senior sister who also covered the acute medical service, a lead nurse for children's services, and a divisional head nurse.
- The department had implemented a nurse in charge role and a doctor in charge role for each shift. This was identified as a concern at the previous inspection because the staff were not supernumerary or had oversight of the department. At this inspection we saw that the role of nurse or doctor in charge was supernumerary and therefore they now have oversight and are able to lead the department. This was an improvement from the last inspection.
- There was an interim clinical lead for the service following a change in lead since our last inspection. The interim clinical lead was an established consultant however they were challenged in being able to lead the department when they were the only trust consultant employed. There was also a high use of locum middle grades in post. This meant that improvements and sustainability were needed for clinical leadership support for the service.
- The nursing leadership for the adult and children's services had improved, with changes being noted and the nursing leads being more visible and accessible to staff, which was positive.
- The service matron who covered several services, still covered several services but were regularly in the department and was observed to be supporting the nursing staff with their leadership of the service.
- Each shift was led by band six nurses who at the last inspection were not all well developed in leadership skills. At this inspection we were provided with information which supported that these staff had received training and development support in leadership skills. Three band 6 nurses we spoke with told us that they found this course to be beneficial.

Culture within the service

- The culture in the department had continued to provide since our last inspection. There was a notable drive amongst staff and a desire to improve the services provided form a nursing perspective. This was evident through many changes the nurses had made to the service they were providing and this was positive.
- There had been a decline in the culture amongst the medical staff due to the number of changes, staff leaving and pressures to cover the rota with limited resources. We were concerned that the medical staff work group required additional support during this difficult period to try and encourage sustainability.
- Staff openly told us about what they were most proud of and where they felt improvements were still required. We assessed that staff were honest about their challenges and what they felt happened to the service following the last inspection. They spoke openly without fear which was positive.
- We observed the escalation process for capacity issues being used during the inspection. The draft procedure states that when black alert is declared the nurse in charge should call a 'stop the line'. We observed that this did not take place when one of the black alerts was declared. We asked why this was and were informed that the staff did not feel this was required.

- Staff were willing to make improvements, and change the service to deliver good patient care, and this was visible from the changes made since the last inspection. However further work was needed to sustain an all-round good culture amongst all medical and nursing staff in this service.

Public engagement

- The service takes part in the Accident & Emergency inpatient survey and also takes part in the A&E friends and family test. There were comments cards and feedback forms available throughout the service to engage the public in providing feedback or ideas for improving the service.
- All patients were given comment cards upon leaving the service to provide feedback specifically about how the service could improve and seek feedback to implement changes where needed.

Staff engagement

- The department did not undertake any local surveys of staff within the emergency department to understand how staff were feeling at any one time. However there had been an increase in staff meetings and sessions to share information.
- Following the last inspection there was a programme of engagement of the department staff taking place. This was part of an overarching improvement plan to improve the service. Whilst this was noted to have taken place and changes made with engagement of staff, this has not continued and has not maintained effectiveness. For example the medical staff were not all engaged in the service due to the lack and instability of the consultant workforce in the months prior to the inspection. Medical staff we spoke with during the inspection did not all feel engaged in what was taking place in the service.
- Nursing staff engagement was taking place through regular band 6 nurse meetings, which was a positive improvement since the last inspection. However we observed that not all band 6 staff were engaged in the processes for the department and escalation and further work to truly embed staff engagement across the workforce.

Innovation, improvement and sustainability

- The department was implementing a front door model of care in the future with the use of therapist support. The aim was to start early intervention and discharge planning before admission and will allow staff to focus on a clear endpoint at the start of the patient's acute journey.
- The matron had developed a trial escalation protocol for the department to recognise their trigger points for escalation at the earliest opportunities. There was positive feedback about this system and the support this brought the department.

Medical care (including older people's care)

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

Information about the service

The medical division had 19 884 admissions between September 2014 and August 2015with just over half being emergency and the majority of the rest being day case. The largest category of admissions was general medicine with 20% being medical oncology. We visited Apple Tree, Cherry Tree and Walnut Wards as well as the Acute Admissions Unit, Medical Short Stay Unit and the endoscopy unit.

We spoke with 29 members of staff and 21 patients and relatives. We reviewed records, conducted interviews and observed care being given and carried out several Short Observational Framework for Inspection (SOFI) observations of care on Walnut ward.

This was a follow up inspection following concerns identified at our inspections of September 2014, January and October 2015.

Summary of findings

We rated medical services as Good overall.

Learning from incidents was consistently shared with staff across the division and formal mortality and morbidity meetings had been introduced and we observed good infection control practices in relation to hand hygiene and the use of personal protective equipment. All patients had their allergies recorded on their medicines chart and medicines were stored securely though prescription charts were not completed fully for time critical medications such as paracetamol though the trust informed us they would be using new charts in the near future. Staff had a good understanding of safeguarding principles and how to make safeguarding referrals and mandatory training had improved compliance across the division. However, records and risk assessments were mainly correct however they did not always reflect the needs of patients and were not updated to reflect changing care or needs.

Patient outcomes were now measured including the reinstatement of stroke audit data. Local audits plans were comprehensive and had lead clinicians identified. Patient care and pathways followed national guidance and best practice and staff had good knowledge of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. However, several patients had been identified as being at risk of malnutrition but we could not see that steps had been taken to address this.

Medical care (including older people's care)

We observed staff interacting in caring and compassionate ways with patients and relatives. Friends and Family Test (FFT) response rates were higher than the England Average and most wards scored highly on the test. Patients we spoke with told us that staff were caring and had kept them involved and up to date with their care and treatment.

The division was meeting referral to treatment times (RTT) and was actively engaging with sustainability and transformation plans and was working collaboratively with neighbouring trusts around the provision of some care including stroke care. There was now a speech and language therapist for patients suffering stroke and other service level agreements for therapy staff providing stroke care and patients had their individual needs met and we saw good practice in relation to dementia care on one ward. However, complaints and concerns were addressed locally. More staff were aware of learning from complaints but half of those we spoke with were unclear on this.

A number of changes in ward leadership and the introduction of a quality matron had become embedded since our last inspection. Governance and risk had been addressed with the implementation of mortality and morbidity meetings and that the findings of root cause analysis was more widely shared. The division was actively engaging with sustainability and transformation plans and collaborative working with other providers. However, we were concerned about the sustainability of some services due to a lack of key staff. Whilst locum staff were in place permanent recruitment had been difficult. The division was aware of these concerns and a review of some specialty care was underway.

Are medical care services safe?

Good

We rated medical services safety as Good because:

- Learning from incidents was consistently shared with staff across the division and formal mortality and morbidity meetings had been introduced.
- We observed good infection control practices in relation to hand hygiene and the use of personal protective equipment.
- All patients had their allergies recorded on their medicines chart and medicines were stored securely.
- Staff had a good understanding of safeguarding principles and how to make safeguarding referrals.
- Modified early warning scores were used consistently and patients reviewed in a timely manner when required.
- Mandatory training had improved compliance across the division.

However, we also found:

- Records and risk assessments were mainly correct however they did not always reflect the needs of patients and were not updated to reflect changing care or needs.
- Prescription charts were not completed fully for time critical medications such as paracetamol though the trust informed us they would be using new charts in the near future.
- There remained some vacancies in medical staffing with a reliance on locum staff in some specialties.

Incidents

- There had been 19 serious incidents (SI) reported between March 2015 and February 2016. The largest category with 9 incidents was pressure ulcers. There had been increases in the prevalence of pressure ulcers in April and September 2015 but this has since fallen. 4 Serious incidents were related to falls with the rest being made up of hospital acquired infection and delay in treatment.
- There had been no never events in the medical division. The definition of a Never Event has changed. Although

each Never Event type has the potential to cause serious patient harm or death, harm is not required to have occurred for an incident to be categorised as a Never Event.
- Trust data showed a reducing number of total falls and falls with harm.
- We reviewed four serious incident reports and found them to be detailed with a full investigation and recommendation for further actions including risk assessing patients routinely and further training. 7 staff we spoke with were aware of a serious incident that had happened within their area and could tell us about learning from the incident, for example, the enhanced monitoring of patients at risk of deterioration.
- 18 staff we spoke with told us they were able to report incidents and were able to discuss the last incident they reported. A new incident reporting system had been put in place and staff had training to ensure they could use it properly.
- Incidents were discussed at staff meetings and 'safety huddles' during shifts. We observed this happening on one occasion during the inspection.
- At our last inspection there was no mortality and morbidity meetings held within the medical division. At this inspection mortality and morbidity meetings were being held regularly. Minutes showed that a sample of cases were reviewed which considered all factors and identified any learning from the case being discussed.
- The Director of Nursing chaired a weekly meeting of any incidents graded moderate and above. Minutes showed there to be clear actions identified and that Duty of Candour was considered for each incident.
- All staff we spoke with were aware of their responsibilities under Duty of Candour. During our inspection, an incident was identified that may trigger this requirement. We saw that the trust took appropriate action to report the incident and spoke promptly with the patient and relatives and offered an apology and offered a face to face meeting. They kept them up to date throughout the course of our inspection.

Safety thermometer

- Safety thermometer data was displayed on all wards and was easily visible for patients and staff to view.
- Data available on Apple Tree ward showed that there had been one pressure ulcer which was attributed to community acquired, four falls and three medicines incidents.
- For Cherry Tree ward hand hygiene compliance had been 99% with no falls and no and no hospital acquired infections. For a previous month there had been 10 falls with no harm. Staff were able to tell us the action they took in relation to the number of falls. This included review by the falls lead for the trust. Investigation showed that the majority happened in the morning and additional safeguards were out in place.
- Walnut ward data showed hand hygiene compliance at 100%, five falls without harm and no hospital acquired pressure ulcers.
- This data was also presented to the board as part of the ward dashboards and exception reporting.
- Safety thermometer data displayed looked consistent with data supplied in board papers and to commissioners.

Cleanliness, infection control and hygiene

- Ward and clinical areas were visibly clean. There were separate cleaning rotas available which showed that areas had been cleaned each day or shift. Regular cleaning audits showed greater than 95% compliance for cleanliness.
- Curtains around the beds had the date when they were first used and were changed if dirty, were up longer than a given period or if there was risk of infection.
- We observed equipment being cleaned and sanitised properly between patient uses.
- "I am clean" stickers were affixed to equipment that had been decontaminated and ready for use.
- Staff used personal protective equipment appropriately when caring for patients or entering side rooms that were being used for the control of infection. Gloves, aprons and other equipment was readily available for staff and visitors as was alcohol hand gel.
- Compliance with hand hygiene and personal protective equipment usage for medical wards showed high levels of compliance of 95% and greater for all medical wards. .
- Patients with an identified infection or potential infection were appropriately identified and cared for in side rooms in line with trust policy and infection prevention and control guidance.

Environment and equipment

- Equipment was properly checked and maintained in line with manufacturers' guidance and recommendations.

- Electrical equipment that required portable appliance testing (PAT) was appropriately tested.
- Emergency equipment including resuscitation equipment was properly checked in line with policy. Regular audits were completed that showed emergency equipment was checked in line with trust policy.
- We checked emergency equipment on all wards and found it to be correct and in line with trust policy.
- The environment was well maintained though cluttered on some wards with trolleys and medical equipment. On one ward we saw an empty bed blocking a fire escape for 20 minutes whilst staff moved other furniture about. Staff told us it was left where it was as it was the only place to keep the bed " out of the way".
- The layout of side rooms on the wards made it difficult to observe patients, particularly if the door needed to be kept closed. This meant staff had to regularly attend patients to ensure their safety and comfort. The trust had risk assessed patients using side rooms due to these concerns.

Medicines

- All medicines were stored securely including controlled medicines.
- Lessons were learnt from medicine incidents and shared across the trust in order to improve patient safety. The introduction of a new system for recording medicine incidents had improved the overall quality of available information. The Medication Safety Committee identified any emerging themes in medicine safety. Information and learning was then shared across the trust in a Medication Safety Bulletin. Recent learning focussed on improving the prescribing of IV paracetamol (April 2016) and also learning points from recent insulin incidents (May 2016). We spoke with nursing staff on three wards who told us that there were definite improvements in learning from medicine incidents. For example, there was an increase in reported medicine incidents about particular insulin. A multidisciplinary team looked at the reported incidents for this medicine and assessed what changes could be made to prevent them happening again. This resulted in simplifying the prescription chart for insulin which was due to be made available on wards following further education and training.
- Checks to ensure that any known allergies or sensitivities to medicines were recorded accurately on patients' prescription charts within 24 hours of admission. This information is important to prevent a medicine being given in error and causing harm to a patient. We checked 14 patients' prescription charts and found that all 14 charts documented the patients' allergy status which followed the trust policy.
- At the time of the inspection the times for medicine administration were not always documented clearly on prescription charts. This sometimes made it difficult to determine at what time certain medicines had been given to a patient. Whilst for many medicines this is not critical there are some medicines such as pain relief where it is important to know what time the medicine was given. This is in order to determine whether a patient can safely be given another dose. However, we were informed that action was being taken with the development of a new prescription chart. Following the inspection the trust informed us they would be changing medicines charts to allow more consistent recording of administration times.
- The recent introduction of medicine waste bins on each ward ensured that medicines were removed immediately from medicine cupboards when they were no longer required. This prevented unwanted medicines remaining in clinic rooms.
- We observed the availability of a student newsletter dated May 2016 which reminded nursing students to follow hospital policy and NMC guidelines when administering medicines to patients.
- We observed the ward pharmacist checking a prescription chart for a new patient to ensure that the medicines were available on the ward and prescribed correctly. They also highlighted on the prescription chart that the patient was prescribed insulin as a reminder to nursing staff.

Records

- Records were stored outside patient bays and additional records at the end of the bed. Notes and records were not always secure and were stored in unlocked trolleys in corridors.
- Most records were kept up to date and accurately reflected the needs of patients using the service. All 17 records we reviewed on Apple Tree, Cherry Tree and the acute medical unit were up to date and reflective of care needs. However, on Walnut ward 5 records we reviewed were not always up to date and reflective of need. On

three records the patient had been identified at risk of falling but nor care plan had been put in place or the assessment reviewed. In 2 further records, pressure ulcer risk assessments had not been reviewed for over 2 weeks despite a change in the patient's condition and one did not take in to account a leg ulcer.

- In three records across the division, patients with complex wound care needs did not have a care plan updated regularly. Two of the care plans had not been updated or evaluated in two weeks. The last entry indicated that the patient still had a wound that required dressing.
- In 8 records risk assessments were completed but not always signed by the person completing the assessment.

Safeguarding

- Safeguarding information was available in ward and clinical areas. 17 Staff we spoke with were confident in the process of when to report a safeguarding and what constituted a safeguarding concern.
- Staff were clear of their responsibilities in reporting safeguarding concerns. All staff we spoke with knew the safeguarding lead for the trust and where to seek advice if required.
- The safeguarding lead was on a ward during our inspection. We saw them assisting staff with a Deprivation of Liberty application for a patient on the ward. Staff told us the safeguarding lead was visible and regularly visited wards.
- Latest available data showed that 97% of staff had completed safeguarding level 2 training.

Mandatory training

- Mandatory training included immediate life support, moving and handling and infection prevention amongst others.
- Senior staff told us that there had been additional mandatory training to ensure staff were up to date with training. Data available at the time of inspection showed that wards had greater than 90% compliance with mandatory training for staff. On Apple Tree ward the figure was 91%, Cherry Tree ward was 96%. Board level data confirmed an improvement in the number of staff completing mandatory training.
- Agency staff completed an induction checklist before commencing work. Two agency staff said that they had been orientated to the ward before commencing work. They worked regularly on the wards and were confident in the processes used. Checklists for agency workers were completed on two wards that were checked.

Assessing and responding to patient risk

- Modified Early Warning Scores MEWS) were used to monitor a patient's level of acuity and to respond appropriately if they were at risk of deterioration. Of 24 records reviewed, all had appropriately completed MEWS scores. Records showed that the patients were referred to the outreach team or hospital at night in the event of a high MEWS score. Patients were reviewed and a care plan put in place to manage their condition.
- Data provided by the trust indicated a falling number of falls with harm across medical wards.
- The Critical Care Outreach Team conducted audits on the usage of MEWS across the trust including the medical division in line with NICE CG50 guidance. Overall results showed improving compliance with MEWS
- All MEWS scores we reviewed during the inspection had been correctly calculated and escalated where appropriate. Observations were recorded at intervals as determined by the tool and/ or medical review.
- Critical care outreach offered a service during the ward until 8pm. Out of hours, support was offered by the clinical site team.
- The Situation Background Assessment Recommendation (SBAR) tool was used for sharing concise and focused clinical information between teams on medical wards.
- All patients in the acute assessment unit were reviewed daily. There were clinical pathways in place for patients to be transferred to other acute providers if they required specialist care, for example primary percutaneous coronary intervention where this had not been identified prior to admission at Hinchingbrooke.

Nursing staffing

- Wards had planned and actual staffing numbers displayed at the entrance to the ward. We found the planned and actual number of staff on duty to be accurate on all the wards inspected.

Medical care (including older people's care)

- We reviewed rotas for three months. They showed that staffing levels were maintained throughout the period with only occasional fluctuations. Ward managers told us that this was due to sickness with insufficient time to arrange cover.
- Nursing handovers were structured and gave the necessary clinical information to enable safe and effective care of patients between shifts.
- The safer nursing care tool (SNCT) had been used to evaluate staffing number in clinical areas which had seen a change in staffing in some areas.
- There were small number of nurse vacancies across the division with 12 whole time equivalent vacancies for qualified nursing staff. This was partly due to a staffing uplift on Cherry tree ward to manage an additional 4 beds.
- Senior staff told us that, wherever possible, they used agency staff that were familiar with the ward and had worked there previously. Agency staff received an induction to the ward they were working on. Records seen on the ward confirmed this.
- Staff were able to describe the process used to request additional staff and that most requests were authorised.
- Sickness rates were around 5% for most medical wards with the exception of Walnut ward that had a 1.8% sickness rate according to January 2016 board reports.

Medical staffing

- There were more consultants than the England average that made up 39% of the medical staffing. There were significantly less middle grade and registrars at 22% than the England average of 45%. There were more junior doctors at the trust at 40% compared to the England average of 22%.
- There were a number of consultant level vacancies across the division including stroke and acute physicians. Senior clinical staff and managers told us that they mitigated this by using long term locum's who knew the hospitals and the processes. Since our last inspection the trust had employed 2 locum consultants and advertised for a full time stroke consultant though they had been unable to recruit to this position. There continued to be vacancies for acute physicians.
- At our last inspection there here was 1.3 WTE respiratory consultants in place at the trust made up of two consultants who worked between the trust and a neighbouring trust. At this inspection there was an additional locum consultant to support the respiratory service. When on leave or sickness, the respiratory consultant cover could be reduced to three days a week. There was no respiratory cover routinely at weekends. During our inspection patients requiring non-invasive ventilation were cared for on the ward and we were told tracheostomy patients also were cared for on the ward. When no respiratory consultant was available, acute physicians cared for patients though the initiation of acute non-invasive ventilation was supervised by a respiratory physician or consultant intensivist.
- Medical Wards in the Trust had medically led handovers on a twice daily basis at 08:00 and 20:00 which gave appropriate detail and identified any patients who may be outlying on other wards.
- There were consultant led ward rounds daily for patients on medical wards. A 24 hour rota to manage emergencies in the endoscopy suite was in place. Junior medical staff we spoke with told us that they were well supported at the trust and they had access to good teaching. Two doctors told us they had received a comprehensive induction when starting at the trust.

Major incident awareness and training

- There was major incident policy in place for the trust and a business continuity plan also in place. This had been reviewed since our last inspection. At our last inspection staff were not fully aware of the policy and their responsibilities under it and this remained the same at this inspection.
- Staff in the Acute Assessment Unit (AAU) had a good understanding of the major incident policy as the AAU effectively became part of the emergency department in the event of a major incident. A major incident protocol was in place for the management of the unit as part of an emergency department.
- A winter escalation plan was in place and part of a wider health economy plan to manage capacity. This had been reviewed ahead of winter 2016 and took into account other work being completed such as the sustainability and transformation plans.

Are medical care services effective?

Good

Medical services effectiveness was rated as Good because:

Medical care (including older people's care)

- Patient outcomes were now measured including the reinstatement of stroke audit data.
- Local audits plans were comprehensive and had lead clinicians identified.
- Patient care and pathways followed national guidance and best practice.
- Seven day services were in place for a number of services and despite uplift in consultant cover there remained a lack of consultant cover in some specialties at weekends and out of hours.
- We observed correctly completed Mental Capacity Act (MCA) assessments. Staff had good knowledge of the MCA and Deprivation of Liberty Safeguards. Training figures had improved for this.
- There was effective multidisciplinary working both with hospital staff and staff in other services.

However, we also found:

- Several patients had been identified as being at risk of malnutrition but we could not see that steps had been taken to address this.
- Only 16% of middle grade doctors had received an appraisal.

Evidence-based care and treatment

- At our last inspection the Trust had a 2015/16 clinical audit plan but there is no evidence that this had been formally agreed or signed off by a board sub-committee. There was no indication of timeframes for completion of local or national audits within this plan. At this inspection there as a full audit plan in place for clinical audit which identified lead clinicians.
- At our last inspection local care pathways for stroke and cardiology followed best practice and NICE guidance including CG80 though potential conflicts with this guidance arose from the commissioning of speech and language therapy in stroke services. At this inspection, the reinstatement of speech and language therapy and physiotherapy meant that pathways within the medical division followed national guidance and best practice.
- There were specific pathways for patients in ambulatory care that followed best practice for example the cellulitis and pulmonary embolism.
- At our last inspection some policies were out of date. On this inspection policies had been reviewed and updated as required and signed off by the appropriate person and committee.
- Staff on both Apple, Cherry Tree and Medical Short Stay wards, discussed how local audits were completed; daily, weekly, bi-monthly and monthly for ward level data, including safety thermometer data, using the electronic audit system,. Staff were able to show us the results of local audit and describe any actions they had taken in response to audits. This included additional support with some staff one the S-BAR tool (a tool used for assessing a patient's condition and planning their care).
- The National Institute of Health and Clinical Excellence (NICE) guidance states that all patients, on admission, receive an assessment of venous thromboembolism (VTE) and bleeding risk. Trust data showed a compliance rate of 98% with the national average being 96%

Pain relief

- Pain relief was given in a timely way for all the patients we reviewed.
- A specialist acute pain team was available for patients requiring specialist input. This service was available Monday to Friday with an on call anaesthetist covering out of hours and weekends..
- Analgesia was administered in a number of ways to ensure it was able to meet the patient's needs. This included oral pain relief, via injection or through a pump or syringe driver.
- A pain tool was available to assess patients' pain. In 12 records we reviewed, only 2 had clear use of a pain tool to assess a patient's pain.

Nutrition and hydration

- Patients were assisted with their fluid and nutritional needs. Assistance was given promptly at mealtimes if required with additional staff available to help them. Patients who may need assistance were clearly identified.
- Patients who were not able to gain enough nutrition orally were supported by other forms of nutrition including enteral feeding via a percutaneous endoscopic gastrostomy (PEG) and total parenteral nutrition (TPN). TPN was prepared in pharmacy for administration on the wards.
- At our last inspection we found cases were mouth care was not carried out as often as required. The trust had

undertaken further teaching and mentoring of staff in this basic nursing skill. Patients we reviewed on this inspection had received appropriate mouth care and assistance.

- On Walnut ward we found 3 records where a patient had been scored as at risk of malnutrition. The care plan indicated that they should be referred to a dietician and other measures taken such as monitoring their food and fluid intake. There was no evidence in the records that this had occurred.
- The trust had identified that they required additional support for the instigation of feeding regimes and had ensured a dietician was in place to assist with emergency feed regimes.

Patient outcomes

- Readmission rates for the trust for elective admissions were better than the England average overall with medical oncology and general medicine having a much lower risk though medical haematology was above the England average.
- Readmission rates for non elective (emergency) admissions were slightly better than the England average.
- At our last inspection SSNAP audit data was not being collected. At this inspection the trust had reinstated SSNAP data collection and a full quarter was submitted between January and March 2016. This data was published in June 2016 and showed that, due to the size of the unit, there were too few patients added to the database to give a benchmarking score for this time frame. It did however demonstrate that the trust was again collecting this audit data.
- Myocardial Ischaemia National Audit Project (MINAP) data showed deterioration in performance between 2012/13 and 2013/14 for patients seen by a cardiologist and being admitted to a cardiac ward and a slight improvement in the number of patients being referred for angiography. The 2013/ 14 data showed that the trust performed better than the England average for patients reviewed by a cardiologist but worse than the England average for patients being admitted to a cardiac ward and number of patients being referred for angiography. Since this data, a number of new pathways had been created between neighbouring trusts to manage patients with heart conditions.
- The Joint Advisory Group on GI Endoscopy (JAG) had awarded the endoscopy unit accreditation in September 2015.
- National Diabetes Inpatient Audit (NaDIA) for 2015 showed that the trust performed broadly in line with the England average for most measures. The number of nurse specialists and consultant hours were better than the England average but the number of dietician hours for diabetic patients was worse than the England average. The number of diabetic patients who had a medication error was worse than the England average but the number of patients with a low blood sugar event (hypoglycaemia) was better than the England average.

Competent staff

- Completion of appraisal rates on Apple Tree ward was 78% in May 2016 though the rest of the staff had their appraisal booked. Walnut ward appraisal rate was 90% and Cherry Tree at 95%.
- In terms of medical staffing for the period 2014/15 83% of the Trust's 56 Consultants had achieved appraisal sign-off. 16% of Staff Grade, Speciality or Associate Specialist Doctors (11) had achieved appraisal sign off within the Trust's timeframe.
- Clinical nurse educators had been employed to work with staff proactively and also to work in areas where there had been identified concerns.
- There was a full induction programme for staff joining the wards. 1 new member of staff confirmed they had received induction, and felt well supported during their induction period.
- We saw that a number of competency assessments had been completed on wards such as intravenous and medicines competencies. On one ward a number of these assessments were dated June 2013 with no indication when they should be reviewed.
- A number of specialist nurses supported clinical services including cardiology and respiratory medicine. Additionally trained nurses from Apple Tree ward supported other wards with swallow assessments.

Multidisciplinary working

- Medical wards had a thirty minute daily 'huddle meeting' which was a mixed nursing and medical staff and allied health professional meeting in the doctor's office to discuss any concerns and plan discharges. This was in addition to the 08:00 and 20:00 handover meetings.

Medical care (including older people's care)

- White board rounds were completed daily by the MDT and this was also attended on occasion by community staff to discuss complex discharges and care.
- There were local and regional weekly MDT's to discuss complex patients and care planning. We attended one of the MDT meetings and found it to be comprehensive with treatment options discussed and plans made. The patient was considered as an individual throughout MDT discussions.
- Ward rounds routinely comprised members of the MDT to effectively manage patient pathways and plan discharges.
- Neurological multidisciplinary team meetings (MDT) took place every Wednesday. Meetings were attended by doctors, nurses, physiotherapists, community nurses and social workers, amongst others. The meetings enabled discharge planning, rehabilitation goals and referrals to be discussed and promote patient outcomes.

Seven-day services

- There were clear on call arrangements for medical staff. Medical and nursing staff we spoke with told us that that there were no problems calling in on call staff.
- There were a number of vacancies for consultant staff and limited cover for some specialties such as respiratory medicine and stroke care. These patients would be seen by acute physicians in the absence of these consultants who word a seven day rota with approximately one weekend in four. All patients that required consultant review at weekends were seen by the on call team.
- Physiotherapy staff worked seven days providing care to ward patients based on need. There was an on call physiotherapy service for patients requiring chest physiotherapy.
- The discharge planning team worked weekends with effect from April 2015 to facilitate timely discharges which staff told us contributed to the reduction in length of stay.
- There was on call pharmacy and radiology services over the weekend and out of hours. Staff we spoke with told us that all essential investigations and support could be ordered and carried out promptly out of hours. Pharmacy services were provided to the Medical Short Stay Unit for three hours on a Saturday morning.

Access to information

- Staff were able to access medical records as and when required which were available to ward staff.
- Test results including radiology and blood tests were usually received promptly according to the staff. Senior managers had expressed some concern over delays in pathology results though ward staff told us they available via an online system.
- During our last inspection a patient with complex needs was admitted from a nearby trust. The patient did not arrive with all the information required to manage their care which meant staff had to work with limited information. At this inspection we were told that the situation had improved and that all patients had the correct information when they returned from another trust. We reviewed two patients who had been repatriated from a neighbouring trust and found there to be a full handover and relevant documentation.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- 9 records reviewed showed that patients signed consent forms before procedures were undertaken. Five patients we spoke with told us they had been asked for consent prior to a procedure and where given the necessary information.
- We observed verbal consent being obtained before care and treatment was given.
- At our last inspection not all staff had received training for MCA and DoLS . At this inspection, 95% of staff had received training in MCA and DoLS. We spoke with 12 staff about the MCA. All had a good knowledge of the Act and their responsibilities,
- 9 Records showed that the Mental Capacity Act had been considered and properly applied. There was good support from safeguarding lead if required.
- We reviewed 3 deprivation of liberty applications and found them to be complete. Staff told us the problem with applications was timely review by the local authority.

Are medical care services caring?

Good

Caring was good within the medical division because:

- We observed staff interacting in caring and compassionate ways with patients and relatives.

Medical care (including older people's care)

- Friends and Family Test (FFT) response rates were higher than the England Average and most wards scored highly on the test.
- Patients we spoke with told us that staff were caring and had kept them involved and up to date with their care and treatment.
- Information received from comments cards were uniformly positive about the quality of care received. Over 40 comments received were positive.

Compassionate care

- Friends and family test (FFT) data for July 2014 to June 2015 showed the trust had a much higher response rate at 63% than the England average of 37%.
- The trust Friends and Family Test (FFT) records the percentage of patients who would recommend the service to their friends or family. The Friends and Family Test performance was 97% between January 2015 and January 2016, which is better than the England average of 96% with the exception of June 2015 and September 2015 where the trust scored less than the England average.
- Apple Tree Ward consistently scored 100% with the exception of October 2015 when it scored 89%. Walnut ward scored consistently above 95% with the exception of June 2015 when it scored 82%. Cherry Tree Ward results were variable with three occasions between July 2015 to January 2016 scoring below 90%. For April 2016, Walnut ward FFT was 91%.
- Patients we spoke with during the course of the inspection, comment cards and listening event were overwhelmingly positive about the care and treatment they received.
- We carried out a Short Observational Framework for Inspection (SOFI) observation on Walnut Ward at the trust. We observed positive staff engagement with patients though there were periods of up to 25 minutes when no member of staff entered the bay.
- Throughout our inspection, we observed patients being treated with compassion, dignity, and respect at all times. Staff drew curtains and respected patient privacy when supporting patients with personal care. Patients were greeted by name and staff introduced themselves. Staff asked patients consent before caring out personal care. Medical staff routinely used Chaperones.
- Patients consistently gave very positive feedback about the staff and the hospital. One Patient told us "the staff are tremendous". Another said, "they can't do enough for you, they are always there to help me".

Understanding and involvement of patients and those close to them

- Patients and relatives we spoke with told us that they were involved with their care and making decisions though one person said that despite daily ward rounds, they felt the plan changed each time.
- We observed staff discussing care and discharge arrangements with a patient and their carers.
- 21 patients we spoke to on Apple Tree Ward, Cherry Tree Ward, Walnut and the acute assessment unit (AAU) told us that staff are very positive and had time to explain anything they didn't understand and met all their personal needs
- Patients and their families told us that they were involved in making decisions around their care and that they knew what was going to happen to them.
- We observed staff discussing care plans with a patient and his carers. This involved a move to a neighbouring hospital for specialist care. The staff discussed how this would impact on the patient's family and found a way of ensuring that relatives could still visit the patient using a community transport service. Staff considered all aspects of the care the patient would receive and explained in detail what they could expect following the treatment.

Emotional support

- We spoke to five patients, three told us that staff always had time to talk with and support them.
- The hospital has an Admiral Nurse who is one of only five in the country. Admiral Nurses are governed and monitored by Dementia UK and provide crucial specialist support to people with dementia. This means thatthe patient and their family and cares can receive expert practical and emotional care and support in relation to dementia care.
- Patients had access to the trust Chaplain to support their spiritual wellbeing. All the patients we spoke with who had received a visit from the chaplaincy team spoke very highly of the service and how it supported them.

Medical care (including older people's care)

- Nurse specialists gave patients contact numbers so that they always had a point of contact when not in hospital.
- We observed staff moving a patient so that their bed was nearest the window. Staff told us the patient had been in for some time and felt that a view outside may improve their spirits.
- A member of staff told us of an occasion when two nurses gave up their lunch time to take an unwell patient to enjoy the sunshine in the garden during their lunch break.

Are medical care services responsive?

Good

Medical services were Good for responsive because:

- The division was meeting referral to treatment times (RTT) and there had been a reduction in length of stay over the last year.
- There was now a speech and language therapist for patients suffering stroke and other service level agreements for therapy staff providing stroke care.
- The division was actively engaging with sustainability and transformation plans and was working collaboratively with neighbouring trusts around the provision of some care including stroke care.
- Patients had their individual needs met and we saw good practice in relation to dementia care on one ward and an Admiral Nurse provided individualised care and support for patients living with dementia.
- The Admiral Nurse and the frailty nurse reviewed patients in the short stay unit to identify early any assistance or specialist care that patients may need.
- 'Nurse in charge' armbands were in use so patients and visitors could easily identify who was responsible for the ward.

However, we also found:

- Half of the staff we spoke with were unsure of any learning from complaints within their clinical area.
- There were 252 bed moves after 10pm at night though this included patients being transferred from the acute assessment unit.

Service planning and delivery to meet the needs of local people

- The trust was actively contributing to the Cambridgeshire sustainability and transformation plan. This included ongoing work to consider further collaboration and partnership with a neighbouring acute trust.
- Some pathways were being reviewed in conjunction with neighbouring providers to ensure skills were shared and that pathways offered the best possible care to patients. This included the stroke pathway.
- The ambulatory care unit provided care to patients directed there from the emergency department as well as GP referrals. It provided prompt treatment and had a direct impact on the reduction in the length of stay of patients at the trust.
- The division had a winter plan and contingency arrangements in the event of high demand for care and treatment. This included close working with other acute and community providers to manage anticipated demand.
- Meeting minutes showed that the division was managing delayed transfers of care (DToC) by utilising community beds closer to patient's homes when they did not require an acute hospital bed.

Access and flow

- The trust was consistently meeting Referral to Treatment Time (RTT) for medicine. Between February2015 and January 2016 showed all specialties were meeting referral to treatment standards at 100% including general medicine, gastroenterology, cardiology and dermatology.
- Data for June 2015 to March 2016 showed that the trust was reaching 80-89% compliance with the 62 day treatment target for cancer patients, delays were reported as due to radiology provision within the Trust, delays in report returns from the pathology and delayed referral receipt from neighbouring trusts. The trust had an action plan in place to address these issues.
- Between September 2014 and August 2105, length of stay for elective admissions was better than the England average at 3.5 days compared to the England average of 3.8 days. Length of stay was better than the England average for clinical haematology and medical oncology though slightly worse for general medicine.

Medical care (including older people's care)

- Length of stay for non elective (emergency) admissions was better overall than the England average at 5.7 days compared to the England average 6.8 days. General medicine was better than the England average with gastroenterology worse than the England average.
- Between February 2015 and January 2016, 82% of patients did not move wards during their admission, 14% had one bed move and 4% moved twice or more which means disruption to patient care is reduced, risk of spreading infections is reduced and patients become familiar and comfortable with the nursing staff providing their care
- There were 252 bed moves after 10pm at night though this included patients being transferred from the acute assessment unit.
- Trust data showed that length of stay had been reduced by one day in the over the last year. There were increasing delayed discharges and transfer of care. At the time of our inspection there were between 8 and 10 delayed transfers. Delayed transfers where validated in a weekly meeting and any barriers to discharge considered and action agreed. Whilst the number of delayed transfers were on a slightly reducing trajectory since January 2016, staff told us that they remained vigilant in the management of delayed transfers of care.
- The discharge and operations team met daily with the community services managers to identify patients able to go home and make arrangements for care to be provided at home where possible. There was a daily meeting with community providers to discuss patients who had been medically fit for discharge for more than 10 days. An escalation plan showed the steps to take such as further consultation with the CCG if delayed transfers were greater than 10%.
- Patients referred by their GP to the AAU and ambulatory care would then be transferred to the short stay unit (SSU) if they were expected to be discharged within 72 hours. However, during our inspection we found a patient who had been on the short stay unit for several weeks.
- Bed capacity meetings were held three times per day with attendance by doctors as required.
- The discharge planning team covered weekends. To help facilitate complex discharges out of hours.
- There were small numbers of medical outliers on non medical wards. Each patient remained under the care of their consultant and was reviewed daily unless otherwise agreed. Outlying patients were tracked through admissions as well as through handover. Out of hours, the on call team tracked outlying patients. Junior medical staff we spoke with were aware of the location of any medical patient's that were being care for on non medical wards.

Meeting people's individual needs

- Bariatric equipment was available within the medical division. If additional resource was required, staff told us it could quickly be arranged.
- A member of staff told us of an occasion when two nurses gave up their lunch time to take an unwell patient to enjoy the sunshine in the garden during their lunch break
- Physiotherapy staff had ensured that their rota meant that female staff were able to attend a patient who had specifically requested female staff.
- Patients who had dementia were identified by a blue butterfly picture above their bed to enable staff to quickly identify patients who may need extra support with personal care. The Admiral nurse, one of only five in acute hospitals in England, provided support for staff, patients and relatives in caring for patients living with dementia. They and the frailty nurse regularly attended the MSSU to identify patients who required additional support and to assess patients promptly to facilitate discharge.
- Staff had received training in caring for patients with a learning disability and there was a learning disability passport of care in use.
- Patients at risk of falling were identified by a leaf picture above their bed so that staff were easily able to identify patients who needed assistance with walking around
- Patients who needed assistance at meal times were given their food on red trays and water jugs had red lids to identify patients who needed extra support with eating and drinking. Staff prioritised these patients for assistance with meals.
- At our last inspection there was limited access to speech and language therapy for patients following stroke. On this inspection we found that a speech and language therapist had been recruited to manage dysphasia in patients suffering stroke and that 4 more nursing staff on Apple Tree ward had been trained to undertake swallow assessments and supported the rest of the hospital with tis if required. .
- At our last inspection a service level agreement for the commissioning of physiotherapy meant that care was

only commissioned for 10 days though staff told us they went beyond this to provide care. On this inspection physiotherapy was provided to all stroke patients for however long they required it.
- Telephone translation services were available and all staff we spoke with were aware of how to access them though we were told they were infrequently used.
- "You say, we did" boards were available on each ward. These included managing a noisy ward at night with the mitigation the ward had taken such as providing ear plugs.
- Staff told us that one theme that had persisted was that relatives and patients did not always know who was in charge of a ward. In response to this shift leaders now wore a red 'Nurse in charge' armband that clearly identified them as the shift leader.
- Frailty assessments were completed on the wards and older people's specialist nurses provided expert advice and care for older people. They formed part of the multidisciplinary team in planning the care and discharge of older patients.

Learning from complaints and concerns

- All the staff we spoke with were aware of the complaints policy and how to assist people who wished to make a complaint or raise a concern.
- We reviewed the most recent complaint on three wards and found that learning had been clearly identified from the complaints. We spoke with 16 staff about complaints. 8 staff told us they had received feedback about complaints that had happened in their area whereas 8 staff were unsure of the last complaint or learning from complaints.
- Two wards meeting minutes showed that complaints were considered as part of the agenda. Safety huddles were also used to consider any complaints and concerns received.
- On Apple Tree Ward, Cherry Tree Ward, Walnut and the acute assessment unit (AAU) the main patient complaints centred on noise in the wards in the evenings from call bells and patients being moved about. Nursing staff were encouraged to close bay doors at night to try to keep unavoidable noise contained
- We saw "you said" "we did" posters displayed in relation to complaints and comments from patients. These were discussed at daily whiteboard meetings.

Are medical care services well-led?

Good

Medial services required improvement in terms of being well led because:

- A number of changes in ward leadership and the introduction of a quality matron had become embedded since our last inspection.
- Governance and risk had been addressed with the implementation of mortality and morbidity meetings and that the findings of root cause analysis was more widely shared.
- Risk management was owned by the division. Senior managers had a good view of their current risks and there was a comprehensive risk register in place which was updated and risks mitigated.
- The division was actively engaging with sustainability and transformation plans and collaborative working with other providers.
- Staff spoke highly about the culture of the service and were positive about the changes that had been made in the preceding year.

However, we also found:

- We were concerned about the sustainability of some services due to a lack of key staff, such as a permanent stroke consultant. Whilst locum staff were in place permanent recruitment had been difficult. The division was aware of these concerns and a review of some specialty care was underway.

Vision and strategy for this service

- Senior clinical staff and managers were aware of the strategy for the division and the trust as a whole. There were plans to consider how the trust would work with a neighbouring trust to ensure services remained sustainable. All the staff we spoke with were aware of the early plans for this. Whilst some of the staff were concerned about the implications, most were positive about the plans.
- At our last inspection staff were able to tell us about the trusts vision but were not sure of a vision or strategy for the division and this remained the same during this inspection. The trust values and vision were displayed in a number of the clinical areas that we visited.

- Staff on some wards considered their own values and that of their ward. At a ward meeting on Cherry Tree, staff discussed how they would like their ward to function and what values they felt most important.

Governance, risk management and quality measurement

- Senior clinicians and managers were sighted on their main risks including medical staffing, inpatient falls and medication incidents. A comprehensive risk register was in place. Ward managers told us they felt able to raise concerns and have them included on the risk register.
- The division had reinstated audit data collection for stroke patients which allowed the trust to measure and benchmark their stroke services. There was a review of the stroke service and collaboration with a neighbouring trust to improve services.
- At our last inspection there were no regular morbidity and mortality meetings within medical services. At this inspection we found that morbidity and mortality meetings were now taking place. Minutes showed that there was discussion around identified cases and any learning identified. .
- The divisional quality matron received a copy of every incident form and attended a monthly risk meeting (the Quality and Risk Meeting) to discuss any issues and identify remedial actions. Minutes showed the items discussed, the outcome and who was responsible for completing the action.
- There was a comprehensive risk register in place. The division owned the risk register and senior managers were aware of the risks in their division. The risk regi9ster was regularly updated and we saw that mitigations had been identified for issues on the register. .
- A full ward dashboard was available to ward managers and matrons. This was also reported at divisional meetings and was fed though subcommittee to the board. All ward managers we spoke with had a good understanding of the data on their dashboard as did senior managers within the division.
- Clinical incident root cause analysis (RCA) reports were discussed with complaints within Governance minutes. At our last inspection how these were shared with all levels of staff. At this inspection we found that outcomes of root cause analysis was shared at ward level and senior and junior staff were aware of the last incident in on the ward. However, they were unable to tell us how they would share learning more widely if they identified a local concern on a ward other than saying they would feed it back to their matron. They were not aware of the process after this for sharing that information.
- Ward staff had access to audit data and were able to discuss the implications for the data for their area. They told us about themes identified and what actions were planned or taken to address any concerns.

Leadership of service

- The division was led by a clinical director, an associate director of nursing and a senior operations manager. They were supported by matrons and senor clinicians in the management of the service.
- There was increased stability in senior appointments since our last inspection. The chief executive had been in place for 9 months. Staff spoke highly of the executive team, one of which was a 'link executive' to each ward. Staff told us that the team were visible on the wards, particularly the link executive though two members of staff we spoke with were unsure as to the purpose of the link executive.
- Ward managers who had been in post for a short period at our last inspection in October 2015. At this inspection the managers had been in post for a longer period. Staff told us that they felt the wards and management were now more stable.
- There was some concern what the proposed joint working with a neighbouring trust might mean for local leadership at Hinchingbrooke. Staff told us they wanted to maintain the leadership at the trust and within the division.
- Quality matrons had been in place for a longer period in clinical areas and leadership on medical wards was more stable with ward managers being in place for more than 7 months. Ward staff told us they felt well supported by the ward managers

Culture within the service

- The 'Stop the Line' initiative was to encourage an open culture and give staff the confidence to report when there was cause for concern and ensured a senior manager reviewed the situation. This had been initiated by a doctor shortly before our inspection due to staffing concerns and volume of patients to be seen. This had

resulted in a board member attending reconsidering staffing across the trust to support the area. Several staff told us that 'stop the line' could be better promoted to patients.
- There had been additional 'stop them line' on Cherry Tree ward following a patient fall. Staff had recognised there was still risk in the area. They told us they received adequate support from the director who attended.
- A new 'Freedom to speak up' [Whistleblowing] policy was introduced in September 2015, which encourages staff to speak up about concerns.
- Senior staff told us they believed that junior staff felt more empowered to 'Stop the line'. Staff we spoke with told us they had called a stop the line previously.
- 4 staff we spoke with told us they were confident in raising concerns and felt they would be considered fully.

Public and staff engagement

- Staff spoke highly of the trust and the area they worked
- "Breaking the cycle weeks had been initiated. GP's had been invited into the hospital to understand how the trust worked and was managed. Senior staff described the relationship with GP colleagues to be much closer than previously.
- There was a detailed action plan in response to the national staff survey. There was general improvement in scores for the division. Data was broken down to ward and division level. Ward managers were aware of the findings of the survey and had contributed to the action plan. This included support from immediate managers and concerns about bullying.
- The trust continued to work with other groups such as Healthwatch to improve services and receive feedback about their services.
- There were ongoing audit plans to gauge patient experience including an audit of the 24 hour support line which was planned for summer 2016.

Innovation, improvement and sustainability

- We were concerned about the sustainability of some services due to a lack of key staff. Whilst locum staff were in place permanent recruitment had been difficult. The division was aware of these concerns and a review of some specialty care was underway including in stroke care.
- The trust was positively engaging with local transformation plans and where identifying service improvements in relation to this.
- The Admiral (dementia care) nurse who supported the medical wards was one of only five Admiral nurses working in acute trusts.

Surgery

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

Information about the service

Hinchingbrooke Health Care NHS Trust provides a range of surgical services including general surgery, elective and trauma orthopaedics, ear, nose and throat (ENT), urology and ophthalmology.

There are five wards and two main operating theatre suites in the surgery services. The Acute Trauma and Surgical Unit, Birch ward, Juniper ward, Mulberry ward and Daisy ward.

Juniper ward is a 30 bedded acute gastroenterology, general medical and colorectal surgery ward, the acute trauma surgical unit (ATSU) is a mixed specialty surgical ward for acute and trauma admissions. Specialties included orthopaedic, gynaecology and urology. Birch ward is the elective orthopaedic surgery ward and the Mulberry suite provides a separate facility for private patients.

The treatment centre accommodates Daisy ward, which has mixed specialty patients including urology, general surgery, gynaecology and orthopaedics.

There are seven theatres in the main hospital and five theatres in the treatment centre.

During our inspection we spoke with 14 patients, nine relatives, nine members of nursing staff, one member of the surgical staff (medical staff), and three managers. We visited Daisy ward, the Acute Trauma and Surgical Unit, Birch ward, Mulberry ward and theatres one and six, and we reviewed eight sets of medical records.

Summary of findings

Surgery services were rated as good overall.

Staff had access to an electronic incident reporting system and knew how to report incidents.

Scrutiny of mortality cases was regular and robust, with all cases being presented at dedicated meetings and actions for improvement being set. There was no increased risk of death for this surgery services at this trust, as the trust performed as expected in the two surgery specific mortality indicators, death in the low-risk diagnosis group and death after surgery. Good hand hygiene techniques and the use of personal and protective equipment such as aprons and gloves was consistent amongst all staff. Surgical site infection rates were low, with two cases being reported for large bowel surgery between April 2015 and December 2015 and zero cases being reported for other surgical specialties. Equipment was regularly safety tested and all equipment checked on our inspection was within date for the next safety check. Resuscitation trolleys were consistently checked with no omissions noted for the time period we checked (January 2016 to May 2016). Medicines were stored securely across surgical wards and access was limited to nursing staff. Learning from medicine related incidents was evident. For example, an insulin-related incident had led to a ward manager completing a course on insulin safety and cascading that learning to their team.

Surgery

World Health Organisation (WHO) surgical checklists were consistently used by the service and their use was audited. Overall training compliance for Mental Capacity Act and Deprivation of Liberty Safeguards was 92% for surgical services which was above the trust target of 90%. The service comprehensively audited its performance each year, including both local and national audits. There was an established pain team and provision was in place for this support to be provided out of hours. The trust performed in line with, or better than the England average in the national hip fracture audit, the national lung cancer audit, and the patient reported outcomes measures for groin hernia, hip and knee replacement and varicose vein surgeries. With the exception of theatres, staff appraisal rates were better than the trust average across the surgery services.

Friends and family responses were positive for surgery services, indicating that between 93% and 100% of respondents would recommend the service to their family and friends. Patients were involved and informed about their care, with a range of patient information leaflets and a hip and knee club for patient undergoing joint replacement surgery. Emotional support was available from an Admiral nurse (a specialist dementia nurse). The Admiral nurse was observed to provide dedicated care to a person living with dementia, ensuring they were settled and had their privacy and dignity respected. The service provided care within 18 weeks of referral in the majority of cases (90% of the time or more). Cancer treatment targets were consistently met or exceeded and the trust was amending cancer pathways with a view to bringing cancer targets down.

The service performed better than the England average in rebooking cancelled operations within 28 days. One theatre was available 24 hours a day, seven days a week for emergency or life threatening surgeries, in line with National Confidential Enquiry into Patient Outcome and Death (NCEPOD) guidelines. There was awareness at ward level of complaints and learning, with ward managers able to give examples of improvements made to their ward areas as a result of learning from complaints.

A clear plan was in place for the development of a surgery strategy that was linked directly to the development of the new trust values. The development of the strategy involved staff and was based on the results of the staff survey. There was good ward level understanding of risk, however the recording of scrutiny of risk and other clinical governance issues was inconsistent across surgical specialties. Almost half of incidents were not reported within 14 days of their occurrence. The acute trauma and surgery unit and Juniper ward consistently performed below trust targets for various infection control and patient safety measures.

The length of stay for elective trauma and orthopaedics was 1.5 days over the national average, and the overall risk of re-admission for elective patients was much higher than the England average at a score of 158 compared to an average score of 100.The service had not appropriately managed an increase in medical outliers. This had led to the displacement of emergency and elective surgical patients and ultimately the cancellation of joint surgeries at the time of our inspection, due to elective and emergency (or patients swabbed for Methicillin resistant staphylococcus aureus (MRSA) and those not swabbed) being placed in bays together.

Surgery

Are surgery services safe?

Good

Surgery services were rated as Good for safe because;

- Staff had access to an electronic incident reporting system and knew how to report incidents.
- There was regular and robust scrutiny of cases of mortality in the service. All cases were presented at dedicated mortality meetings and discussion took place around the care provided, with actions for improvement being set at these meetings.
- The trust performed as expected in two surgery-specific mortality indicators, meaning that there was no increased risk of death for surgery services at this trust.
- Staff were consistently observed performing good hand hygiene techniques and using personal and protective equipment such as aprons and gloves.
- Equipment was regularly safety tested and all equipment checked on our inspection was within date. Resuscitation trolleys were consistently checked.
- Medicines were stored securely across surgical wards and access was limited to nursing staff.
- World Health Organisation (WHO) surgical checklists were consistently used by the service and the use was audited monthly. The target of 100% compliance had been missed by between one and two percent and an action plan was implemented. This had led to a recent achievement of the trust target.

However:

- The acute trauma and surgical unit (ATSU) and Juniper ward consistently performed below trust targets for some infection control and patient safety measures.
- Safety thermometer assessments and reassessments did not always happen in a timely manner on ATSU.
- The quality of patient records was inconsistent across surgical wards.

Incidents

- Staff knew how to report incidents and near misses onto an electronic reporting system. This system was available on all computers accessible to staff. Ward managers were aware of their main incident trends, and incident numbers were presented on white boards on ward corridors for patients and visitors to see.
- The trust reported five serious incidents between February 2015 and March 2016, including one pressure ulcer, one allegation against a health care professional, one treatment or operation without consent and two confidential information leaks. A never event, which was a wrong site surgery, occurred in December 2015. The definition of a Never Event has changed. Although each Never Event type has the potential to cause serious patient harm or death, harm is not required to have occurred for an incident to be categorised as a Never Event.
- There was a process in place for investigating incidents and undertaking root case analyses (RCA's) to identify learnings. We reviewed one initial three day report from a serious incident occurring in April 2016 and the root cause analysis was in the process of being investigated.
- The average time taken to include incidents on the National Reporting and Learning System database was 20 days.
- Mortality was discussed at monthly mortality review meetings. Mortality cases were presented at the meeting and discussed to ascertain that the care provided was appropriate. This was consistently well documented in the meeting minutes. Each meeting had a set of actions to disseminate learning to the appropriate teams and people.
- A mortality summary report dated May 2016 showed that for the two surgical-specific mortality indicators, death in the low risk diagnosis group and death after surgery, the trust performed as expected. This meant that there was no increased risk of mortality within the surgical services.
- There was evidence of the duty of candour being used in a recent serious incident, where it was recorded that a consultant communicated with the family of a deceased patient.

Safety thermometer

- Patient safety thermometer data is a tool to measure and monitor harm in care and looks at falls, pressure ulcers, urinary tract infections in people with catheters in place, and venous thromboembolisms.
- Between May 2015 and May 2016, ATSU reported two new pressure ulcers, one falls with harm and two new urinary tract infections.

- For the same time period, Birch ward reported two new pressure ulcers, zero falls with harm, zero new urinary tract infections in people with catheters, and zero new venous thromboembolisms.
- For the same time period, Daisy ward reported zero new pressure ulcers, one fall with harm, zero new urinary tract infections in people with catheters, and zero new venous thromboembolisms.
- For the same time period, Juniper ward reported two new pressure ulcers, six falls with harm and one new urinary tract infection.
- For the same time period, Mulberry ward reported zero new pressure ulcers, falls with harm, new urinary tract infections in people with catheters and venous thromboembolisms.

- In all four sets of records checked on Daisy ward, patient risk assessments were completed on admission and re-assessments were completed thoroughly and within the appropriate timeframes.
- Out of four records checked on the acute trauma and surgical unit (ATSU), two had thorough safety thermometer checks reassessed within the correct time frame. This was indicative that the timeliness of safety thermometer checks was inconsistent on ATSU.

Cleanliness, infection control and hygiene

- Screening for methicillin resistant staphylococcus aureus (MRSA) was audited by the trust with compliance scored in a traffic light rag rating system. For the period January 2016 to February 2016 MRSA screening compliance was rated as green (compliance of 95% and above) for all surgical wards with the exception of ATSU ward with an amber rating of 90.07% and Juniper ward with a red rating of 92.7%.
- The trust's infection control policy stated that screening of MRSA was to be completed for all patients admitted for surgery or into surgical areas and specifically detailed high risk cases such as those requiring orthopaedic surgery.
- There were 5 cases of clostridium difficile (C Diff) for the period April 2015 to December 2015. This was better than the target of no more than four cases per month. There was one case of MRSA in November 2015, which was over the trust target of zero cases.
- Staff were observed using personal protective equipment (PPE) such as aprons and gloves.
- Staff were observed to be compliant with correct hand hygiene techniques on Juniper ward. There were metal sinks within each bay that had been declared not fit for purpose by the ward manager. The sinks were due to be replaced as part of a trust wide programme. This meant that all Juniper ward staff had to share the use of one hand washing sink in the corridor of the ward.
- Housekeeping staff were observed to be cleaning the wards throughout the inspection. One patient on Juniper ward stated that "the ward is cleaned continuously".
- There were two episodes of surgical site infections for the period April 2015 to December 2015, both after large bowel surgery. There had been no cases of surgical site infections following knee and hip surgery since the period April 2013 to March 2014.
- A peripheral intravenous cannula care tool had not been completed appropriately in one patient on Juniper ward. The patient had a second cannula fitted to replace an older cannula. The older cannula was not removed at the same time. Despite being told by the patient which cannula was new, a nurse started an infusion into the old cannula.
- The hospital measured visual phlebitis scores (VIP) by ward. ATSU, Birch and Mulberry wards were all compliant with completing peripheral vascular catheter (PVC) continuing care tools and achieved 100%. Daisy ward achieved 93.33% and Juniper ward achieved 68.75% for the period 1st February 2016 to 29th April 2016. Birch, Daisy and Mulberry wards were compliant with all patients having completed PVC insertions at 100%, 96% and 100% respectively. ATSU and Juniper wards achieved 43.75% and 83.78% respectively. A review of reported incidents for the service for the period August 2015 to February 2016 did not show any reported incidents relating to cannula care.

Environment and equipment

- Three pieces of equipment on Juniper ward, two pieces of equipment on Mulberry ward and two pieces of equipment in theatres were checked and all had 'I am Clean' stickers with the date of their last clean, of which they were all in date, and all were within date of their last safety test.
- Resuscitation trolleys on Juniper and Mulberry ward were checked. Log books were checked for January 2016 to the end of April 2016. Daily checks for the exterior of the trolleys, weekly checks for the interior of

the trolleys and monthly checks for airway bags were all signed and dated with no omissions. All trolley drawers were locked and secured with plastic tags marked with serial numbers which was noted in the log books.
- The environment in theatres was visibly clean and well maintained. A selection of equipment we reviewed was properly maintained and serviced in line with manufactures recommendations.

Medicines

- Medicines were stored securely with access limited to nursing staff.
- Green medicine bins for returns of medicines to pharmacy had been introduced. This helped to removed unwanted medicines from the cupboards and kept them clear and tidy.
- Medicine incidents were recorded onto a new electronic reporting system, which ensured staff could receive direct feedback after reporting a medicines-related incident.
- We spoke with two patients about their prescribed medicines. One patient was prescribed pain relief and told us ''I am in no pain. It is well controlled by the medicines''. The second patient commented '' although I am still waiting for my medicines from pharmacy I am very happy with the hospital. Please say it is very good''.
- Learning from medicine incidents was shared. One ward manager described learning from a recent medicine error which had highlighted the need for further training in diabetes. The ward manager had found an on line course about 'insulin safety' which had been shared with nursing staff.
- We observed the availability of a student newsletter dated May 2016 which reminded nursing students to follow hospital policy and Nursing and Midwifery Council (NMC) guidelines when administering medicines to patients.
- Allergies or sensitivities to medicines were recorded on patients' prescription charts. We checked eight prescription charts which had been correctly documented, signed and dated by the doctor. This followed trust policy.

Records

- The quality of patient records was inconsistent across the surgical wards. We looked at eight sets of records in total. We reviewed four sets of patient records on Daisy ward and found all records to have completed risk assessments, medical reviews and admission booklet checklists.
- However, a range of information such as the name and grade of doctor/nurse reviewing the patient, venous thromboembolism (VTE) risk reassessments, daily ward round reviews, antibiotic reviews, multidisciplinary team (MDT) input, assessment of nutritional status and notes being signed and dated were missing across three out of four records checked on ATSU.
- One patient record had no inpatient admission booklet checklist or baseline observations within their admission booklet, no admission checklist completed, their intravenous (IV) therapy form was not completed and their falls assessment was not re-done post operatively.

Safeguarding

- Staff were aware of the safeguarding lead nurse and said the nurse was accessible. An example was given of a concern raised by a staff nurse on Juniper ward to the safeguarding lead nurse who investigated the concern and the need to refer. Another example was given where a young adult was referred to the local safeguarding team. Staff were supported to liaise with social care and had input into the arrangement of a new care package.
- Training compliance across surgical services for safeguarding vulnerable adults and safeguarding children was above the trust target of 90% at 98% for safeguarding level 2 for children and 96.5% for safeguarding vulnerable adults at level 2.

Mandatory training

- The trust had a mandatory training target of 90% compliance. Mandatory training for staff covered fire safety, infection control, moving and handling, information governance, safeguarding children and vulnerable adults, equality and diversity, mental capacity assessment and deprivation of liberty safeguards, and PREVENT (counter-terrorism basic awareness).
- For the period April 2015 to March 2016, Birch ward and Daisy ward staff were compliant with their mandatory training with scores of 96% and 94% respectively. ATSU, Juniper ward and Mulberry Suite were not compliant with their mandatory training with scores of 83%, 82% and 87% respectively. Overall, theatre and anaesthetic

staff were not compliant with a score of 73%. Mandatory training compliance was listed on the service's draft improvement plan, although no actions were stated to address this.
- Information provided by the trust showed that agency staff received an induction to the area

Assessing and responding to patient risk

- The modified early warning scoring system (MEWS) was used to assess the condition and any deterioration of patients. The trust conducted a MEWS and escalation audit for the period October 2015 to December 2015. Juniper, Acute Trauma & Surgical Unit (ATSU), Mulberry, Daisy, and Birch wards were included in this audit.
- Correct documentation and calculation of the MEWS achieved an average of 91% across the trust. Juniper, ATSU, and Birch wards scored 100%. However improvement was required on Mulberry ward where only 80% of charts met the target. An action plan was in place and included named staff with responsibility for each action and set time frames.
- The five steps of safer surgery was used by the trust. Wold Health Organisation (WHO) surgical safety checklists (which is step three of the five steps) were used for all surgery undertaken within the division. We observed a WHO surgical checklist team briefing in theatre which followed the requirement of the checklist.
- A WHO checklist quality audit was carried out for the period June 2015 to February 2016 following a never event in March 2015. The trust set compliance targets at 100% and consistently achieved between 98% and 99% each month. Recommendations were put in place to improve these scores. Monthly snap shot audits showed overall compliance to be 99% for both February 2016 and March 2016, and 100% in April 2016. This indicates an improvement was starting to take place from the recommendations.
- Training was given to all registered nurses and health care assistants for recognising and responding to deteriorating patients. The target for compliance to this training was set at 60% of registered nurses and 40% of health care assistants. Overall, 66% of all health care assistants had completed the training and 61% of all registered nurses had completed the training across all surgical wards and the critical care unit.

Nursing staffing

- A safer nursing care tool assessment was completed in February 2016 to assess the sufficiency of the set establishment. The results of this were not available at the time of inspection.
- The sickness rate target was 3% or below. Sickness rates over the target on the surgical wards were 3.3% on ATSU and 5% on Juniper ward.
- The vacancy rate target was 5% or under. Staffing vacancies were covered by the use of bank and agency staff. Areas where there were significant gaps in substantive staff were Juniper ward with 72% of whole time equivalent (WTE) in post, and the acute trauma and surgical ward (ATSU) with 73% of WTE in post.
- Although Daisy ward had 97% of their budgeted staff in post, there was not sufficient staff in post to cover weekends. Daisy ward operating at weekends was an interim extension to the ward's opening times. This meant that there was a reliance on bank and agency staff to ensure that out of hours and weekend shifts were covered. This was acknowledged on the service's risk register and had been a live risk since February 2014.
- Mulberry ward had 134% of their WTE in post. Substantive nurses from Mulberry ward supported agency nurses on Daisy ward at weekends, and were backfilled by agency nursing if required. Birch ward had 96% of their budgeted WTE in post
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- The turnover of staff target was 10% or below. Turnover of staff rates over the target on surgical wards were 21.9% on ATSU and 40% on Juniper ward. A surgical nursing recruitment and retention plan was in place at the time of our inspection to manage nurse staffing. The turnover of nursing staff on Juniper ward had decreased by 7% from our previous inspection although a long term positive impact could not be ascertained at the time of our inspection.
- Nursing handover was observed on ATSU. The handover was well-led, structured and robust. Data sheets were given to staff detailing the patients, their diagnosis and their needs, and staff were well informed of their caseloads for their shift.

Surgical staffing

Surgery

- There were eight general surgeons, seven orthopaedic surgeons, four urological surgeons, two plastic surgeons, 13 anaesthetic consultants, three ears, nose and throat (ENT) surgeons, and five ophthalmologists supporting the surgical services.
- Handovers took place at 8am across all specialities. On-call rotas were supported by consultants.
- Electronic and verbal communications from clinical leads to surgical staff had led to an increase in consultant presence to ward rounds.
- General surgery was supported by nine junior doctors and eight middle grade doctors. Trauma and orthopaedics was supported by eight junior doctors. The musculo-skeletal service was supported by eight junior doctors and four registrars. The urology service was supported by four middle grade doctors.
- The surgical rota ensured there was an appropriate skill mix of senior staff out of hours and at weekends.
- There was enough doctors to ensure that patients were reviewed in a timely way.

Major incident awareness and training

- There was a major incident policy available on the trust's intranet for staff to access.
- One sister explained that more experienced nurses would be able to assess patients and decide who was well enough to be transferred in the case of a major event, and who was not.
- There was a site management team who would give clear direction for all staff with support from the senior sister of the day, in the event of a major incident.

Are surgery services effective?

Good

Surgery services were rated as good for effectiveness because;

- The service comprehensively audited its performance each year, including both local and national audits.
- Care pathways were evidence and guidance based.
- There was an established pain team and provision was in place for this support to be provided out of hours.
- Patients felt that their pain was appropriately managed.
- The trust performed better than the England average in the national hip fracture audit and demonstrated improvement from the previous year.
- The trust performed better than the England average for all three measures of the national lung cancer audit.
- The trust performed in line with the England average for the patient reported outcomes measures for groin hernia, hip and knee replacement and varicose vein surgeries.
- With the exception of theatres, staff appraisal rates were better than the trust average across the surgery services.
- Training compliance for Mental Capacity Act and Deprivation of Liberty Safeguards was above the trust target of 90% at 92% overall for surgery services.

However;

- The trust scored red (between 0% and 49%) against two measures in the national emergency laparotomy audit, six measures were scored amber and three measures scored green.
- The overall risk of re-admission for elective patients was much higher than the England average at a score of 158 compared to an average score of 100.

Evidence-based care and treatment

- Surgical care pathways were evidence-based. The hip and knee surgical pathway was underpinned by guidelines from the National Institute of Clinical and Healthcare Excellence (NICE).
- The colorectal surgical pathway was underlined by British Society of Gastroenterologists. The colon cancer pathway ensured that referrals met National Institute of Health and Care Excellence (NICE) guidelines and that the care was delivered as part of the Anglia Cancer Network.
- The hip fracture collaborative care plan was evidence based and followed guidelines from both NICE and the British Orthopaedic Association and Association of Anaesthetists in Great Britain and Ireland.
- Surgical services followed relevant national guidance and best practice as part of surgical pathways and care.

Pain relief

- A pain scoring tool used throughout the service and was included in care rounding. The Abbey pain scoring tool was used to ascertain pain levels in people living with dementia who were not able to verbalise.
- There was a dedicated pain team consisting of two pain nurses. If the team was required out of hours or at weekends then support was provided by recovery nurses and an anaesthetist.

- We spoke with two patients about their prescribed medicines for pain relief who told us ''I am trying to reduce the amount of pain relief I take together with help from the doctors", "I have found the pain relief to be excellent" and one relative who told us that "the nurses are brilliant, they respond to my requests for my relative to have more pain relief".

Nutrition and hydration

- Fluid balance charts were consistently completed in the eight sets of patient records we observed. In addition, three fluid balance charts were seen in recovery and all were completed thoroughly.
- Anti-sickness medication was prescribed in advance for surgical patients to be administered in recovery and on the surgical ward post operatively. This meant that patients could receive ant-sickness medication in a timely manner when required.
- Patients were supported with nutrition and hydration needs in a number of ways including the use of total parenteral nutrition (TPN) and percutaneous endoscopic gastrostomy as alternative methods of nutrition when patients could not take food orally. Hydration needs were met through the use of intravenous and subcutaneous liquids were patients need additional support.

Patient outcomes

- The trust performed better than the England average for six of the seven measures in the Hip Fracture Audit, 2014. Comparisons between the 2014 and 2015 results showed improvement against seven measures.
- In the 2015 hip fracture audit, the trust performed better than the England average in five of the seven measures. The trust scored very well against the standards, 'patient received falls assessment' (100%) and 'bone health medication assessment' (100%). This trust's result for mean length of acute stay and mean total length of stay was higher than the England average in both the 2014 and 2015 audits. All other results were better than the England average in the 2015 audit.
- The percentage of fractured neck of femur patients seen within 48 hours was 84%, which was above the England average of 75.6% and above the regional average of 72.1%.
- This trust showed good performance in the National Bowel Cancer Audit in 2014. Trust performance for the number of cases submitted to the audit and data completeness for patients having major surgery was good, with a rate of more than 80% for both measures. The trust scores for patients being seen by a specialist nurse was 50% compared to the national average of 87.8%.
- Latest data for the National Bowel Cancer Audit 2015 showed the trust to be within expectations for all measures.
- The 2014 Lung Cancer Audit found that the trust was better than the England average for all three measures. Scores were a 100% for patients discussed at multidisciplinary team (MDT) level and percentage of patients receiving computerised tomography (CT) before bronchoscopy.
- Results from the Patient Reported Outcome Measures (PROMs) for Groin Hernia, Hip Replacement, Knee replacement and Varicose Veins were similar to the England average.
- 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). A green rating indicated a performance result between 70%-100%, an amber rating was between 50%-69% and red rating were between 0%-49%.
- The trust scored green in three out of the eleven indicators including consultant surgeons being present and arrival in theatre in a timescale appropriate to the urgency of the case. The trust scored amber in six of the eleven indicators including consultant and anaesthetist presence together in theatre. The trust scored red against two of the eleven indicators which were 'consultant surgeon review in less than 12 hours of emergency admission and anaesthetist and assessment by a medical crisis in older people (MCOP) specialist in patients aged over 70 years'.
- The trust had acknowledged these audit results on their improvement plan, with the aim of validating the percentages submitted to the audit. There were clear actions identified within the improvement plan to address shortcomings in audit data.
- There was a comprehensive audit plan in place for surgery services for the period April 2016 to March 2017.

This audit plan included both local and national audits and stated the aims and objectives of each audit, a named clinician leading the audit, and expected start dates and completion dates.

- The overall risk of re-admission for elective patients in surgical services at Hinchingbrooke Hospital between August 2014 and July 2015 was much higher than the England average at 158 compared to 100. A value below 100 is interpreted as a positive finding, as this means there were less observed readmissions than expected. A value above 100 represents the opposite. Most recent data indicated that the trust level readmissions were in line with the England average.
- Trauma and orthopaedics had a re-admission rate of 163 above the England average of 100. General surgery had a rate of more than double the England average with 220 compared to 100. Rates for non-elective patients were lower than the England average across all specialities.
- High readmission rates were on the surgical service's improvement plan, with a plan to review of how the mitigation for this issue was evaluated.

Competent staff

- With the exception of theatres, surgery services had exceeded the trust average of 74% for completing staff appraisals. Birch and Juniper wards achieved 97%, Mulberry ward achieved 96%, Daisy ward achieved 78%, and ATSU achieved 92%. However, theatres achieved 52%.
- Registered nursing staff competencies included epidural, patient controlled analgesia, nasogastric tube insertion and catheter insertion.
- There was a link on the staff intranet for revalidation advice and support, and clinical nurse educators were assisting nursing staff with their revalidation.
- Surgical staff (doctors) had their revalidation supported by the trust appraisal lead.

Multidisciplinary working

- There was physiotherapy, occupational therapy, and dietetic support on the surgical wards. Pharmacists were assigned to the surgical wards which meant that the provision of medicines took place in a timely manner.
- The trust had close working relationships with other trusts providing specialist care for conditions such as complex spinal surgery.
- Multidisciplinary teams for patients with complex conditions were supported by the specialist providers in the region.

Seven-day services

- All surgical specialities had a range of junior and middle grade doctors providing ward cover and on-call cover, between 8am and 8:30pm and 8:30pm and 8am on a rotational basis.
- There was a 'hospital at night' provision between the hours of 8pm and 8am.
- There was cover for emergency ophthalmology patients between the hours of 8am and 5pm Monday to Friday. Patients requiring emergency care outside of these hours were required to attend the nearest tertiary care provider.
- Pharmacy support to surgical wards on Saturdays was between 8am and 2pm, and on Sundays support was provided from an on call rota.
- Physiotherapy, occupational therapy and x-ray were all available at weekends. Physiotherapy and occupational therapy were provided through an on call system at weekends and the radiology service was an established seven-day service.

Access to information

- Nursing and surgical staff (doctors) had the access required to patient records, including medical histories, so that they could provide appropriate care. Staff also had access to computers to request and view blood tests and other investigations.
- Test results and results of radiology investigations were available on computer systems accessible to nursing and medical staff throughout the surgery service.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We reviewed eight sets of medical records and consent was consistently recorded, including the planned surgery, possible risks of the surgery and signatures from both surgical staff (doctors) and patients.
- A doctor was observed on Birch ward clarifying consent with an elderly patient and their relative, talking through the treatment plan and gaining consent.
- Mental Capacity Act and Deprivation of Liberty Safeguards training compliance was above the trust target of 90%, with an overall performance across all surgery services of 92%.

Surgery

Are surgery services caring?

Good

Surgery services were rated as good for caring because;

- Friends and family responses were positive for surgery services, indicating that between 93% and 100% of respondents would recommend the service to their family and friends.
- Throughout our inspection, patients gave consistently positive feedback about receiving compassionate care and being involved in their care.
- Patients were involved and informed about their care, with a hip and knee club for patient undergoing joint replacement surgery.
- Emotional support was available from an Admiral nurse, or specialist dementia nurse. The Admiral nurse was observed to provide dedicated care to a person living with dementia, ensuring they were settled and had their privacy and dignity respected.

Compassionate care

- The trust had a 44.3% response rate in the Friends and Family test, better than the England average of 35.5% for the 12 month period from February 2015 to January 2016. Daisy Ward and Juniper Ward had the lowest response rates of 34%. The percentage of friends and family that would recommend the service ranged from 93% to 100% for most wards. The lowest score of 84% was recorded during September 2015 for Juniper Ward.
- Protected meal times were in place on surgical wards and ensured that patients could eat their meals with privacy and without interruption.
- Patients consistently gave positive feedback about their care throughout our inspection. One patient on ATSU stated "I feel valued here; they treat me as a person all the way from the doctors to the care staff". A patient on Juniper ward stated "my care has been good, I can't fault it, the staff treat me with respect". A patient on Birch ward stated "the staff have been brilliant, you ask for anything and they'll fetch it".
- We observed a consultant on Birch ward approach a patient with warm greeting and used body and verbal language that visibly put the patient at ease.

Understanding and involvement of patients and those close to them

- There was a hip and knee club for patients. Patients joined the club before their surgery and met other patients and staff for support, advice and information. A knee club patient advice leaflet was created by the orthopaedic physiotherapists with advice on basic exercises and contact details.
- One patient on ATSU stated "consultants talk and explain things to me and the staff are caring". A patient on Birch ward stated "the doctor keeps me informed of my progress". A relative on Birch ward stated "I feel that the staff take what I say about mum seriously". A patient on Juniper ward stated "I cannot fault the care at all, I have my questions answered and the staff talk to me and with me, not across me".
- A ward manager was observed helping a patient get back in bed who was experiencing pain. The ward manager discussed the cause of the patient's pain with them and demonstrated that they knew the patient's needs before being told. This shows that the ward manager was involved in, and had knowledge of, the needs of the patients on their ward.

Emotional support

- A specialist nutritional nurse and an Admiral nurse (specialist dementia nurse), were available to ward staff for advice and support, alongside clinical nurse specialists for specific specialities.
- We observed the presence of the Admiral nurse on Juniper ward. The nurse was supporting an agitated patient, and arranged for them to be moved into a side room to maintain their dignity, and came back to check on the patient throughout the day.
- The chaplaincy team visited all wards regularly to provide emotional and pastoral support to all patients and staff.

Are surgery services responsive?

Good

Surgery services were rated as good for responsiveness because;

- The service provided care within 18 weeks of referral in the majority of cases (90% of the time or more).

- Cancer treatment targets were consistently met or exceeded and the trust was amending cancer pathways with a view to bringing cancer targets down.
- The service performed better than the England average in rebooking cancelled operations within 28 days.
- One theatre was available 24 hours a day, seven days a week for emergency or life threatening surgeries, in line with National Confidential Enquiry into Patient Outcome and Death (NCEPOD) guidelines.
- Staff were made aware of patients requiring assistance at mealtimes by the provision of red trays and red lidded water jugs. This respected patients' dignity as only staff understood what the colour red meant at mealtimes.
- An Admiral, or specialist dementia nurse supported patients and staff with specialist care and advice.
- There was awareness at ward level of complaints and learning, with ward managers able to give examples of improvements made to their ward areas as a result of learning from complaints.

However;

- Complaints were not responded to in a timely way with an average of 75 days taken to give a full response to a complaint.

Service planning and delivery to meet the needs of local people

- Mulberry ward was part of a suite that included an outpatients department for private patients. This meant that private patients had a dedicated space for consultations; inpatient care and outpatient follow up care. Mulberry ward was also used for NHS patients if there was a shortage of beds in the main hospital and they had beds available on the ward.
- During our inspection, Birch ward was reallocated as a trauma ward from an elective orthopaedic ward due to increasing service demand, and Daisy ward was being used at weekends, in addition to its scheduled Mondays to Fridays, due to an increase in the number of medical outliers. Medical outliers received appropriate review from the medical team throughout each day.
- In October 2015 Juniper ward had started to use its five escalation beds within the main ward, increasing the number of available beds from 25 to 30, due to increase in demand. This was still the case at the time of our inspection seven months later.
- There was one spinal surgeon at the trust. This meant that patients presenting with acute spinal surgical needs, or patients who deteriorated after spinal surgery out of hours were taken to a neighbouring trust by ambulance service. This arrangement was in place until the planned decommissioning of the spinal surgery service in the summer of 2016.
- Bays in the surgical wards were single sex and each bay had its own bathroom facility. Single bathrooms were also available outside of the bays.

Access and flow

- Between February 2015 and January 2016 the percentage of patients waiting less than 18 weeks from referral to treatment (for the admitted pathway) ranged from 88% to 94.6% However during the full 12 month period trust performance was better than the England average for incomplete pathways.
- Patients waited less than 18 weeks in four of the five specialties. 89 percent of patients were treated within 18 weeks of referral within general surgery. Plastic Surgery was the best performing specialty, with 99% of patients seen within 18 weeks. General surgery is made up of several surgical specialties so numbers are a result of odd patients from all specialities in general surgery.
- All cancer targets were consistently met or exceeded. All individual cancer breaches were reviewed and actions taken to mitigate future risks were agreed and overseen at the cancer management group meeting. Daily tracking of all cancer patients was in place and weekly patient tracking line meetings took place. The trust was working to amend the pathways to bring cancer targets down.
- The average length of stay overall was slightly higher than the England average for both elective and non-elective patients. General surgery had the longest average stay for elective patients of 4.9 days, which was longer than the England average of 3.5 days. Non elective patients in trauma and orthopaedics' had an average stay of 10.2 days while the England average was 8.7 days.
- Single surgeons provided the spinal surgery service and the shoulder surgery service. Work was ongoing with the local clinical commissioning group, with notice given to decommission the spinal service, leading to a backlog. The trust aimed to work with the new provider to bring down the backlog ready for the handover of service in the future.

- The trust planned to expand the shoulder service once the spinal surgery service had been decommissioned. An associate specialist was currently undergoing training to operate independently from July 2016.
- For the period 1st February 2016 to 1st April 2016, there were 307 bed moves across the surgical wards. 33 of these bed moves occurred beyond 10pm. The trust stated that although they do not record the reasons for night time bed moves, this would only ever happen when there was clinical need.
- Discharges were planned from the point of admission, with staff having access to a discharge coordinator and social care input as required.
- Discharges were consultant led on Mulberry ward for private patents. Medications to take home were prescribed by the anaesthetist and discharge summaries were completed in the outpatient department within the Mulberry Suite where the private administrators were based. NHS patients on Mulberry ward had their discharges planned the same as the surgical wards in the trust.
- The trust's percentage of last minute cancelled operations was marginally higher than the England average for four of the seven quarters from quarter one of 2014 - 2015 to quarter three of 2015 - 2016. Last minute means on the day the patient was due to arrive, after the patient has arrived in hospital or on the day of the operation or surgery.
- From 4th January 2016 to 11th May 2016 there had been 246 operations cancelled. Of these 246, 66 (27%) cancellations were the responsibility of the hospital. Cancellation reasons were identified as being due to having no anaesthetist, equipment failures and administrative or other reasons. Compared to the total number of admissions this means that 1 in 67 operations were cancelled. Cancelled operations as a percentage of elective admissions were lower than the England average.
- When a patient's operation is cancelled by a hospital at the last minute for non-clinical reasons, the hospital should offer another binding date within a maximum of the next 28 days, or fund the patient's treatment at the time and hospital of the patient's choice. The trust cancelled nine operations in the period April 2014 to March 2015, and three in the period April 2015 to March 2016, where patients were not treated within 28 days. The trust's performance has been better than the England average since the period October 2014 to December 2016.
- At time of our inspection there were 14 medical outliers on the acute trauma and surgical unit (ATSU). Trauma patients had been moved from ATSU to Birch ward to accommodate these outliers. One staff member stated that elective or planned surgical patients had been screened for Methicillin resistant staphylococcus aureus (MRSA) and they were accommodated in bays with non-swabbed patients, leading to their surgeries were being cancelled to reduce the risk of potential MRSA transmission. However data provided by the trust showed that no orthopaedic operations had been cancelled for this reason in the period December 2015 to May 2016.
- Surgery patients moved between wards received appropriate review from the surgical team, and the trust took action to reduce the number of medical outliers, with 14 medical patients being moved to more appropriate beds during the time of the inspection.
- Elective theatre utilisation was at 111% at the time of our inspection. This meant that more surgeries were being performed at this time which was in line with the increase in service demand.
- A system was in place where attendance in theatre by consultants was based on clinical risk alone. This had also been identified in the national emergency laparotomy audit. The issue was taken to the theatre user group for discussion. Minutes of the last two meetings of the theatre user group meeting in December 2015 and January 2016 showed that discussion took place around the reordering and allocation of theatre lists.
- One theatre was available 24 hours a day, seven days a week for emergency or life threatening surgeries, in line with National Confidential Enquiry into Patient Outcome and Death (NCEPOD) guidelines.

Meeting people's individual needs

- Small sharps boxes with educational leaflets were available for patients who were being discharged back to the community who were required to inject specific blood thinning medication.

- Patients requiring assistance to eat and drink were identified by the use of a red tray and a red lid water jug. This ensured that staff could easily identify who required their help whilst maintaining the dignity of the patients.
- Staff had access to translation services for patients who were not able to speak English.
- There was a learning disabilities nurse available throughout the trust to provide advice and support in caring for patients with learning disabilities. A flagging system was in place on the electronic whiteboards that alerted ward staff to consider learning disability patients who may have additional needs.
- An Admiral (specialist dementia nurse) was available to staff and patients to provide specialist support when required.
- Patients for hip and knee replacements received patient information packs specific to their surgery. These packs contained information around their joint replacement and advice on the pre-admission phase and healthy living, with contact details for the orthopaedic practitioners.
- Ward welcome packs for elective patients were available. The pack contained information on the pre surgery stage, the stay in hospital and discharge home.

Learning from complaints and concerns

- There were 51 complaints for surgery between November 2015 and April 2016. 25 were around communications and staff attitude, 15 were around access to treatment.
- The average time to close a complaint was 75 days. 100 percent of applicable complaints were acknowledged within the deadline of three working days.
- Ward managers were aware of complaints trends and took action to improve the service. For example, on Juniper ward, the ward manager identified that complaints were usually related to poor communication between surgical staff and patients and families. More broad visiting times had been implemented so that families had more opportunity to speak to surgical staff (doctors) directly during ward rounds.
- The Patient Advice and Liaison Team (PaLS) team managed complaints that were not resolved at ward level. Staff told us that complaints generated on the wards were referred directly to PaLS if an informal resolution could not be reached.

Are surgery services well-led?

Good

Well-led was rated as good for surgery services because;

- There was a clear plan in place for the development of a surgery strategy that was linked directly to the development of the new trust values. The development of the strategy involved staff and was based on the results of the staff survey.
- There was good ward level understanding of risk.
- Ward managers understood the status of their wards at any given time and worked well with each other to flex their staff and support one another.
- Staff reported a positive change in culture, stating that the environment felt more open and honest over the past year.
- The leadership had actively engaged staff in the development of a new surgery services strategy.

However;

- Recording of clinical governance issues and risk was not consistent across all directorate management committee meetings.

Vision and strategy for this service

- The trust values were in the process of being developed at the time of our inspection and the plan was to have representation from 35 staff members from all services, including the surgical services, feeding into their development.
- A clear plan was in place for the development of the surgical strategy and involved the engagement of staff. The surgical division had created three main priorities based on the recent staff survey results and the surgery strategy was due to be developed out of these three priorities and the new trust values. The planning for this development was in its infancy at the time of our inspection so we could not assess its effectiveness.

Governance, risk management and quality measurement

- There was a clear assurance pathway for the escalation of clinical governance issues. Clinical governance was discussed in directorate management committees for

surgical services, which in turn fed into a divisional management committee. This committee fed into the executive performance meeting and then on to the appropriate sub-board committee.
- Despite a clear pathway of assurance being in place, the scrutiny of clinical governance issues was not robustly recorded. Minutes from surgical directorate management committees between May 2015 and February 2016 showed that some specialties recorded discussion of incidents, serious incidents, complaints, audits and risk registers. However some committees had no record that these issues were being scrutinised.
- Ward managers understood what the current risks were for their wards. For example, the ward manager for Juniper ward explained that the hand washing facilities in bays were not fit for purpose and were on a capital replacement programme. This was on her risk register as staff all used the hand washing facility in the main corridor of the ward. The ward sister on Mulberry ward stated that the risk register for the ward was available for their staff on the ward computer. Risks included the placement of NHS patients in side rooms on Mulberry ward (where all beds were in side rooms) who might require closer observation. This had been risk assessed and was managed by the ward staff by placing higher acuity NHS patients in side rooms located near to the nurses station.
- The division had a comprehensive risk register in place. Senior managers were clearly sighted on the risks in their division. The risk register showed that risks were regularly reviewed and that mitigation was put in place to address such risks.
- Divisional performance reports clearly showed performance as well as risk across the division and how these were shared across divisions and formed part of the board assurance framework.

Leadership of service

- The division was led by a clinical director, an associate director of nursing and a senior operations manager.
- Ward managers provided strong leadership to ward staff. Ward managers were aware of the status of their wards including their staffing numbers and requirements, incidents and complaints, and shared learning with their staff.
- A senior 'sister of the day' initiative had been implemented approximately three weeks prior to our inspection. The aim of the role was to provide senior sister leadership on a rota basis. The role helped in the development of band seven nurses, with staffing solutions, and attended ward meetings if required and spoke to patients and relatives when they had a concern.
- There was a standard operating procedure for staffing escalation in place. This set out clear leadership responsibilities from ward to executive level for ensuring the hospital remained appropriately staffed. This included a ward buddy system where nursing staff could flex to assist their buddy ward. This was confirmed to work in practice with substantive staff on Mulberry ward often supporting the agency staff on its buddy ward, Daisy, at weekends.
- The ward manager on Juniper ward was planning to implement the objectives for the ward into individual staff member's appraisals. This was a proactive way of engaging staff in the vision for their working environment.

Culture within the service

- Ward managers on both Daisy ward and the acute trauma and surgical unit stated that they felt there was "a more open and honest" working environment over past year.
- Staff felt that they worked well across the service and were willing to flex between wards to support each other as required.

Public and staff engagement

- Patient feedback was displayed on electronic whiteboard in ward corridors for patients and visitors to see.
- The 2015 staff survey had largely negative responses for the clinical support services and the musculo-skeletal directorates within the surgical service, in the areas of 'my job' (which covered motivation, satisfaction, support, and involvement), 'my manager' (which covered support, value, and feedback), 'my health and wellbeing' (which covered stress, pressure, incident reporting, feedback, and discrimination), 'my development' (which covered training, effectiveness of training and appraisals), and 'my organisation' (which covered the friends and family test, acting on concerns, and communications). The trust was in the process of addressing this by re-developing its values based on these results.

Surgery

- 35 values champions were nominated trust-wide and included staff from the surgical services. The values champions had been nominated by their local and senior management, and were expected to take part in re-developing the trust values and feeding into their development. The work of the values champions was in its infancy at the time of our inspection.

Innovation, improvement and sustainability

- A surgery improvement plan was in draft form, covering a range of improvement initiatives relative to patient safety and experience, leadership and clinical effectiveness. The plan was incomplete at the time of our inspection regarding some actions to address concerns, expected outcomes and measures of these outcomes and dates for when the actions were expected to be complete.

End of life care

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

Information about the service

The end of life services at Hinchingbrooke Hospital comprised of a specialist palliative care team (SPCT) that provided support to staff caring for patients who were end of life in ward settings. The hospital also provided bereavement and chaplaincy services. The SPCT supported people affected by life-ending or life-limiting conditions and their families, including patients with cancer who required complex symptom management. The service received patient referrals from other hospitals, the local St John's hospice, and the community.

The bereavement team offered a comprehensive bereavement service that included mortuary services, and alongside the chaplaincy service, provided a wide range of support to families, relatives, and friends of the dying and deceased.

Between April 2015 and March 2016, the palliative care team received 745 referrals to its service. Fifty-three percent of referrals were for patients with a primary diagnosis of cancer and 46% none cancer, these conditions included, but was not limited to, respiratory diseases, heart and circulatory disease, degenerative nervous system diseases, and multiple sclerosis. Data provided by the trust identified 1% of patients with no specific condition recorded. Between April 2015 and March 2016, 553 patients died at Hinchingbrooke Hospital.

Patients older than 86 years accounted for 30% of referrals to the palliative care team, patients aged 81 to 85 years accounted for 18% and 61 to 80 years 43%. Patients aged 40 to 60 years accounted for 8% of referrals and less than 1% of referrals were for patients under 40 years of age. These figures reflected the local demography of the population the hospital served.

The SPCT provided a seven-day a week service between the hours of 9am and 5pm, on call advice was provided by consultants at the local St Johns Moggerhanger Hospice, with staff rotating weekend working. Weekend working also included community based palliative care nurses who would work at the hospital on a rotational basis to provide specialist palliative care services to patients.

The SPCT comprised of one whole time equivalent (WTE) practice development nurse and a 0.6 WTE lead palliative care consultant, complimented by a 0.2 WTE palliative care consultant. The team were led by a full time palliative care team leader, with two 0.8 WTE and one 0.6 WTE specialist palliative care nurses.

The mortuary team comprised of bereavement and mortuary manager, a senior bereavement officer and a bereavement officer providing an 8am to 4pm service Monday to Friday. There was provision for out of hour's services via an on call system where staff were rostered during evenings and available 24 hours a day over weekends to provide bereavement and viewing services.

The mortuary service had the capacity for 36 deceased patients and additional provision for two deceased bariatric patients; however, at the time of inspection, capacity was reduced to 34 due to four of the refrigeration units being out of service. The trust was due to carry out plans to significantly remodel and improve this area of its services at the time of our inspection, the team felt that the

End of life care

reduction in capacity was not an issue at this time, as it would be a false economy to repair equipment that was to be replaced. The bereavement suite had dedicated areas to support people wishing to view deceased patients. These included a private toilet area, waiting area, viewing room with dedicated equipment, for example a child's bed, cribs, and homely furniture and fitments and linen to create a relaxed and homely viewing area and a memorial garden maintained by the bereavement staff.

The chaplaincy service provided a seven day a week multifaith support service operating from 8am to 6pm daily, with an out of hours on call chaplain available at all other times. The service had a dedicated multifaith area and 'seasons of life' quiet garden, where patients and families could visit and spend time on reflection, celebrate their religion or beliefs and leave messages of hope and reflection. The service had dedicated volunteers and provided chapel services for various religions, faiths, and beliefs at various times of the week throughout the year.

We visited the Cherry Tree and Apple Tree wards, the critical care centre (CCC), medical short stay unit (MSSU), emergency department (ED), acute trauma and surgical unit (ATSU), mortuary and bereavement services and multifaith chapel. We spoke with two patients during our inspection, unfortunately, other patients were too ill and it would have been inappropriate to approach them for interview, and at the time of the visit, we saw no relatives or family of patients. We spoke with four members of the palliative care team including the lead consultant for palliative care, practice development manager, and palliative care team leader and all of the bereavement and mortuary team. We spoke with 10 nurses, a deputy ward sister, health care assistants, and a chaplain. We looked at 15 sets of patient records, 11 prescription cards and 15 do not attempt cardiopulmonary resuscitation records (DNACPR) along with a number of polices, standard operating procedures and records relating to the delivery of the service.

Summary of findings

End of life care was good at Hinchingbrooke Hospital as patients received safe, effective, and responsive care that met their individual needs and protected them from abuse.

Infection, prevention, promotion, and control was good and patients benefitted from visibly clean environments that were routinely audited and cleaned. Staff knew how to respond to safeguarding concerns and reported these appropriately. Staff reported incidents using the trust electronic incident reporting system and learning from incidents was shared across the staff teams.

Equipment was appropriate for the patient's needs and the bereavement, mortuary, and chaplaincy team made use of a number of key environments to enable relatives and families to access private areas for reflection and practice their religion or belief. The mortuary team provided a caring and empathetic approach and created a homely and comforting environment for families to see their deceased loved ones.

The trust ensured staff were trained, appraised, and supervised appropriately. Improvements were seen in end of life training for all staff, particularly junior doctors, and the number of staff completing the Quality End of Life Care for All (QUELCA) training had increased. Patients were cared for using best practice guidance, for example, National Institute for Health and Care Excellence (NICE), and individual care planning promoted patient nutrition, hydration, and the effective use of pain relief to manage patients' symptoms.

Patient records were of a very high standard, reflected the patient's individual needs and choices, and demonstrated multidisciplinary (MDT) working to support patient outcomes. There had been improvements in the way do not attempt cardiopulmonary resuscitation (DNACPR) was recorded and the trust carried out audit activity to ensure quality was measured in key areas of its services. Patients were referred to the specialist palliative care team in a timely and professional way, this meant that patients accessed last days of life care and treatment that met their individual needs.

End of life care

Patients and their families were cared for with high levels of dignity, compassion, and respect throughout our inspection. Staff gave examples of good practice that enhanced patients' physical, psychological, and emotional wellbeing. Families were offered a wide range of information to help them deal with death and dying and the trust collaborated effectively with external providers, for example, funeral homes, counselling services and patient advice services.

The trust had a clear strategy and vision in place for end of life care with staff roles and responsibilities clearly set out within it. The culture across the service was one of support and mutual respect among the staff team and there was a significant focus on improving staff knowledge and competence in end of life care.

Are end of life care services safe?

Good

We rated the safety of end of life care services as good because;

- Incidents were reported and staff were trained to use the trust electronic reporting system, learning from incidents was shared with the staff team and improvements made.
- Infection prevention, promotion, and control (IPPC) was good within the specialist palliative care and mortuary teams.
- Specialist equipment was available for staff and was safe to use.
- Records were of a very high standard and reflected good communication within staff teams.
- Staff knew how to report safeguarding concerns for adults and children, and patients were safe from avoidable harm.
- Staffing levels were appropriate and staff were competent to carry out their respective roles.

Incidents

- There had been no 'Never Events' in the end of life services between January 2015 and February 2016. The definition of a Never Event has changed. Although each Never Event type has the potential to cause serious patient harm or death, harm is not required to have occurred for an incident to be categorised as a Never Event.
- There were 15 incidents recorded for "end of life and mortuary" care between November 2015 and February 2016 and all of the incidents were reported using the trusts electronic incident reporting system and had been fully investigated.
- Staff knew how to report incidents and all of the specialist palliative care team (SPCT) had received training in using the trust electronic incident report writing system.
- Feedback from incidents and investigations was given to the SPCT and mortuary team via team briefings,

discussed at the end of life steering group meetings, mortality and morbidity meetings and all staff that reported incidents could request a copy of any findings when making the initial notification.

- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents' and provide reasonable support to that person. This was understood by the staff we spoke with within the SPCT and mortuary teams.

Cleanliness, infection control and hygiene

- Staff adhered to the trust hand hygiene and 'Bare below the Elbow' policy, and wore personal protective equipment such as gloves and aprons during care. Staff washed their hands in line with the World Health Organisation's "Five Moments of Hand Hygiene" guidance between personal care activities with patients.
- Data supplied by the trust showed that at the time of our inspection, 100% of the housekeeping and mortuary staff were up to date with their infection, control, prevention, and promotion refresher training.
- The mortuary infection, prevention, promotion and control (IPPC) audit was completed February 2016 and due for reassessment in June 2016, no major IPPC issues were identified on the trusts own audit.
- Staff could explain the protocol for patients with possible infectious disease and demonstrated they had good understanding of IPPC in their day-to-day activities with patients.
- Mortuary staff had access to specialist protective equipment including full body suits, facemasks, wellington boots, and other protective equipment for handling the deceased; these were stored appropriately in the mortuary store area. The mortuary area was visibly clean and we saw records of daily environmental hygiene checks displayed within the department that were up to date at the time of our inspection and been completed for previous weeks.

Environment and equipment

- Equipment required to care for patients at the end of their life was available when needed. Ambulatory syringe drivers met the current NHS patient safety guidance. This meant that patients were protected from harm when a syringe driver was used because the syringe drivers were tamperproof and had the recommended alarm features installed and working.
- The mortuary environmental risk assessment was reviewed and updated in April 2016, it clearly identified any potential risks and gave mitigating actions to minimise risks in the environment.

Medicines

- The trust had a comprehensive anticipatory prescribing policy. Staff told us that patients who required end of life care were prescribed anticipatory medicines and we saw prescription cards were visible, accurate, legible and that anticipatory medicine had been given timely and appropriately (Anticipatory medicines are medicines that are prescribed in case they are required).
- The SPCT gave advice to the ward team on anticipatory prescribing for patients when it was required. Prescription cards showed that anticipatory medication could be accessed in a timely manner for patients who had expressed a preference to die at home.
- Patients who expressed a preference to die at home had access to medicines to support them at the end of life, the SPCT would liaise with consultants, and community nurses to ensure these were in place.
- There was specific guidance for medical staff regarding anticipatory prescribing to ensure effective control of symptoms such as pain relief and nausea.

Records

- We looked at 15 records for patients who were at the end of their lives. Records were completed to a high standard, detailed, and recorded the information shared with relatives; the multidisciplinary team and the patient to ensure their individual needs and choices were met.
- There were explicit records within patient's notes of discussion with the family and patients around decisions made in respect of do not attempt cardiopulmonary resuscitation (DNACPR), and these were supported where necessary by mental capacity assessments, consent forms, and dementia checklists.
- Staff made written records with great empathy and care, often staff recorded rest in peace within records once a

patient had died, and recorded whether the patient died peacefully or in an agitated state. Staff recorded the support offered to family who attended at the time of the patient's death, as well as any patient last wishes or information of importance.

- The SPCT used a care in "the last days of life" document; this was a holistic document, which included an initial medical assessment and nursing assessment. Staff we spoke with on the wards were aware of the document and we saw that these were fully completed when carrying out our review of care records.
- All of the 15 records reviewed for patients requiring end of life care had a ceiling of care recorded. (This is a document that describes what not to do so as not to put patients through unnecessary procedures.) It is used in hospitals to provide continuity of care and good communication and should always include symptom relief.
- The trust carried out DNACPR audits and set a 100% completion rate target for the correct completion of the DNACPR form. The trust audit for the period January 2016 to March 2016 showed that 94% of DNACPR forms were dated and timed, 97% of patient information was completed correctly, and legibly, 99% of DNACPR forms were signed by the correct grade of staff and 97% had the principle diagnosis completed. We looked at 15 patient DNACPR forms during our inspection and found all of them completed correctly; however, one DNACPR form stated 'old age' as a contributory reason for the DNACPR. We brought this to the attention of staff and were assured this would be dealt with immediately.

Safeguarding

- Staff knew their roles and responsibilities in relation to safeguarding people at risk, and how to escalate concerns in relation to the abuse or neglect of adults or children.
- We saw the trust had safeguarding policies in place and clear procedures to follow if staff had concerns; safeguarding posters were visible across the trust site including how to make a referral and who to contact.
- Staff were aware of the trust's whistleblowing policy and knew how to raise a concern.
- Safeguarding training was included as part of the mandatory training package. The palliative care team told us they had completed training in safeguarding adults and children and data supplied by the trust showed that 100% of the team were up to date with level one and two child and adult safeguarding training.
- All of the bereavement and chaplaincy team were in date for their mandatory level one safeguarding children and adults training.

Mandatory training

- The trust includes end of life care in mandatory training to all nurses and health care assistants (HCA) as part of its essential staff training days and at induction to new starters.
- Trust mandatory training data provided for the four bereavement staff and one chaplain showed 100% had completed equality and diversity training, infection, prevention, promotion and control. Three staff had completed information governance, two required updates in fire safety, and two required updates in low risk moving and handling and three required PREVENT training (This is the government agenda to counteract terrorism and acts of violence and aggression against the UK). There were no significant concerns regarding the completion of mandatory training by the team.
- The specialist palliative care team was a small team, data provide by the trust at the time of our inspection showed that 100% of staff were up to date with mental capacity act training, equality and diversity, deprivation of liberty safeguards, fire safety and infection, prevention, promotion and control, adult basic lifesaving and information governance. One member of the team required an update in PREVENT training, and one in basic life support, there were no significant concerns regarding the completion of mandatory training by the team.
- A two day Advanced Communication Skills for End of Life Care course is offered to nurses and HCA by St John's Hospice. Since April 2016, end of life training has been an essential for all medical staff and training was provided to foundation years and core medical trainee doctors.

Assessing and responding to patient risk

- Staff used a patient referral form on the trust intranet system and faxed this to the SPCT when patients required end of life care. The referral forms gave staff an

urgency of referral rating, this enabled staff to identify if a patient needed a visit within 24 hours, two days, or three days. The referrals were accurate, legible and records showed that patients were seen in a timely way with urgent referrals usually seen the same day. Ward nursing staff confirmed the SPCT responded very quickly to referrals and records we saw corroborated this.

- The SPCT maintained a central a list of all patients who were at the end of their lives, showing the ward areas where they were accessing treatment. This enables the SPCT to quickly identify patients on the last days of life and provide them timely treatment and support.
- The trust utilised do not attempt cardiopulmonary resuscitation (DNACPR) documents for patients that were end of life and these clearly documented actions that should or should not be taken should a patient deteriorate at any given time.

Nursing staffing

- The team were led by a full time palliative care team leader, with two 0.8 whole time equivalents (WTE) and one 0.6 WTE specialist palliative care nurses.
- The team had been successful in obtaining Macmillan funding for a two year one WTE practice development nurse. The post holder commenced work in February 2016 to provide end of life care training and the trust had agreed funding for the post following the end of the Macmillan funding.
- The Association of Palliative Medicine for Great Britain and Ireland, and the National Council for Palliative Care recommends that there should be a minimum of one specialist palliative care nurse per 250 beds in a hospital. Hinchingbrooke currently has 266 beds, trust staffing meets this recommendation and were appropriate and sufficient for the service.
- The seven-day service meant that a staff roster was in place that included the community palliative care nurses in order to provide specialist palliative care support and advice across the hospital.
- The SPCT provided a seven-day a week service between the hours of 9am and 5pm. Weekend staff cover is provided from 9am to 5pm, face to face by the palliative care team in the hospital. Out of hours cover is provided for health care professionals via switchboard from the consultant on call rota at St Johns Moggerhanger Hospice. The hospital also have specialist nurse input out of hours.

Medical staffing

- The consultant leading on the care for the patient's condition managed the overall care of a patient.
- The trust had one 0.6 WTE lead palliative care consultant, this was complimented by a further 0.2 WTE palliative care consultant, working days were split between the consultants, who also worked at the local St Johns hospice.
- Out of hours cover (weekend and nights) was provided by the trusts own palliative care consultants and if necessary, the team could call the staff at the local St John Hospice for guidance and support.

Major incident awareness and training

- The trust had a major incident plan and service contingency plan in place to support its mortuary services should a major incident occur that would disrupt any of its services. The plan covered events like loss of power, access to buildings, computer system failure, and equipment failure. Staff were aware of the plan and how the key roles would come together in a major emergency as well as who to contact and the actions to take if a major incident was to occur. There were additional cooling blankets for emergency use if the mortuary refrigeration system was to fail and the trust had developed relationships with other services, for example, local undertakers, for storage capacity should the mortuary not have enough space or facilities.

Are end of life care services effective?

Good

We rated the effectiveness of end of life care services as good because;

- Care provided was based on national guidance and best practice in end of life care.
- Patient pain relief was prescribed in line with the trusts medicine policy and procedures.

End of life care

- The trust participated in the national End of Life Care Audit 2016 scoring above the national average in three of the five clinical indicators.
- The trust provided a seven-day palliative care service that was supported by specialist palliative care consultants.
- Staff routinely assessed the mental capacity of patients and sought their consent to treatment at the end of life and we saw good evidence of best interest decisions.
- Medicines were managed in line with the trust medication policy and patients accessed timely pain relief to manage their symptoms.

Evidence-based care and treatment

- The specialist palliative care team based the care they provided on the National Institute of Care and Excellence (NICE) quality standards in end of life care. These quality standards define best practice in end of life care for adults. We observed staff worked towards these standards, for example, the last days of life tool, which was a system to identify people approaching the end of life in a timely way, meeting quality standard one.
- The last days of life document along with individualised care planning, the provision of pain relief and nutrition and hydration met the recommendations set out in NICE guidelines, Care of Dying Adults in The last Days of Life (2015).

Pain relief

- Patient pain relief was prescribed in line with the trusts medicine policy and procedures. We reviewed 11 patient prescription cards and saw medication prescribed in a timely fashion; in line with trust policy and where medication was stopped, staff recorded full explanations for the stoppage.
- The trust last days of life care plan contained guidance for prescribing pain relief in end of life care, including anticipatory medication and who to seek help and guidance from. This was accessible on the trust intranet.
- The trust carried out a bereaved relative's survey between January and March 2016 asking relatives if the patient appeared to be in pain during their last week. Sixty-seven percent of respondents said that the patient didn't appear in any pain, 22% said some of the time and 11% said most of the time.
- A patient told us, "If I need oramorph, I don't have to wait long, maybe ten to fifteen minutes at the most, I have never had better care."

Nutrition and hydration

- We reviewed 15 patient records and saw that malnutrition universal screening tool (MUST) scores were used for patients. The last days of life document gave staff a prompt for planning nutrition and hydration for patients at the end of life.
- Nutrition and hydration needs were included in the patient's care plan and evidence of multidisciplinary support from dieticians, speech and language therapists, and physiotherapists was apparent in the records we reviewed. This included advice on the types of nutrition and hydration available for patients, how to improve a patient's posture to ease eating and drinking, and supplements that may be available to encourage hydration and nutrition.

Patient outcomes

- The trust participated in the national End of Life Care Audit 2016 scoring above the national average in three of the five clinical indicators, including documented evidence recognising that the patient would probably die in the coming hours, discussing this fact with those people important to the patient, and giving the patient an opportunity to have their concerns listened to.
- We reviewed 15 sets of records in relation to patients who were at the end of life, in all of the records it was clearly documented that the patient was end of life or receiving end of life care and the strategies staff should employ to achieve patient outcomes, for example anticipatory medicines.
- The trust scored below the national indicators with regard to documentary evidence of discussing the needs of the patient with those important to them and a lack of documentary evidence in the last twenty-four hours of life of a holistic assessment of the patient's needs regarding an individual plan of care. The implementation of the practice development nurse and staff training aimed to improve this score overall.
- In September 2015, the specialist palliative care team (SPCT) undertook a spot check audit to assess levels of general knowledge regarding access to the SPCT, last days of life documents and caring for dying patients.

The SPCT spoke to three nurses on each of the eight acute wards. They interviewed a mix of senior and junior nursing staff and identified that 100% of respondents knew they should keep relatives of end of life care patients informed daily or as needed, face-to-face or via the telephone. Ninety-six percent of staff said they felt comfortable having discussions with patients or relatives about end of life care. Ninety-two percent of staff were aware that completing last days of life documentation was both a medical and nursing responsibility. However, 25% of staff did not know how to refer patients to the SPCT, 29% did not know where to find last days of life documents or how to complete it, and 25% of staff did not know how to access out of hours advice. The spot check happened prior to the implementation of the seven-day service. During our inspection, staff we spoke to were confident to contact out of hours services and knew where to find key documentation including end of life documentation and referral forms to refer patients to the SPCT showing improvement over time.

- The trust carried out an audit of the 'amber car bundle' from July 2015 to December 2016. The audit identified improvements in the medical plan being agreed in patient notes, escalation plans being documented, conversations with patients and families documented and personal plans of care completed. The trust identified that at that time documented decisions in the do not attempt cardiopulmonary resuscitation (DNACPR) had declined. Of the 15 DNACPR forms we reviewed during inspection, all had discussions with patient or relatives documented, or the reason why they were not included in the discussion.
- The trust carried out DNACPR audits and set a 100% completion rate target for the correct completion of the DNACPR form. The trust DNACPR audit between January 2016 and March 2016 showed that 94% of DNACPR forms were dated and timed, 97% of patient information was completed correctly, and legibly, 99% of DNACPR form signed by correct grade of staff and 97% had the principle diagnosis completed, showing the trust was slightly below its 100% target of completion.

Competent staff

- The trust had made significant efforts to improve its end of life training to all staff including junior doctors. All staff completed end of life training on their induction to the trust and it was part of the essential training programme for all other staff. We saw a newly designed training workbook created by the lead palliative care consultant used to train staff in end of life care. This demonstrated an understanding of the previous issues faced by the trust and showed how they were aiming to raise awareness of end of life care and increase competence amongst the staff team.
- Trust data showed that the palliative care team had all received appraisals within the last twelve months. Staff told us that appraisals were a positive experience and enabled them to discuss their performance and training needs. Clinical supervision for the SPCT was provided where appropriate and could be accessed at any time if required, however staff plan for this on a monthly basis.
- The bereavement and mortuary manager had attained the gold standard for bereavement training and seeking consent in paediatric and perinatal pathology in order to offer high standards of bereavement care, guidance, and support. We saw the bereavement team staff had attended a

number of other relevant courses that enabled them to provide support, care and a professional service for patients at the end of life, for example care of dying for different faiths. .

- Between September 2015 and April 2016, 49 staff received training in the safe use of the McKinley T34 Syringe Driver to ensure staff were competent in its safe use and could support patient's pain management and comfort at the end of life. This meets standard four of the National Institute of Care and Excellence (NICE) quality standards in end of life care by ensuring that services are available and systems are in place to meet the physical and specific psychological needs of people approaching the end of life, including access to medicines and equipment, in a safe, effective and appropriate way at any time of day or night
- Nurses were offered training on the one week Quality End of Life Care for All (QUELCA) course at St John's Hospice in order to help them create compassionate, end of life care focussed environments on the wards they lead. Data provided by the trust shows that during 2015-16, ten band six nurses and ten band five nurses successfully completed this training.

End of life care

- The mortuary team no longer delivered an introduction to the mortuary staff and its services during new hospital staff induction. We were informed that the reason for the removal from the induction schedule was due to some staff finding the experience too upsetting. The bereavement team felt they should be included in the process and they could adjust their induction session accordingly to ensure staff were not upset, as the team felt it was a key part in raising new staff awareness of the roles of the mortuary and bereavement team.
- The bereavement and mortuary team staff accessed supervision on a four weekly basis from a psychologist to help them deal with their emotion and any trauma after supporting the deceased and their families.

Multidisciplinary working

- There were regular multidisciplinary team (MDT) meetings to discuss patient care needs on the wards. We saw evidence of MDT working recorded in patient notes to coordinate care towards patient outcomes and ensure care was of a consistently high standard.
- The SPCT had good links with end of life care services in the community. For example, they had worked together with the community palliative care nurses to organise a rota that provided seven-day specialist end of life care support and advice across the hospital as well as community nurses working weekends as part of the seven-day service.
- The trust used an electronic recording system to enable the recording and sharing of people's care preferences and key details about their care, on a care performance indicator (CPI) flagging system. This ensured care was co-ordinated and delivered in the right place, by the right person, at the right time. The system was accessible by all staff that could see the CPI flag and clearly identify if a patient was seen by the SPCT.
- Staff knew they could get support from the SPCT when required and said they would get this via calling the team on the hospital pager system or via emails. All of the medical and nursing staff we spoke with told us the SPCT team were always supportive, shared their knowledge and expertise, and gave professional advice on the care of dying patients.

Seven-day services

- The SPCT were available for face-to-face consultations in the hospital seven days a week from 9am to 5pm, weekend were covered on a roster, and the community palliative nurse team played an active part in providing the seven-day service at weekends.
- The chaplaincy service provided 24 hour, on-call support seven days a week for staff, patients, and their representatives.
- The mortuary and bereavement team provided an 8am to 4pm service Monday to Friday. There was provision for out of hour's services via an on call system where staff were rostered on call during evenings and on call 24 hours a day over weekends to provide bereavement and viewing services.

Access to information

- All SPCT staff had access to information that the trust held in order to assist in the planning of care for individual patients, medical notes and nursing notes were easily accessible within clinical area when required. All members of the MDT documented in the same place within the records, which meant that all members of staff could access and follow all the records appropriately.
- Records written specifically by the SPCT were available in the patients' notes for staff caring for the patient to read.
- Staff could access the trust intranet system to access a wide range of information to enable them to perform in their roles; this included training materials, signposts to alternative services and referral pathways.
- The staff provided a great deal of information in the form of leaflets and advice guides to patients and relatives. This was evident in the bereavement and mortuary area where relatives and friends could access guidance on a range of issues in relation to death and dying.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- All staff we spoke with during the inspection were aware of their role and responsibilities in relation to the Mental

End of life care

Capacity Act 2005 (MCA) and where appropriate we found that MCA assessments for patients lacking capacity had been completed correctly and in line with the trust policy.
- Individual patient records clearly documented where consent had been sought for various activities from the patient and where necessary as part of a best interest decision involving other professionals.

Are end of life care services caring?

Good

We rated caring of end of life care services as good because;

- Mortuary and bereavement staff and the specialist palliative care team demonstrated compassion and respect for patients, relatives, and carers.
- We saw evidence that patients and relatives were involved in decisions about end of life care.
- Chaplaincy staff were visible within the trust, and religious representatives from all denominations could be accessed when required. The mortuary and bereavement team supported the needs of patients of various faiths and beliefs.

Compassionate care

- The trust participated in the End of Life Care Audit – Dying in Hospital, National report for England 2016. The trust scored better than the England national average for the questions: Is there documented evidence within the last episode of care that health professional recognition that the patient would probably die in the coming hours or days (imminent death) had been discussed with a nominated person(s) important to the patient and is there documented evidence that the patient was given an opportunity to have concerns listened to?
- The mortuary staff assured us they rarely had any concerns relating to how patients were treated at ward level following their death. If they had concerns, for example, a patient transferred inappropriately from the ward to the mortuary, they reported these as incidents via the trust electronic incident reporting system, and we saw one incident report that confirmed that staff had used this system to report an incident.
- The trust had an up to date policy on care of the deceased patient, including last offices (the term last offices relates to the care given to a body after death) and a protocol for the removal of deceased patients from wards.
- During our inspection, we visited the mortuary and spoke with the mortuary manager and bereavement officers. Staff gave examples of where they had demonstrated compassion and respect. For example, staff explained how they preserved the dignity and privacy of patients following death by keeping private body areas covered at all times, limiting the amount of people who see the deceased and using the deceased own clothing.
- The mortuary team encouraged ward staff to leave intravenous lines intact with the deceased, as removal often caused issues later in the preparation of the deceased due to staining or fluid loss.
- The trust carried out a bereaved relative's survey between January and March 2016. The survey asked how much of the time was the patient treated with dignity and respect in the last week of life, 67% or respondents said all of the time, 22% most of the time and 11% most of the time.

Understanding and involvement of patients and those close to them

- The National Care of the Dying Audit (May 2014) showed the trust scored 92% in relation to health professional's discussions with both the patient and their relatives and friends regarding their recognition that the patient was dying, which was better than the England national average of 75%.
- The survey also showed the trust scored 64% in communication regarding the patient's plan of care for the dying phase, which was better than the England average of 59%.
- Staff told us that following bereavement, families could view deceased relatives out of hours; mortuary staff were available 24 hours a day, seven days a week as part of an on call system to support viewings.
- We looked at 15 sets of end of life patient records throughout the wards we inspected, and saw evidence that on all occasion's patients and their families were involved in making decisions about their end of life care.

End of life care

- In the bereaved relatives survey carried out by the trust between January and March 2016, relatives were asked if they felt the health care team involved them in care decisions. Sixty-seven percent of respondents said yes all of the time, 22% said some of the time and 11% said no, they were not involved.
- The mortuary and bereavement team had developed a wide set of resources for supporting various faiths and beliefs. These included respecting various faiths practices, for example, washing of the deceased and working with local funeral homes who offered specific services for ethnic communities.
- Staff offered families the opportunity to take a small angel charm, to either keep themselves, or place with the deceased, in their hand, or in a pocket. Often families of deceased children would request photographs of children holding the charm and the team supported the families to access this process.
- The mortuary team no longer used shrouds and wherever possible dressed the deceased in their own clothes or items supplied by the family to promote the deceased maintaining their identity after death.

Emotional support

- The specialist palliative support team (SPCT) received specialist communication training to enable them to have difficult discussions with patients and their families at the time of a patient dying or moving onto the last days of life.
- The viewing of deceased patients was by appointment in a dedicated room within the mortuary. The viewing room was non-denominational and people were afforded privacy to pay their respects to their loved ones in a way that respected their religion or beliefs.
- Mortuary and bereavement staff described how they prepared and supported relatives before taking them to the viewing room to see their loved one, sometimes by walking in the memorial garden or waiting in the quiet waiting room and reading a book of prayers or listening to music.
- The trust had a chaplaincy service that was available for patients and their families or carers to use. There was a chapel within the hospital. The chaplain told us they could access religious representatives from all denominations as required. There was a separate dedicated prayer room for Muslim men and women if required.
- The chaplaincy service had access to lay and ordained volunteers who were able to support families in the hospital and in the community. The chaplaincy staff offered bereavement support to relatives, as well as spiritual support to patients and families. This service was provided 24 hours a day by employed staff working flexible hours during the day and by on call volunteers out of hours.
- The trusts bereaved relatives survey results showed that between January 2016 and March 2016 100% of relatives said the healthcare team dealt with them in a sensitive manner after their relative had died.

Are end of life care services responsive?

Good

We rated responsiveness of end of life care services as good because;

- Patients were referred appropriately and in a timely way to the palliative care team. In addition, the amber care bundle was embedded in the service.
- Care was planned for patients on an individual basis using the last days of life documentation.
- The trust had increased the number of staff working in the palliative care team to meet the needs of patients, and the use of community palliative care nurses encouraged communication and team working.
- The trust had completed audits on the last days of life and preferred place of patient death.
- Staff were aware of the trust complaints policy and were able to show examples of how this was used, and learning from complaints.

Service planning and delivery to meet the needs of local people

- Between April 2015 and March 2016, the specialist palliative care team (SPCT) received 745 referrals to its service. Fifty-three percent of referrals were for patients with a primary diagnosis of cancer and 46% none cancer, these conditions included, but was not limited

to, respiratory diseases, heart and circulatory disease, degenerative nervous system diseases, and multiple sclerosis. Data provided by the trust identified 1% of patients with no specific condition recorded.

- Patients older than 86 years accounted for 30% of referrals to the palliative care team, patients aged 81 to 85 years accounted for 18% and 61 to 80 years 43%. Patients aged 40 to 60 years accounted for 8% of referrals and less than 1% of referrals were for patients under 40 years of age. These figures reflected the local demography of the population the hospital served.
- The SPCT had 191 referrals between 1 January 2016 and 30 April 2016. The SPCT had developed a referral form for ward staff that gave ward staff an urgency of referral rating to the SPCT, this enabled ward staff to identify if a patient needed a visit within 24 hours, two days, or three days. Eighty-nine patients were seen within 24 hours of referral, which is a 78% compliance rate. Forty-seven patients were seen within two days of referral, which is an 81% compliance rate and 14 patients were seen within three days, which is a 74% compliance rate. The team reviewed individual cases to identify any issues that had led to a delay in referral in order to reduce this happening again in the future where possible.
- The trust preferred place of death audit in April 2016 included 58 patients, 45% of patients died in their preferred place of death and 8.5% of patients did not, often because of waiting for community discharge. Patients' who's preference for place of death was unknown accounted for 46.5% of the audit figures; this was for a number of reasons including the patient deteriorating suddenly, patient dying before being seen, or discussions with the patient not being appropriate. The trust monitored this data and specifically discussed each case to identify any learning from events that affected the preferred place of death in order to improve performance and meet individual requests at the end of life.
- Patients requiring end of life care were cared for throughout the trust. There were no designated beds or wards for patients who required end of life care. However, staff told us that wherever possible, side rooms would be used for patients who were in their last days of life. The SPCT also kept a central register of all patients receiving end of life support including ward location, to reach patients who may need their support.
- The SPCT numbers had increased in response to the need to cover seven day working and the use of community palliative care nurses at weekends had encouraged team working and a better understating of the needs of patients both in the hospital and in the community setting. Staff felt this new working relationship was extremely positive for the team and for the patients who could now access a full seven-day end of life care service.
- The trust carried out a bereaved relatives survey between January and March 2016 asking relatives if they were told the patient was likely to die soon, 78% of respondents said yes, 11% said no and 11% didn't give a response.

Meeting people's individual needs

- We saw from patient records and data supplied by the trust, that patients were referred appropriately and in a timely way to the SPCT and that the amber care bundle was embedded in the service.
- Following the Liverpool Care Pathway (LCP) removal, the trust introduced the Last Days of Life care plan on 10 July 2014 and this was active from this date. It was fully implemented with the End of Life Care Strategy that was launched in October 2015. The last days of life care plan, along with individualised care plans written by ward nurses, ensured that each patient was assessed and individualised care delivered. Both last days of life forms and individualised care planning were seen in all clinical areas inspected.
- The chaplaincy in the hospital recognised people of all faiths and beliefs. The hospital's chaplain told us they had excellent links with pastoral care from lay staff. The chaplaincy also had a 'seasons of life' quiet garden, which was wheel chair accessible and enabled people to sit quietly and engage in personal prayer or reflection.
- We did not see any patients where English was not their first language, however staff told us that translation services were available within the hospital.
- Staff in the bereavement office told us that they had numerous resources available to support people of all ages, faiths, and beliefs following the death of a patient.

We saw they had numerous guides for children of all ages who had suffered a bereavement. There were also many services for families affected by suicide, sudden infant death, and teenage bereavement.

- Chaplaincy staff were visible within the trust, the chaplain told us that they could access religious representatives from all denominations as required and they supported people who preferred not to follow a particular faith or belief.
- The bereavement and mortuary area had a private room where relatives could be seen in private and a memorial garden where people could take time to reflect or spend time alone.
- Free parking and food was available for visitors to the bereavement office. There was a large amount of information available to relatives including a booklet called 'guidance following bereavement'. Staff were skilled in dealing with those affected by bereavement and we saw them supporting a family dealing with the recent death of a child, showing high standards of compassion and respect.
- The trust used a staff buddy system, which enabled staff during ward handovers to be aware of a patient who is end of life and support them nominate a named nurse or health care assistant to be their buddy. This member of the team would then act as the patients and family's main contact point for discussion on any points in relation to the patients care or treatment.
- The water cooler for drinking water had been removed from the mortuary area, staff were concerned that this decision had taken away fresh drinking water from relatives who often needed water at times of distress.
- Mortuary facilities included a private toilet area, waiting area and viewing area for relatives. The bereavement team had considered the environment and used 'homely' equipment to make it less clinical. For example, the staff used soft bed linen, coloured homely blankets, a child's bed and wicker cots, soft toys, art work and statues to create a more relaxed and homely feel in the relatives viewing area.
- The memorial garden to the side of the mortuary was a well-kept, calming area used by staff to help relatives take air and have privacy at times of distress or quiet reflection, the bereavement team cared for this area. All of the ornaments and flowers in the memorial garden were purchased through voluntary donations or by the mortuary staff buying items themselves

Access and flow

- Staff at ward level referred patients requiring end of life care and support. All staff we spoke with were clear about the referral criteria for the SPCT, how to make a referral using the fax system and staff told us that patients were seen in a timely manner.
- The specialist palliative care team completed daily ward rounds. We saw the team on a ward round and observed the team involved in decisions about patient's end of life care, including offering advice and support around relief of symptoms and appropriate pain relief.
- The mortuary service had the capacity for 36 deceased patients and additional provision for two deceased bariatric patients; however, at the time of inspection capacity was reduced 34 due to four of the refrigeration units being out of service. The trust was due to carry out its plans to significantly remodel and improve this area of its services. The team felt that the reduction in capacity was not an issue, as it would be a false economy to repair equipment that was to be replaced.
- The trust's End of Life Care Strategy describes how they aims to engage with other service providers, patients and the public to influence the development of future services, including monitoring discharges and fast-track discharges. End of life patients are discharged by fast track continuing care, the hospital have not set a target internally so cannot report data on this process. The hospital have however, increased the number of patients facilitated to die at home since introducing the seven day end of life service.

Learning from complaints and concerns

- There were six complaints to the end of life care services between January 2016 and April 2016 including complaints in relation to poor staff attitudes and communication issues.
- Staff told us that complaints about the service did not happen often, but if they did, they were made aware of the nature of the complaint and any actions taken by the trust team to ensure the issues that led to the complaint did not happen again.

End of life care

- The bereavement and mortuary team were able to talk us through a recent letter of complaint and discussed it with the team to identify where to make improvements in the service.

Are end of life care services well-led?

Good

We rated well led of end of life care services as good because;

- The trust produced a new end of life care strategy that comprehensively set out the vision for end of life services until 2019.
- End of life services had a dedicated risk register that was up to date and reflected current risks associated with the delivery of end of life services.
- Staff were clear on the roles and responsibilities of managers and leaders within the service.
- There was a culture of mutual respect amongst the staff team, and ward staff particularly welcomed the specialist palliative care team (SPCT) guidance and support.
- Following the trusts last inspection it had implemented a bereaved relative's survey based on the national care of the dying hospitals audit 2014.
- We saw evidence of engaging with patients who may be at risk of isolation due to their criminal and social background, to promote quality care at the end of life.

Vision and strategy for this service

- The trust had produced a new end of life care strategy for 2016 to 2019. We saw that there had been significant improvements in this area of the trust end of life provision and that the strategy laid a corner stone for the future development of its end of life services. The strategy clearly identified strengths and weakness of the trust's end of life service along with setting six key priorities to ensure the service meets the needs of the local population whilst adopting the National End of Life Care Strategy (DoH, 2008) and Leadership Alliance's Five Priorities for Dying Patients (2014).
- Knowledge of the trust end of life strategy was still in its infancy amongst the staff team, due to the document and strategy being introduced at the end of February 2016. However, most of the staff we spoke to were aware that the trust had developed an end of life strategy and of its commitment to delivering the best end of life care.
- The vision for end of life at Hinchingbrooke hospital had six key priorities, personal needs and preferences, coordinated care, rapid access to specialist advice and clinical assessment, high quality care and support in the last days of life, services that treat people with respect, in dignified ways and offering appropriate support and advice for carers and their staff.
- The vision had clear milestones to measure achievement over time and was equality impact assessed to ensure it did not discriminate patients against any of the nine protected characteristics set out in the Equality Act 2010.

Governance, risk management and quality measurement

- End of life had a dedicated risk register that was up to date and reflected current risks associated with the delivery of end of life services. The specialist palliative care team (SPCT) knew about the risk register and the risks associated with the delivery of services.
- The SPCT team carried out a number of quality audits, including spot checks, amber care bundle audit, last days of life and staff development to measure the quality and effectiveness of the service.
- Significant improvements had been made since the last inspection in the way that staff identify patients on the last days of life including the use of information technology. Care performance indicators (CPI) flags were used on the trust IT systems to identify patients at end of life and an electronic patient record system was accessible to both hospital and community staff enabling staff from both the hospital and community to track patients in need of end of life care support.

Leadership of service

- The trust had identified a dedicated lead for its end of life services and strategy, this was the Director of Nursing, Midwifery and Quality who also attended various quality meetings and forums in relation to the quality auditing and leadership of end of life care. The

end of life care strategy was being disseminated across the trust via divisional clinical forums; the palliative care teams practice development nurse was leading this process, and the clinical lead for end of life care.

- Staff were clear on the roles and responsibilities of managers and leaders within the service and we saw posters and information displayed around the hospital advising staff on various roles and responsibilities within end of life care.
- The end of life care strategy referred directly to a number of national directives in order to inform the development of its end of life services, these included National Institute for Health and Care Excellence (NICE) guidance, and the NHS Ombudsman's report on the failures in end of life care, death without dignity (2015).
- The new practice development role within the SPCT had begun to implement training evaluation and analysis of staff competencies within end of life care to identify areas of weakness and deliver training to drive improvement across the teams. This mirrored the strategic actions set out in the end of life strategy to undertake a baseline review of end of life education activity.
- The SPCT were clear on the vision and strategy for end of life services.

Culture within the service

- The SPCT were positive about their roles and the impact they were having on end of life services across the trust. It was clear there was a culture of mutual respect amongst the staff team, and that ward staff particularly welcomed the SPCT guidance and support.
- The team ethos and team working was excellent amongst the bereavement and mortuary team, we found the culture to be one of mutual respect, learning, and support to ensure the services offered to the deceased and their families were of a very high standard.
- Multidisciplinary team (MDT) working was at the heart of the culture within SPCT and patients benefitted from a wide range of professionals working jointly towards offering high quality services.

Public engagement

- The trust gained people's views about services in a number of ways, including generic feedback requested from the friends and family test questionnaires. These were available in locations throughout the hospital. Following the trust's last inspection, it had implemented a bereaved relatives survey based on the National Care of the Dying Hospitals Audit 2014, the audit stated that all hospitals should undertake local audit of care of the dying, including the assessment of the views of bereaved relatives, at least annually.
- At the time of our inspection, the SPCT had a public engagement stall in the hospital main reception area, offering the public an opportunity to discuss a wide range of services with the SPCT team.
- The trust was utilising a number of computer screen savers across the departments to advertise that it was 'dying matters week' at the time our inspection. This gave advice and information to staff regarding dying matters including organised events, learning materials and how they could get involved.

Innovation, improvement and sustainability

- Staff described how they were working with Little Hay Prison where consultants review patients that are at the end of their lives and work with prison and hospital staff to ensure that patients were safely admitted to the hospital or referred to the local St Johns hospice. This was evidence of engaging with patients who may be at risk of isolation due to their criminal and social background to promote care quality and equality at the end of life.

Outstanding practice and areas for improvement

Outstanding practice

- The trust employed an Admiral Nurse to support people living with dementia, their relatives and carers as well as staff. This was one of only five Admiral Nurses in acute trusts in England.
- Staff worked with a local prison where consultants review patients that are at the end of their lives and work with prison and hospital staff to ensure that patients were safely admitted to the hospital or referred to the local hospice.

Areas for improvement

Action the hospital MUST take to improve

- Ensure that there are sufficient numbers of suitably qualified, skilled and experienced medical staff on duty in the emergency department. Also ensuring that there are robust contingency plans and which forecast shortages and ensure that sufficient cover is provided.
- Ensure that the time to treatment from a clinician in the emergency department is reviewed and times to treatment are improved.
- Ensure that the triage process for ambulance arrivals is received to ensure that the pathway for patients is safely and times of assessment accurately recorded.
- Ensure that infection control practices within the emergency department are improved.
- Ensure that the processes for the checking of equipment, particularly blood glucose and anaphylaxis boxes, in the emergency department is improved and safe for patients.

Action the hospital SHOULD take to improve

- Review the observation and seating arrangements for the children's area to ensure parents and children only sit in this areas.
- Should ensure that fridge temperatures are routinely checked.
- Should allow staff to attend and receive updated mandatory training.
- Review the need to monitor the culture of staff within the emergency department.
- Review the environment and provision of children's services and where children are treated.
- Ensure that records are used in a consistent way across wards, that they are contemporaneous; reflect patient needs and appropriate actions taken following risk assessment.
- Review the relative risk of readmission for surgery patients as data shows this to be significantly above the England average.
- Review the complaints process and the time taken to provide people who complain with a full response.
- Should ensure that audits are undertaken locally within the emergency department to improve quality measurement and assurance.
- Should ensure a consistent monitoring of preferred place of death for patients receiving end of life care.
- Should ensure that there is a clear target for fast track discharge of patients requiring end of life care and ensure consistent monitoring of the timeliness of these discharges.