Care Quality Commission

Kettering General Hospital NHS Foundation Trust

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

Summary of findings

Letter from the Chief Inspector of Hospitals

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

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

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

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

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

Our key findings were as follows:

- Risks identified by the service were not being assessed, monitored and mitigated via effective, comprehensive risk registers. Risks we identified on inspection were not recognised by the service, including the failure to escalate deteriorating patients, poor junior doctor cover for medical wards, security and access to the children's ward, paediatric nurse competent in the children's ED and the poor completion and storage of patients' records. We were therefore not assured staff at every level in the service had an effective understanding of all the risks to patient safety and were able to assess, mitigate and monitor all known risks.
- There was not a holistic approach to the monitoring of safety and performance data, supported and informed by effective, ongoing clinical audits. Actions plans had not always been developed to address areas of risk or poor performance and those that were in place were not always effectively monitored.
- The hospital had serious concerns around the accuracy and quality of its referral to treatment (RTT) data and reported position, with the correction of this being a hospital priority. The hospital was working on a plan of data improvement including education, training, changes to systems and process and validation of patient pathways. Some patients also experienced long delays waiting for treatment, specifically for urology, maxillofacial and ear, nose and throat (ENT). Patients and stakeholders were not involved in service development. In some cases, waits were in excess of 52 weeks. The service did not have the capacity to meet the needs of patients and ran additional clinics to manage waiting lists. There were long waiting lists for the majority of specialities, including medical oncology. The services' own figures from October 2016 showed that 69% of patients were seen within 18 weeks against the national standard of 92%. The hospital was not nationally reporting referral to treatment time (RTT) performance at the time of inspection due to historical problems with the validity of data.
- The hospital had taken action to minimise the delays in diagnostics and imaging reporting by outsourcing their radiology reporting. At the time of inspection, there were 11,733 images awaiting a radiology report. These were classified as non-urgent images.
- Complaints were not always handled in a timely manner in almost all services.
- Services risk registers were not comprehensive and any of the risks did not have sufficient assurance that mitigating actions were being monitored. Ward dashboards referred to some local risks but these were not systematically escalated to the service risk register.

Summary of findings

- There was a lack of capacity in the leadership team to consistently embed learning from incidents and audits throughout services to drive improvements. There had not been sufficient improvement in areas of concerns highlighted during our February 2016 inspection.
- There were not enough registrars and junior doctors to cover the medical wards out of hours and at weekends. Doctors told us there was no electronic handover system and no electronic list of priority patients to alert them to problems out of hours and at weekends in the medical wards. The hospital did not operate a multi-speciality hospital at night team and handover was focused on medical care wards. Working to seven day working in the service was variable.
- There were inadequate numbers of nursing and medical staff to meet the needs of patient's in adults and children's ED. There were not effective processes in place to ensure that all staff were competent to carry out the roles they were tasked within the ED. The coronary care unit had nurse staffing numbers that were below the recommended number stipulated by the British Cardiovascular Society. There was inadequate medical staffing cover in the children and young people's service. The maternity service did not always have sufficient staff, of an appropriate skill mix, to enable the effective delivery of care and treatment. There were times the consultant obstetrician was not present on the labour ward as they would be covering obstetrics and gynaecology and undertaking elective caesarean section lists. The critical care outreach team was not fully established to provide the necessary support and education to the rest of the hospital. The neonatal unit did not always operate in accordance with the required staffing levels. The paediatric outpatient department was not always staffed by registered children's nurses. Nursing staff in both fracture and ophthalmology clinics treated children but did not have level three safeguarding training in line with national recommendations. The trust took action to address this after the inspection.
- The children's waiting area did not provide adequate space for patients waiting to be seen and staff in the children's ED were not able to observe patients waiting at all times in line with guidance. The ED did not have safe and adequate facilities or processes in place to manage patients who presented with mental health illness and were a significant risk to themselves and others.
- Staff were not always completing safeguarding processes in line with hospital policy and had not received the appropriate level of training. In the ED, staff did not always follow safeguarding processes and safeguarding training levels did not meet the hospital's target or national recommendations. Risks to patients had not been actioned. Only 37% of nursing staff and 29% of medical staff had completed safeguarding level three training at the time of the inspection. Not all staff had completed the required level of children's safeguarding training.
- The hospital did not have a baby abduction policy; it had a flowchart for staff to follow in an event of an abduction. The trust took actions to address this after our inspection. The environment on Skylark ward was not safe, particularly for patients who may be at risk of self-harm or suicide. The trust took actions to address this once we had raised it as an urgent concern.
- The ED was not consistently meeting national targets for service delivery but it had shown improvements in the last three months with performance better that the England average. From July 2016 to October 2016, the average performance against the target was 88%. There were a substantial number of delayed ambulance handovers. This meant that patients were not always receiving an initial clinical assessment in a timely manner and ambulance crews were not made available to respond to 999 calls.
- Nurses on medical care wards had not always followed the escalation process for high risk patients by informing a doctor when a patient's NEWS score was raised or when the patient's oxygen saturation showed a downward trend. There were NEWS charts which showed dates and times that were not clearly stated and some were not legible.
- Patients were exposed to the risk of receiving inappropriate care and treatment due to poorly written and incomplete care plans. For some patients, there were no individualised care plans; in some cases, the same written care needs were simply copied to a new sheet and changing needs had not been reflected or incorporated.
- Patients' individual care records were not always written and managed in a way that kept patients safe from avoidable harm. Confidential information was not always kept in accordance with the Data Protection Act 1998.

Summary of findings

- Medicine storage was not always in line with the national guidance in outpatient areas. For example, fridge temperatures were not checked regularly in some outpatient areas. Expired medication was found in the cardiac unit. Patient's medical notes were not always stored securely in some outpatient areas. Medicine reconciliations had not always been done. Patients had not always been assessed for needing prophylactic medication to combat venous thromboembolisms (VTEs).
- Outcomes for patients were variable in medical care. The hospital had produced poor results in two national audits that the hospital recently participated in. The Sentinel Stroke National Audit Programme (SSNAP) audit showed a poor score of D and E in all four quarters of the reporting year. The hospital participated in the 2015 National Diabetes Inpatient Audit: the hospital was worse for 13 out of 15 indicators. There were mixed patient outcomes in surgery and not always an action plan to ensure improvements. Examples included the hip fracture audit and the bowel cancer audit.
- Patient flow and bed capacity to meet demand had been a significant pressure for the hospital for a number of months. Senior managers were in ongoing discussions with commissioners and stakeholders regarding the most appropriate ways of managing the DTOC position as the medical care beds being used were placing a significant pressure on the effective patient flow through the service. Discharges were sometimes delayed due to patients having to wait for ongoing care packages.
- All staff were passionate about providing high quality patient care. Patients we spoke to described staff as caring and professional. Patients told us they were informed of their treatment and care plans.
- Generally, staff understood their responsibility to report incidents both internally and externally. Feedback received was variable. Learning from incidents was not always effectively embedded throughout services.
- Most areas of the hospital were visibly clean and were cleaned regularly. Generally, effective infection control procedures were in place.
- Despite significant staffing pressures, generally patients' needs were met at the time of the inspection in most areas. Actual staffing levels were comparable to the planned levels for most of the wards we visited.
- Pain of individual patients were assessed and managed appropriately. Patients' nutritional and hydration needs were generally appropriately assessed and the food and fluid charts were well maintained.
- Staff understood and respected patients' personal, cultural, social and religious needs, and took these into account and services were generally planned and delivered in a way that took account of the needs of different patients.
- Local leaders within services were generally visible and approachable. Staff told us that the senior leadership team, including both senior management and lead clinicians and nurses, were generally visible and effective.
- Most staff felt involved in the hospital's CARE values which brought staff together to discuss ways to improve services and provide quality care to patients. Staff felt supported and able to speak with the lead nurse if they had concerns.
- There were clear processes and procedures in place regarding the completion of the Five Steps to Safer Surgery checklist. Intensive Care National Audit and Research Centre data showed the intensive care unit to be in line with the England average for all areas except delayed discharges. The hospital had received the United Nations Children's Fund (UNICEF) Baby Friendly Initiative full accreditation for its maternity department.
- The hospital had a replacement for the Liverpool Care Pathway (LCP) called the 'Guidance to implement care for the dying patient, and their family and friends'. The document was embedded in practice on the wards we visited. Do not attempt cardio-pulmonary resuscitation (DNACPR) records we reviewed were signed and dated by appropriate senior medical staff. There were clear documented reasons for the decisions recorded.

We saw several areas of outstanding practice including:

- The hospital had direct access to electronic information held by community services, including GPs. This meant that hospital staff could access up-to-date information about patients, for example, details of their current medicine.
- Sixty volunteers supported the chaplaincy service through a programme of daily and weekly visits to wards and clinical departments. Volunteers attended a 10 week training programme, which included awareness sessions on end of life care, dementia, and hearing and visual impairment.

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- There was a well-embedded play worker team, funding was sourced through donations from local businesses as well as fund raising activities. This was used to pay for new equipment as well as weekly visits from a music therapist, pet therapist and magician. The unit had modern toys and facilities for the children including a new projector, which projected moving images onto the floor, which entertained children under the supervision of a play worker.
- The hospital had launched a "Joint School" education session for hip and knee replacement patients. The aim was to give patients a clear indication of what to expect from their operation and what was expected form them by the hospital.
- The hospital had launched a new laser operation to support patients who required treatment for benign enlargement of the prostate by using a light laser to reduce the size of the prostate. This process had reduced the surgical time and the length of stay was no more than one day.

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

Importantly, the hospital must take action:

- Ensure that there are sufficient numbers of nursing and medical staff in adults and children's ED to meet the demands of the population and ensure safe care is delivered. To ensure that staff working in children's emergency department (ED) have the correct skills, competence and support to care for children.
- Ensure there is a sufficient number of medical registrars and junior doctors to cover out of hours and weekend shifts at all times across medical care wards. To ensure there is the required level of consultant obstetrician presence on the delivery suite.
- To ensure care and treatment are provided in a safe way for service users by following the British Cardiovascular Society guidance on nurse staffing numbers in the Coronary Care Unit. Ensure there is a sufficient number of nurses working in the Coronary Care Unit at all times.
- To ensure a qualified children's nurse works in the outpatient department in accordance with Royal College of Nursing guidance, 'Defining staffing levels for children and young people's services' which states that, 'a minimum of one registered children's nurse must be available at all times to assist, supervise, support and chaperone children'.
- To ensure that suitably qualified staff in accordance with the agreed numbers set by the hospital and taking into account national policy are employed to cover each shift. In the children's and young people service, there must be suitable numbers of staff trained in Advanced Paediatric Life Support and / or European Paediatric Life Support.
- Ensure that there are effective systems in place to prioritise, assess and treat all patients attending the ED. Ensure that there are effective processes in place to measure time to initial clinical assessment for ambulance handovers and self-presenting patients.
- To review the streaming competency framework and ensure that staff in this position have the necessary skills to identify a deteriorating or seriously ill patient in adult and children's ED. To ensure that all staff in outpatients who have direct contact and assess and treat children have the appropriate level of paediatric competencies to provide safe care and treatment.
- To ensure the security of the paediatric ward and Rowan ward at all times and review security system on the postnatal ward to minimise the risk of visitors accessing the ward without being challenged.
- Ensure staff in medical care follow the hospital's medication policy in the safe prescribing, cancelling, handling, storage, recording and administration of medicines. Ensure staff follow the hospital's medication procedure for obtaining medicines for patients out of hours. The disposal of controlled drug ampules which have only been partially administered to patients must be recorded in the controlled drug register in the children's and young people service. To ensure that all medications are stored in outpatients areas in line with hospital policy and national guidelines.
- Ensure that the safeguarding children and vulnerable adult policies include all relevant information, specifically, details about female genital mutilation, child sexual exploitation as well as the referrals process for vulnerable adults. Ensure that all staff are trained to the required level of safeguarding children's training and adhere to hospital safeguarding policies.

Summary of findings

- To ensure all staff have the required statutory and mandatory training and effective systems are in place to monitor this. To ensure that staff in the radiology department are up-to-date on basic life support training. To ensure that radiation dose awareness in plain film by the radiographers is in line with national standards.
- To ensure staff in ED and medical care have had sufficient training in the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).
- To ensure there are processes and procedures for staff in surgery to adhere to the Food Safety Act 1990 and the Food Hygiene (England) Regulations 2006 (Temperature Control Schedule 4 EU Regulation No.852/2004).
- To ensure that theatre staff comply with the Standards and Recommendations for Safe Perioperative Practice 2011 by the Association of Perioperative Practice or the hospital's operating theatre policy and the theatre standard operating procedure regarding the wearing of cover gowns and footwear when leaving and entering the theatre area.
- To ensure staff are aware of the escalation policy including triggers for escalation in ED and medical care and that these process and reviewed and monitored. Ensure National Early Warning Score (NEWS) charts are filled in clearly, accurately and legibly.
- Ensure that patients' records are completed with appropriate information to understand their care plans. Ensure all patients have person-centred care plans that are well maintained and reflect appropriately patients' changing needs and treatment.
- Ensure all confidential patient information in medical care, surgery and gynaecology and outpatients and diagnostics are stored in accordance with the Data Protection Act 1998.
- To monitor patients' referral to treatment times, and assess and monitor the risk to patients on the waiting list in surgery, children and young people's service and outpatients and diagnostic services.
- To develop an effective programme of cyclical audits to measure performance with evidence-based protocols and guidance in the ED. To establish a system for continuous monitoring of action plans developed in response to local and national audits. To ensure all clinical guidelines are up to date and reviewed in a timely manner in the maternity and gynaecology service. To ensure the local maternity dashboard meets RCOG good practice No.7 Maternity dashboard, clinical performance and governance scorecard standards.
- To ensure complaints are handled in line with hospital policy and effective systems are in place to monitor this.
- To ensure all staff are supported to recognise and escalate potential risks to the safety and quality of care and treatment for all patients and to ensure effective systems are in place to assess, mitigate and monitor these risks. The hospital should ensure that the risk registers are accurate and reflective of risks in services.
- To review the incident reporting processes in children's and young people service to ensure all incidents are reported and investigated and that actions agreed correlate to the concerns identified, are acted on and lessons learned are shared accordingly. Ensure ligature audits are undertaken and acted upon in the children's and young people's service.

In addition the hospital should take action to improve:

- To review the environment in reception area in ED so that patients' privacy and confidentiality can be respected.
- To monitor the dedicated mental health room so that it meets national recommendations and poses minimum risks to patients and staff.
- Review ways to improve the 'whole system approach' to managing overcrowding in the ED.
- To provide training to staff in dementia awareness, learning disabilities and complex needs in ED.
- Review staff training and awareness of major incident policy and equipment.
- To monitor that equipment in ED is properly maintained and checks for resuscitation equipment are completed in line with trust policy.
- Consider ways to meet the standards in the intercollegiate document 'Standards for children and young people in emergency care settings, 2012'.
- To review the function and use of the emergency decisions unit to ensure that the eligibility criteria are being adhered to.
- To review medical cover for the Discharge Lounge.

Summary of findings

- To continue to work to recruit full time staff in an effort to reduce the reliance on agency staff in medical care.
- To monitor that fabric chairs and privacy curtains within the breast pre-assessment clinic have the date of cleaning identified.
- To monitor that the processes and procedures in place to manage the medicines stored in all clinical rooms which exceed the required temperature.
- To support all staff to understand the trust's vision and strategy so that it is embedded within the service.
- To review systems and processes that are in place to ensure the cleanliness of surgical wards.
- To review pharmacy provision to meet the needs of the ICU and be in line with national guidance.
- Review systems for staff in ICU to provide level three safeguarding children's training.
- To review the provision of the outreach service to allow effective utilisation of this service.
- To review processes so that patients are discharged from the ICU within four hours of the decision to discharge to improve the access and flow of patients within the critical care unit.
- To review processes so that the hospital meets the needs of patient requiring admission to ICU at all times.
- To review the data collecting methods to monitor the length of time patients are nursed in recovery whilst either waiting for a bed in ICU or following discharge from ICU.
- To record ambient room temperatures where fluids are stored that requires this, taking action when required.
- Steps should be taken to improve multidisciplinary working within the department between medical staff, nursing staff and allied healthcare professionals.
- To review seven day services in medical are and critical care to ensure patient needs are met.
- To review assessment and screening of delirium for patients cared for in the ICU.
- To review systems for recording essential checks on equipment, including resuscitation equipment in critical care.
- To review facilities so women's privacy and dignity is always protected on the delivery suite.
- To review staffing in maternity so that sufficient staff to ensure midwife-to-birth ratio is at the national average of 1:28.
- To review the current practice where women who were having a termination due to abnormalities were cared for on the delivery suite in rooms next to women delivering healthy babies and Gynaecology and obstetrics patients and women attending for these appointments shared the same waiting room.
- Monitor processes for patients who present with mental health needs are suitably risk assessed when admitted to the children and young people's service to ensure care and support provided meets their needs and that staff are competent to manage difficult behaviours, including restraint.
- Monitor staff training in mental health needs of patients and in the use of tracheostomy in the children and young people's service.
- A comprehensive clinical audit plan should be developed, completed and monitored in the children's and young people service. Policies which are out of date should be reviewed and revised.
- A dashboard should be developed in the children's and young people service to report on and monitor operational performance data each month. Business plans should be developed which consider accurate operational activity data and performance. Objectives should be clearly defined and supported with effective action plans.
- To review the provision of a face-to-face specialist palliative care service, aiming to achieve as Monday to Sunday service, including bank holidays.
- To review the data collected for patients so that the hospital can assess the number of referrals for patients with or without cancer.
- To review the collection of data in order to assess the percentage of patients who were discharged within 24 hours to their preferred location.
- To review the processes to in the mortuary so that medicines for coroner's inquests are recorded on receipt and transfer to pharmacy for disposal.
- To consider increasing the education and training provision in the SPCT in line with national guidance.
- To monitor the safety of patients who wait over 40 weeks for non-urgent outpatient appointments.

Summary of findings

- To review how clinic waiting times and clinic delays are appropriately displayed and communicated to waiting patients.
- To review facilities so that consultation rooms in all outpatient areas can accommodate wheelchair users when needed.
- To review and monitor all patients on waiting lists to ensure effective prioritisation systems are in place to identify and minimise patient harm.
- Review how the standard operating procedure for managing outpatient clinics cancelled within six weeks is implemented and embedded.

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

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

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	Inadequate	Overall, we rated the service as inadequate because: • There had not been sufficient improvement in areas of concern highlighted during our February 2016 inspection. This included risk assessments not being carried out in line with hospital policy and paediatric staffing levels were not always adequate. • There were not effective processes in place to ensure that all patients who self-presented to the ED were safe to wait up to two hours to see a clinician. The initial clinical assessment for patients who self-presented to the ED was not conducted in line with national reporting guidelines. • There were inadequate staffing levels to meet the needs of patients in ED, including children. Daily consultant cover did not meet national recommendations. • Staff did not always follow safeguarding processes and safeguarding training levels did not meet the hospital's target or national recommendations. Risks to patients had not been actioned. Only 37% of nursing staff and 29% of medical staff had completed safeguarding level three training at the time of the inspection. • There were a substantial number of delayed ambulance handovers. This meant that patients were not always receiving an initial clinical assessment in a timely manner and ambulance crews were not made available to respond to 999 calls. • The ED did not have adequate facilities or processes in place to manage patients who presented with mental health illness and were a significant risk to themselves and others. The children's waiting area did not provide adequate

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space for patients waiting to be seen and staff in the children's ED were not able to observe patients waiting at all times in line with guidance.

- There was not an effective cyclical audit programme to monitor the consistency of practice against evidence-based guidance. This meant that areas for improvement and opportunities for identifying best practice were not always identified.
- Outcomes from audits were worse than expected. Clear action plans were not consistently developed in response to conducting audits or monitored or reviewed regularly to ensure that objectives were being met. There was a lack of action to drive improvements following national audits over time.
- There were not effective processes in place to ensure that all staff had the correct skills, knowledge and experience to undertake all the duties they were tasked with, for example, competency frameworks in children's ED and streaming area were not routinely checked or monitored.
- The department was not consistently meeting national targets for service delivery but it had shown improvements in the last three months with performance better that the England average. From July 2016 to October 2016, the average performance against the target was 88%. The percentage of patients waiting between four and twelve hours after a decision had been made to admit was comparable to the England average.
- Services were not always delivered in a way that took into account the needs of different people, in relation to age, gender, religion and disabilities.
- There was a lack of capacity in the leadership team to consistently embed learning from incidents and audits throughout the ED to drive improvements. There had not been sufficient

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improvement in areas of concerns highlighted during our February 2016 inspection. There was a lack of clear focus and support in the ED leadership up to board level.

- The governance and risk management systems did not always operate effectively to support the delivery of safe patient care. Processes in place to measure key aspects of quality patient care, such as ambulance handovers, were not in place.
- There was not a holistic approach to the monitoring of safety and performance data, supported and informed by effective, ongoing clinical audits. Actions plans had not always been developed to address areas of risk or poor performance and those that were in place were not always effectively monitored.
- Risk identified during our inspection had not been recognised by the service. Risk registers were not effective and not reflective of the current risks in the ED.

However, we also found that:

- Staff were caring and compassionate. Feedback from patients was positive.
- All areas were visibly clean and were cleaned regularly. Medicines were generally managed appropriately.
- The department had developed a frailty service to manage patients with complex needs that could be cared for in the community.
- Local leaders in the ED were visible and approachable.

Medical care (including older people's care)

Requires improvement

Overall, we rated medical care as requires improvement. Three key questions, safe, effective and well led were rated as requires improvement and caring and responsive were rated as good. We found that:

- Care plans did not always reflect the needs of patients and deteriorating patients were not always managed effectively. Nurses had not always followed the escalation process for

high-risk patients by informing a doctor when a patient's NEWS score was raised or when the patient's oxygen saturation showed a downward trend.

- Patients were exposed to the risk of receiving inappropriate care and treatment due to poorly written and incomplete care plans. For some patients, there were no individualised care plans; in some cases, the same written care needs were simply copied to a new sheet and changing needs had not been reflected or incorporated.
- Patients' individual care records were not always written and managed in a way that kept patients safe. Patients' medical notes were mainly kept in lockable trolleys which were not locked when not in use and in some wards, they were kept on open shelves in the bays. This meant that confidential information was not always kept in accordance with the Data Protection Act 1998.
- There were not enough registrars and junior doctors to cover the medical wards out of hours, especially between 5pm to 9pm (Monday to Friday) and at weekends.
- Doctors told us there was no electronic handover system and no electronic list of priority patients to alert them to problems out of hours and at weekends in the medical wards. The hospital did not operate a multi-speciality hospital at night team. Working to seven day working in the service was variable.
- The coronary care unit had nurse staffing numbers that were below the recommended number stipulated by the British Cardiovascular Society.
- Entries on prescription charts had been cancelled without being signed and dated. Medicine reconciliations had not always been done. Patients had not always been assessed for needing prophylactic medication to combat venous thromboembolisms (VTEs).
- Outcomes for patients were variable. The hospital had produced poor results in two national audits it had recently participated in. The Sentinel Stroke National Audit Programme (SSNAP) audit showed a poor score of D and E in

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all four quarters of the reporting year. The hospital participated in the 2015 National Diabetes Inpatient Audit: it was worse for 13 out of 15 indicators than the England average.

- Discharges were sometimes delayed due to patients having to wait for ongoing care packages.
- Compliance with dementia awareness training was variable across wards
- Complaints were not always handled in a timely manner.
- Risks identified by the service were not being assessed, monitored and mitigated via an effective, comprehensive risk register. Risks we identified on inspection were not recognised by the service, including the failure to escalate deteriorating patients, poor junior doctor cover for medical wards, and the poor completion and storage of patients' records. We were therefore not assured staff at every level in the service had an effective understanding of all the risks to patient safety and were able to assess, mitigate and monitor all known risks.
- Not all staff were fully aware of the service's plans to remodel the beds in the service, which was designed to improve patient flow. Some staff described it as a 'stop, start' process with delays in the reconfiguration of beds and wards. Staff were not generally aware of the timescales for this reconfiguration.

However, we also found that:

- Staff treated patients with compassion, kindness, dignity and respect. Patients gave positive feedback about the care and service provided.
- Despite significant staffing pressures, generally patients' needs were met at the time of the inspection. Actual staffing levels were comparable to the planned levels for most of the wards we visited.
- Generally, the design, maintenance and use of facilities and premises met patients' needs. The maintenance and use of equipment kept people safe from avoidable harm. Appropriate infection control procedures were being followed.

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- Arrangements were in place to safeguard adults and children from abuse that reflected relevant legislation and local requirements. Overall, the service was just below the hospital target of 85% for statutory and mandatory training at 83%.
- Pain of individual patients were assessed and managed appropriately. Patients' nutritional and hydration needs were appropriately assessed and the food and fluid charts were well maintained.
- Staff generally had the right qualifications, skills, knowledge and experience to do their job. A multi-disciplinary team approach was evident across wards
- The service had an effective escalation procedure in use for supporting demand for beds.
- Staff understood and respected patients' personal, cultural, social and religious needs, and took these into account and services were generally planned and delivered in a way that took account of the needs of different patients. The dementia strategy was being implemented and appropriate care was provided for patients living with dementia.
- Patient flow and bed capacity to meet demand had been a significant pressure for the hospital for a number of months. Senior managers were in ongoing discussions with commissioners and stakeholders regarding the most appropriate ways of managing the DTOC position as the medical care beds being used were placing a significant pressure on the effective patient flow through the service.
- Leaders within the service, of all levels, were generally visible and approachable. Staff told us that the senior leadership team, including both senior management and lead clinicians and nurses, were generally visible and effective.
- Staff felt involved in the hospital's CARE values which brought staff together to discuss ways to improve services and provide quality care to patients. Staff felt supported and able to speak with the lead nurse if they had concerns.

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- There were a large number of volunteers from the local community working in various departments in the hospital.

Surgery

Requires improvement

We rated the service as good for effective, caring and well-led and requires improvement for safe and responsive. Overall, we rated the service as requires improvement because:

- The hospital had not provided data for referral to treatment time (RTT) for admitted performance for surgical services since November 2015. The service had a RTT recovery programme and was exceeding its trajectory of 77% by the end of November 2016. Private providers had been contracted to support the treatment to some of their patients.
- Nursing staffing was not appropriate on Ashton ward whereby registered nurses left the ward unattended during the night shift at times. We raised this as a concern with the hospital and they took immediate action to ensure a registered nurse was on this ward at all times.
- Infection control precautions were not always effective. We observed staff on Geddington and Deene B wards not decontaminating their hands after being in direct contact of care with patients. Clinical waste bins were conveyed through the maxillofacial service. These frequently leaked which meant there was a risk of infection control putting both staff and patients at risk. The breast pre-assessment clinic had fabric chairs and privacy curtains. The chairs and curtains had no date when last changed or cleaned which meant there could be a risk of cross infection due to inappropriate cleaning. Nursing staff did not adhere to the handling of food safely guidance. Theatre staff did not adhere to the hospital and national standards by wearing of cover gowns and footwear when leaving and entering the theatre area.
- The environment within the maxillofacial service area was cramped and not conducive to patients who were partially sighted, hard of hearing or disabled. They had limited to no access to the

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x-ray room due to the entrance being too small for a wheelchair. This contravened the Equality Act 2010. The service had a business plan in place for the relocation of this area.

- Medicines were not always stored or handled appropriately. Medicines were stored with sterile instruments, on open shelves within the maxillofacial service. Medicine clinical rooms (Geddington, Barnwell B and C, DASU and the surgical day case unit) had temperatures above the recommended 25º celsius which were detrimental to some drugs. We found topical medicines and liquids which had been used with no date of opening.
- Patient records on DASU and Geddington ward were left unattended during our visit. Also on Geddington ward, records were kept in an unsupervised, unlocked room.
- The environment of Barnwell wards B and C were found to be visibly dirty and very dusty. This was brought to the attention of senior staff and the hospital. During our unannounced visit on 24 October 2016, the ward had undergone a deep clean and it was visibly clean.
- There were mixed patient outcomes and not always an action plan to ensure improvements. Examples included the hip fracture audit and the bowel cancer audit. This had not been identified on the surgical and anaesthetist risk register as an area of concern.
- Reported complaints took an average of 69 days to investigate and close. This was not in line with the hospital's complaint policy.
- Staff had little awareness of the new CARE values introduced by the hospital.
- Routine audits and monitoring took place across the service. However, not all audits had actions or outcomes to improve performance. This had not been identified on the service's risk register.

However, we found that:

- Staff understood the importance of reporting incidents and had awareness of the duty of candour process. The team meeting minutes identified shared learning from incidents.

Summary of findings

- There were clear processes and procedures in place regarding the completion of the Five Steps to Safer Surgery checklist.
- Nursing handovers were well structured and comprehensive.
- Training levels met the recommended target set by the hospital and staff understood their roles and responsibilities around the Mental Capacity Act 2005 and had an awareness of the Deprivation of Liberty Safeguards. The appraisal rates were just above the hospital target at 86% for the service.
- Patients received care according to national guidelines such as the National Institute of Health and Care Excellence (NICE) and the Royal College of Surgeons.
- Medical and nursing staffing was appropriate across almost all the surgical wards and in theatres. There was effective multidisciplinary team working that delivered coordinated care to patients. Staff had access to patient related information when required.
- Patients were supported, treated with dignity and respect and were involved in planning their treatment and care. Feedback from patients and those who were close to them was positive about the way staff treated and cared for them.
- The cancer 62 day standards showed the hospital had met 92% of its urgent GP referrals.
- The 'butterfly' scheme was used to discreetly identify patients living with dementia. Staff had access to admiral nurses to provide support when required.
- There was a clear governance structure in place within the surgical clinical business unit to review areas such as; infection control, incidents, health and safety, estates and policies.
- There was a positive culture within the teams and staff felt supported by their managers. Staff confirmed the senior management team was visible, conducted daily walkabouts and often visited the ward and theatres to observe practices.

Critical care

Good

Overall, we rated the critical care service as good because:

Summary of findings

- There were systems in place to protect patients from harm and a good incident reporting culture.
- The department complied with the Department of Health's Health Building note HBN 04-02, which sets standards for critical care units.
- Effective infection control practices were in place throughout the unit and visitors were encouraged to take part in the prevention of infection.
- Safe numbers of staff cared for patients using evidence-based interventions.
- Staff at all levels had a good understanding of the need for consent and systems were in place to ensure compliance with the Deprivation of Liberty Safeguards.
- Patient's pain, nutrition and hydration was appropriately managed.
- Intensive Care National Audit and Research Centre data showed the intensive care unit to be in line with the England average for all areas except delayed discharges.
- Staff were compassionate and put patients at the centre of the work. They obtained consent prior to procedures and maintained patient privacy and dignity.
- Complaints were dealt with in a constructive and timely way, ensuring that patients or relatives were kept up to date with any actions resulting from their complaint.
- Staff had access to communication aids and translators when needed, giving patient the opportunity to make decisions about their care, and day to day tasks. There were very few complaints about the services and staff dealt with complaints appropriately.
- Dementia training and staff guidance was suitable and staff showed a good understanding of how to provide quality care for those living with dementia.
- There was good local leadership on the unit and staff reflected this in their conversation with us.

However, we also found that:

- There was a lack of sufficient pharmacy support within the department, leading to potentially avoidable medicine incidents.

- The critical care outreach team was not fully established to provide the necessary support and education to the rest of the hospital.
- There was no delirium screening process in place.

Maternity and gynaecology

Requires improvement

We rated the maternity and gynaecology service as requires improvement overall. We rated the service as requires improvement for safe, responsive and well-led. We rated the service as good for effective and caring. We found that:

- The service did not always have sufficient staff, of an appropriate skill mix, to enable the effective delivery of care and treatment. There were times the consultant obstetrician was not present on the labour ward as they would be covering obstetrics and gynaecology and undertaking elective caesarean section lists.
- The locally devised maternity dashboard data did not meet Royal College of Obstetricians and Gynaecologist Guidelines (RCOG) good practice No.7 Maternity dashboard, clinical performance and governance scorecard. Risk information regarding maternity was not all available on all risk documents seen, and as a result, we were not assured the service had oversight of all information to monitor the service.
- Rowan ward did not have sufficient security to minimise the risk of visitors accessing the ward without being challenged. The hospital did not have an abduction policy; it had a flowchart for staff to follow in an event of an abduction.
- Compliance with mandatory training did not meet the hospital target.
- Patient outcomes were variable: in the 2015 National Neonatal Audit Programme (NNAP), the hospital was below the NNAP standard for four of the five indicators. The caesarean section rate for 2015/16 was 30%, which was higher than the national average of 26.5%.
- The hospital had serious concerns around the accuracy and quality of its referral to treatment (RTT) data and reported position. The hospital had not met the set targets for RTT waiting times non-admitted, admitted and incomplete. The service was monitoring their RTT performance as

part of their improvement plan. Figures from October 2016, showed gynaecology was were performing below the national standard of patients being seen within 18 weeks. 76% of patients were being seen within 18 weeks, although below the national standard of 92%, the hospital was on track to achieve their trajectory target of 77% by the end of November 2016.

- There was no data for the hospital's performance on: 31 day wait for second or subsequent treatment, 31 day wait for second or subsequent treatment radiotherapy, 62 day wait for first treatment from consultant screening service referral : all cancers, maximum waiting time of 4 hours in A&E from arrival to admission, transfer or discharge.
- Gynaecology services were not always responsive to patient's needs for example; there were no side rooms on the gynaecology ward. This meant that women who were having a termination due to abnormalities were cared for on the delivery suite in rooms next to women delivering healthy babies.
- The maternity and gynaecology clinics ran concurrently. Gynaecology and obstetrics patients and women attending for these appointments shared the same waiting room. This meant that patients who may be having difficulty in conceiving or had experienced a miscarriage were sharing the same area with pregnant women and this was not sensitive to their needs.
- Lack of medical staffing resources to deliver the gynaecology clinic meant the service was breaching the referral to treatment times. Gynaecology was performing below the national standard of patients being seen within 18 weeks.
- The service had not met the trust's timescales for responding to complaints in the period August 2015 to July 2016, but following the introduction of a revised complaints' policy in July 2016, with longer timescales for a response, improvements

Summary of findings

had been made in responding to complaints with an average response timescale of 27 days (in the period April to September 2016). This was now in accordance with the trust's policy.

- There was limited evidence to demonstrate information about midwifery issues were taken to the board therefore, we were not confident the board had oversight and understanding of issues affecting maternity service. There was evidence not all risks were identified and placed on the risk register
- Whilst a new strategy for the service had been developed and implemented, it was not yet fully understood by all staff in the service. We were not assured progress against delivering the strategy was regularly monitored and reviewed.

However, we also found that:

- There was good leadership at a local level, wards and units were well managed. Local leaders demonstrated they understood the challenges to good quality care and had identified the actions needed to address them.
- Women and those close to them were positive about the care and treatment they had received.
- The service provided a vulnerable midwifery team. A dedicated bereavement midwife led on bereavement services for women who had experienced pregnancy loss.
- Individual care records were written in a way that kept people safe from avoidable harm.
- The service used the World Health Organization (WHO) surgical safety checklists in maternity and gynaecological surgery. The overall compliance for the checklist was 100% between April 2016 and June 2016.
- The hospital had received the United Nations Children's Fund (UNICEF) Baby Friendly Initiative full accreditation for its maternity department.

Services for children and young people

Inadequate

Overall, we rated children and young people's services as inadequate because:

Summary of findings

- The environment was not safe and secure, particularly for patients who may be at risk of self-harm or suicide. The hospital took actions to address this once we had raised it as an urgent concern.
- Assessments were not always made for patients who required one to one care and this care was provided at times by the patient's parent or carer, rather than trained professionals.
- Safeguarding children and adult policies were not effective and not all staff had completed the required level of children's safeguarding training. Relevant safeguarding checks were not always recorded.
- Nursing staff had not completed training in Advanced Paediatric Life Support and only a small number had completed European Life Support. Daily shifts on the paediatric ward did not have the support from a nurse with the appropriate level of training. Nursing staff had not received training in mental health needs of patients. Nursing staff had not been assessed for the competence in use of tracheostomy
- Staffing levels on Skylark ward and in the neonatal intensive care unit levels did not always meet patients' needs. The paediatric ward did not use an acuity tool to inform staffing levels and did not always meet staffing levels recommended in accordance with national guidance. There was inadequate medical staffing cover.
- The paediatric outpatient department was not always staffed by registered children's nurses.
- Incidents were not always reported on a timely basis and some had not been investigated within a reasonable period. Lessons learned from incidents were not always shared so that improvements were not made. Ligature audits had not been undertaken.
- Patient's care was not consistently planned and delivered in line with evidence based guidance. Guidance had not been developed for all care requirements and some did not reflect the most up to date guidance. Audits were not used to effectively monitor the standard of care provided.

Summary of findings

- The clinical audit plan was not suitable to ensure audits took place to monitor care provided against expected standards. Procedures and guidance available to staff was not always up-to date. Action plans following some audits lacked detail and were not monitored and it was unclear whether they had been implemented.
- Patient records were not always available on the ward and there was high usage of temporary notes. GP discharge letters were not sent out on a timely basis.
- Service planning had not used evidence based data and the needs of the local population had not always been considered. Patients and stakeholders were not involved in service development. Formal transition arrangements were not in place for all specialities when patients transferred from paediatric to adult services.
- Patients admitted to the ward with mental health needs or who required a musculoskeletal survey had long delays in waiting to be assessed and discharged.
- Some patients also experienced long delays waiting for treatment, specifically for urology, maxillofacial and ear, nose and throat (ENT). In some cases, waits were in excess of 52 weeks.
- There was a significantly high conversion rate between patients who attended the emergency department and those admitted to the paediatric ward.
- There was limited support from a psychologist for patients diagnosed with long-term conditions. There was limited support for patients with a learning disability. Communication tools for patients who were unable to communicate verbally lacked detail.
- Complaints were not responded to on a timely basis or in line with policy. There was limited learning from complaints.
- Significant risks identified on inspection had not been recognised, assessed or mitigated by the service. There was not a holistic understanding throughout all staff teams of the risks in the

Summary of findings

service. Leaders did not always recognise the significance of risks throughout the service or weaknesses identified as part of audits or reviews.

- The service did not have a clear vision. Objectives in the business plan had been set but were generic and not specific to the service and were not supported by clearly defined actions.
- There were delays in investigating and closing incidents. The clinical audit plan lacked focus and failed to ensure the provision of care was adequately monitored. Complaints management systems were not effective.
- There was limited patient involvement to provide feedback to the service

However, we also found that:

- Good standards of cleanliness and hygiene were maintained.
- The paediatric department, including NICU, had adequate equipment to meet the needs of children and young people, which was maintained and portable appliances had been subject to relevant safety tests. Clinical waste was appropriately stored and disposed of.
- There were suitable arrangements in place for management of medicines, which included the safe ordering, prescribing, dispensing, recording, handling and storage of medicines.
- Most patient records contained accurate information, were legible and up to date; records were stored securely.
- Assessments were made of patient's pain levels and generally arrangements made to ensure their pain was managed effectively. Patients' nutritional and hydration needs were met during their stay in hospital.
- Most staff within the clinical business unit had received an appraisal and the hospital target of 85% had been met. All medical and nursing professionals had an up to date registration.
- Staff understood the relevant consent and decision making requirements of legislation and guidance and consent was obtained in line with legislation.

Summary of findings

- Staff interactions with patients were positive and patients were treated with dignity and respect. Patients told us that staff were helpful and that they explained things to them in a manner they could understand and that their relatives or carers were involved.
- There was a play specialist who provided additional support for children on the paediatric ward who required support during their admission.
- The length of stay was in line with the national average.
- There were facilities to engage and occupy young children and teenagers admitted to the ward. There were overnight facilities for parents to stay on both the paediatric ward and NICU.
- Local leaders were visible and approachable. The service was supportive of staff and care provided was patient focussed. Staff felt well supported and listened to, there was a strong culture of putting the patient first.

End of life care

Good

We rated the service as good for the safe, caring, responsive and the well-led key questions and requires improvement for effective. We found that:

- There were systems in place to protect patients from harm and a good incident reporting culture.
- Medicines were provided in line with national guidance. We saw good practice in prescribing anticipatory medicines for patients who were at the end of life.
- The hospital had a replacement for the Liverpool Care Pathway (LCP) called the 'Guidance to implement care for the dying patient, and their family and friends'. The document was embedded in practice on the wards we visited.
- Do not attempt cardio-pulmonary resuscitation (DNACPR) records we reviewed were signed and dated by appropriate senior medical staff. There were clear documented reasons for the decisions recorded.
- Patients were happy with the care they received and felt involved in their care planning at the end

of their life. Nurses, doctors and the specialist palliative care team (SPC) demonstrated compassionate patient centred care throughout the inspection.

- Relatives rated end of life care provided by nurses and doctors to their relative at the end of life, as 'excellent to good'.
- Sixty volunteers supported the chaplaincy service through a hospital wide patient-visiting programme, which included support to patients at the end of life.
- Care and treatment was coordinated with other services and other providers. The specialist palliative care team (SPCT) had good working relationships with discharge services and their community colleagues. This ensured that when patients were discharged their care was coordinated.
- All adult wards had end of life care champions who were trained in specialist end of life care and were a direct link to the SPCT.
- The SPCT saw 100% of patients within 24 hours of referral.
- The hospital had an executive and a non-executive director on the hospital board with a responsibility for end of life care.
- There was a clear vision and strategy for end of life care supported by an outcome based work plan, led by the transformational lead nurse and medical lead for end of life care.
- Risks regarding the management of bariatric patients in the mortuary were identified on the support services risk register.
- Risks associated with end of life care were recorded within individual clinical business units (CBU) and recorded on the corporate hospital risk register. Staff had taken action to mitigate against risks.

However, we also found that:

- The hospital performed worse than the England average for the five clinical outcomes in the End of Life Care Audit: Dying in Hospital (NCDAH) 2014/15, published 2016.

Summary of findings

- The hospital had scored particularly poorly for the multidisciplinary recognition of patients dying, communication regarding plans of care, and meeting the spirituality and religious needs of patients.
- The hospital was not collecting information on the percentage of patients discharged to their preferred place of death within 24 hours.
- The service did not provide face-to-face access to specialist palliative care for at least 9am Monday to 5pm to Sunday. This did not meet the recommendations from the National Institute for Health and Care Excellence (NICE) guidelines for end of life care for adults.
- There was no practice educator post in the SPCT in line with national guidance.

Outpatients and diagnostic imaging

Inadequate

Overall, we rated the outpatients and diagnostic imaging services as inadequate. It was rated as inadequate for safe, responsive and well led, and good for caring. We inspected but we do not rate effectiveness for outpatients because CQC do not currently have the methodology to rate the effective key question. We found that:

- Whilst the service had taken action to manage the delays in image reporting and the waiting list for outpatient appointments, comprehensive risk assessments were not always carried out for people who were waiting to use services in outpatients. Whilst the service had a harm review process in place, not all patients waiting over 40 weeks had been reviewed at the time of the inspection.
- Radiologists employed by the hospital were not up-to-date on basic life support training (BLS).
- There were not always effective systems in place regarding the storage and handling of medicines. Contrast media was not stored securely and could be accessed by unauthorised staff and patients.
- There were not always reliable systems in place to protect patients and staff from the risks of radiation exposure. This had been rectified by our unannounced inspection.
- Not all staff treating children in outpatient clinics at both the phlebotomy department in Kettering

general hospital and Nene Park outpatient clinic were able to evidence that they had paediatric competencies in line with national guidance. The trust took actions to address this once we raised it as a risk.

- Arrangements were in not always in place to safeguard adults and children from abuse that reflected relevant legislation and local requirements.
- Patients were unable to access the majority of services in a timely way for initial assessments, diagnoses or treatment. At the time of inspection in October 2016, the service had 18,816 patients on the waiting list for new appointments in outpatient services. Trust data showed that 413 patients had been waiting over 52 weeks; however, this data had not been validated so we could not be assured of how many patients waited for long periods of time. The services' own figures from October 2016 showed that 69% of patients were seen within 18 weeks (for incomplete pathways) against the national standard of 92%.
- There were delays in reporting diagnostic images. There were 11,733 images awaiting a radiology report. These were was classified as non- urgent images and scans. The service was meeting performance standards for urgent images and scans.
- The "did not attend" (DNA) rate remained above the England average and at the time of inspection was 10%.
- The hospital had a number of clinic cancellations. This was 3% of clinics in October 2016.
- Services were not always provided in an environment that met people's needs.
- Patients told us that it was difficult to contact the department to book, rearrange or cancel appointments.
- The service had not met the trust's timescales for responding to complaints in the period August 2015 to July 2016, but following the introduction of a revised complaints' policy in July 2016, with

Summary of findings

longer timescales for a response, improvements had been made in responding to complaints with an average response timescale of 26 days (in the period April to September 2016).

- There was a lack of an effective governance framework to support the delivery of quality patient care. There was not a holistic understanding and management of risks in the service. The risks the service had identified were not always managed appropriately.

However, we also found that:

- Care and treatment was explained in ways that patients and relatives could understand and patients were encouraged to make their own decisions.
- Staff generally understood their roles and the need to raise concerns using the electronic incident reporting system.
- Cleanliness and infection control procedures were adhered to and potential risks to the service were anticipated and responsive actions planned.
- The hospital had an action plan for reducing the waiting list for outpatient services and was working ahead of its trajectory. Data quality issues were being addressed.
- Some specialities had introduced one-stop clinics, which reduced the number of appointments patients had to attend and facilitated timely access to care.
- The hospital had taken action to minimise the delays in urgent diagnostics and imaging reporting by outsourcing their radiology reporting.

Kettering General Hospital

Detailed findings

Services we looked at

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

Detailed findings

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Background to Kettering General Hospital

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

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

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

This was the second comprehensive inspection of the hospital the first taking place in September 2014 when it was rated as requires improvement overall.

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

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

Our inspection team

Our inspection team was led by:

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

Head of Hospital Inspections: Bernadette Hanney, Care Quality Commission

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

Detailed findings

How we carried out this inspection

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

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

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

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

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

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

Facts and data about Kettering General Hospital

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

The hospital serves a population of around 300,000.

In 2015/16 the hospital had:

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

Our ratings for this hospital

Our ratings for this hospital are:

Detailed findings

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

Notes

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

Urgent and emergency services

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

Information about the service

The Emergency Department (ED) at Kettering General Hospital provides a 24 hour, seven day a week service for a population of approximately 320,000 people across North Northamptonshire and South Leicestershire.

The main ED consists of 13 bays for patients within majors, six treatment areas for patients within minors, resuscitation spaces for up to five patients and six areas in the Emergency Decisions Unit (EDU).

The department has its own children's ED with a separate waiting area, three cubicles, and an assessment area.

Patients present to the department either by walking into the reception area or arriving by ambulance via a dedicated ambulance-only entrance. Patients who transport themselves to the department report to the reception area where they are assessed and streamed to either minors, majors or the externally run GP service (GP service was available 10am to 10pm, seven days a week).

From April 2015 to March 2016, there were 82,986 ED attendances: 17,077 of these attendances were children aged 0 to17 years.

During this inspection, we conducted an announced inspection 12 to 14 October 2016 and an unannounced inspection on 24 October 2016. We spoke with 42 members of staff, 16 patients and four ambulance crews and we reviewed 48 sets of patient's records. We did not inspect the GP service during our inspection, as this was an external provider and as such, would form a part of a separate inspection.

Summary of findings

Overall, we rated the service as inadequate because:

- There had not been sufficient improvement in areas of concern highlighted during our February 2016 inspection. This included risk assessments not being carried out in line with hospital policy and paediatric staffing levels were not always adequate.
- Safety was not a sufficient priority. Opportunities to prevent or minimise harm were missed. Risk assessments were not being carried out in line with hospital policy and paediatric staffing levels were not always adequate.
- There were not effective processes in place to ensure that all patients who self-presented to the ED were safe to wait up to two hours to see a clinician. The initial clinical assessment for patients who self-presented to the ED was not conducted in line with national reporting guidelines.
- There were inadequate staffing levels to meet the needs of patients in ED, including children. Daily consultant cover did not meet national recommendations.
- There was insufficient attention to safeguarding children and adults. Staff did not always follow safeguarding processes and safeguarding training levels did not meet the hospital's target or national recommendations. Risks to patients had not been actioned. Only 37% of nursing staff and 29% of medical staff had completed safeguarding level three training at the time of the inspection.

Urgent and emergency services

- There were a substantial number of delayed ambulance handovers. This meant that patients were not always receiving an initial clinical assessment in a timely manner and ambulance crews were not made available to respond to 999 calls. From April 2016 to September 2016, there were 15,604 ambulance handovers of over 15 minutes. This included 2,202 handovers of over 30 mins and 323 'black breaches'.
- The dedicated room for patients who had mental health illness and posed risks to themselves and others was not in line with Royal College of Emergency Medicine (RCEM, 2013) guidelines. The facilities for these patients were not safe. The children's waiting area did not provide adequate space for patients waiting to be seen and staff in the children's ED were not able to observe patients waiting at all times in line with guidance.
- There were inadequate process in place to manage risks with anticipated future events or emergency situations. Not all staff knew where the emergency incident store was located.
- There was not an effective cyclical audit programme to monitor the consistency of practice against evidence-based guidance. This meant that areas for improvement and opportunities for identifying best practice were not always identified.
- Outcomes from audits were worse than expected. Clear action plans were not consistently developed in response to conducting audits or monitored or reviewed regularly to ensure that objectives were being met. There was a lack of action to drive improvements following national audits over time.
- There were not effective processes in place to ensure that all staff had the correct skills, knowledge and experience to undertake all the duties they were tasked with, for example, competency frameworks in children's ED and streaming area were not routinely checked or monitored.
- The department was not consistently meeting national targets for service delivery but it had shown improvements in the last three months with performance better that the England average. From July 2016 to October 2016, the average performance against the target was 88%. The percentage of patients waiting between four and twelve hours after a decision had been made to admit was comparable to than the England average.
- Services were not always delivered in a way that took into account the needs of different people, in relation to age, gender, religion and disabilities.
- There was a lack of capacity in the leadership team to consistently embed learning from incidents and audits throughout the ED to drive improvements. There had not been sufficient improvement in areas of concerns highlighted during our February 2016 inspection. There was a lack of clear focus and support in the ED leadership up to board level. Quality and safety were not a top priority.
- The governance and risk management systems did not always operate effectively to support the delivery of safe patient care. Information used to monitor performance or to make decisions was unreliable and inaccurate.
- Processes in place to measure key aspects of quality patient care, such as ambulance handovers, were not in place. There was a lack of understanding in the leadership of the definition of 'black breaches' for ambulance handover times and effective time to initial clinical assessments for patients.
- There was not an effective system for identifying, capturing and managing risks at team, directorate and organisation level. There was not a holistic approach to the monitoring of safety and performance data, supported and informed by effective, ongoing clinical audits. Actions plans had not always been developed to address areas of risk or poor performance and those that were in place were not always effectively monitored.
- Significant issues that threatened the delivery of safe and effective care were not identified. Risk identified during our inspection had not been recognised by the service. Actions had not been taken to manage these risks. Risk registers were inadequate and not reflective of the current risks in the ED.
- Some staff said there was an emphasis on 'breach avoidance' to meet targets and that they were often required to move patients to an inappropriate area to meet a performance target or avoid a 12 hour

Urgent and emergency services

breach in ED. Some staff told us that they sometimes felt that there was not a whole hospital approach to maintaining access and flow through the ED and if targets were not achieved it was an 'ED' problem.

However, we also found that:

- Staff were caring and compassionate. Feedback from patients was positive.
- All areas seen were visibly clean and were cleaned regularly. Medicines were generally managed appropriately.
- The department had developed a frailty service to manage patients with complex needs that could be cared for in the community.
- Local leaders in the ED were visible and approachable.

Are urgent and emergency services safe?

Inadequate

Overall, we rated the service as inadequate for safety because:

- Safety was not a sufficient priority. Opportunities to prevent or minimise harm were missed. Risk assessments were not being carried out in line with hospital policy and paediatric staffing levels were not always adequate.
- Streaming and triaging process were not effective to ensure that all patients who self-presented to the ED were safe to wait up to two hours to see a clinician. The initial clinical assessment for patients who self-presented to the ED was not conducted in line with national reporting guidelines. Some poorly patients were not seen in a timely way.
- There was no effective process in place to ensure that all children received an initial clinical assessment (including pain score) within 15 minutes.
- There were inadequate staffing levels to meet the needs of patients in ED, including children. The children's ED was left unattended with children present.
- There was insufficient attention to safeguarding children and adults. Staff did not always follow safeguarding processes and safeguarding training levels did not meet the hospital's target or national recommendations. Risks to patients had not been actioned. Only 37% of nursing staff and 29% of medical staff had completed children's safeguarding level three training at the time of the inspection.
- There was little evidence of learning from events or action taken to improve safety. Learning from incidents had not been used to drive improvements in safety.
- There was a substantial number of delayed ambulance handovers. This meant that patients were not always receiving an initial clinical assessment in a timely manner and ambulance crews were not made available to respond to 999 calls. From April 2016 to September 2016, there were 15,604 ambulance handovers of over 15 minutes. This included 2,202 handovers of over 30 mins and 323 'black breaches'.

- The dedicated room for patients who had mental health illness and posed risks to themselves and others was not in line with Royal College of Emergency Medicine (RCEM, 2013) guidelines. The facilities for these patients were not safe.
- There were inadequate process in place to manage risks with anticipated future events or emergency situations. Not all staff knew where the emergency incident store was located.

However, we also found that:

- Medicines were stored securely and in line with hospital policy and statutory requirements for controlled drugs.
- Staff followed the hospital's infection control procedures.

Incidents

- The emergency department (ED) had systems in place to monitor an appropriate range of safety information. There was a monthly dashboard that was used to set the targets for safety performance and nurse sensitive indicators such as compliance with infection control protocols and care associated risk assessments. The dashboard also included numbers of incidents and complaints, which was discussed at governance meetings.
- The hospital had developed an on-going urgent care improvement plan in December 2015 to improve aspects of safety and performance that was monitored, reviewed and reported to the hospital's board.
- Staff told us they aware of their responsibility to report incidents both internally and externally and used the hospital's electronic reporting system.
- Staff understood the importance of recording incidents to help improve performance and patient safety. Some staff told us that they were not able to complete them in a timely manner due to workload pressures; however, they would complete them retrospectively and reference the reason for delay in the incident. We saw evidence of this during our inspection.
- Staff told us they always received acknowledgement of incidents reported; however, they did not always receive feedback regarding incidents. We spoke with two members of staff who told us that they had not received feedback after reporting incidents.
- There were no never events reported for this service from September 2015 to August 2016. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- There was one serious incident reported to the Strategic Executive (STEIS) from September 2015 to August 2016: this was described as a delay in treatment for a patient with a traumatic injury. The incident was under investigation at the time of our inspection. The hospital's policy was in line with the Serious Incident Framework 2015, which states that all serious incidents should be investigated to identify opportunities for learning and implement actions to minimise the risk of the incident re-occurring.
- The hospital had a comprehensive incident policy that described how incidents were graded. There were five levels of incidents grading, which was in severity ranging from 'no harm' to 'catastrophic/death'.
- From September 2015 to August 2016, there were 869 incidents reported to the National Reporting and Learning System (NRLS) that related to the ED. Of these incidents, two were related to deaths and there was no identified learning points from these. Four had been categorised as severe, two incidents had been categorised as physical abuse against staff, 21 moderate, 110 low harm and all others were categorised as 'no harm'.
- Themes of incidents were discussed at monthly governance meetings. For example, minutes from the meeting held in March 2016 showed that there had been a high number of patient falls reported and a discussion had taken place regarding whether or not these had been avoidable. A review of the data showed that falls' risks assessments had been completed where appropriate and individual feedback had been given to staff.
- The ED formed a part of the urgent care division and we saw that through a variety of departmental and divisional meetings, daily briefings and departmental newsletters, information regarding incidents was distributed at all levels in the ED. For example, we observed senior nursing staff discuss incidents at a daily shift handover for all staff and the senior ED managers attended hospital wide governance meetings where incidents were discussed, which was then disseminated at local departmental meetings. However, we were not

assured that learning from incidents was embedded. Staff that we spoke with did not describe any improvements or specific learning from incidents. For example, the May 2016 staff newsletter had a 'learning from incidents' section which described an incident where a child's observations had not been scored appropriately using the paediatric early warning system (PEWS – this is a chart used to identify and escalate deterioration in a child's condition) and the child later deteriorated on the ward and made a full recovery. One of the learning actions was that children should not be waiting in the main waiting room with adults and that PEWS scores must be documented. During our inspection, we saw children waiting in the main waiting area and two out of the 12 children's records we reviewed had no PEWS score documented. Staff that we spoke with were not aware of the incident or associated learning. Staff told us that they had received training on using PEWS.

- The mortality and morbidity rates for the hospital were discussed formally at multi-disciplinary meetings. We saw that consultants from ED attended these meetings and that deaths that occurred within the urgent care division were reviewed at senior ED managers' meetings. Nursing staff told us that they were invited to attend the hospital wide mortality and morbidity meetings, however, they were not always given time to attend. There was no evidence that actions were taken as a result of learning from these meetings. For example, minutes from the meeting held in August 2016 showed that for two incidents the national early warning system (NEWS) escalation processes had not been followed for deteriorating adult patients. For one of those incidents, the sepsis pathway had not been completed in line with the hospital's policy. The learning points recorded from the meeting included the fact that escalation scores were not being acted on and observations not conducted in line with protocols. During our inspection, we saw three instances where escalation scores had not been acted upon in line with the hospital policy and we escalated this to senior staff and appropriate actions were taken. There was no action plan in place to address the issue, the ED quality dashboard showed that from April 2016 to June 2016 an average of 90% of NEWS scores had been calculated correctly against a target of 100%.
- From November 2014, NHS providers were required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and reasonable support to the person.
- Staff at all levels were aware of the duty of candour regulation and we saw information relating to healthcare professionals' statutory requirements was published in the ED departmental newsletter.

Cleanliness, infection control and hygiene

- Standards of cleanliness and hygiene were generally well maintained. Reliable systems were in place to prevent and protect people from a healthcare associated infection in line with National Institute of Health Care Excellence guidelines (NICE QS61, 2014).
- The ED was visibly clean and we saw domestic staff cleaning areas throughout the day and recorded the date and time on cleaning schedules in the areas of ED.
- There were weekly and monthly infection prevention and control (IPC) audits conducted for all areas in ED. These included environmental audits, hand hygiene compliance, cannula management and insertions of vascular devices such as central lines to minimise the risk of health care associated infections (HCAIs). We saw that from January 2016 to August 2016, the compliance with hand hygiene protocols in ED was an average of 98%, which was above the hospital target of 95%. All months showed 100% compliance, except for April 2016 which was 80%.
- We saw evidence that poor compliance with IPC procedures was addressed both formally and informally. For example, we saw senior nursing staff reminding doctors and nurses to use personal protective equipment such as aprons and gloves. We also saw that consistent poor performance was highlighted through incident reporting and appropriate actions taken when required.
- From April 2015 to July 2016, there were no cases of hospital acquired MRSA, MSSA or C. Difficile reported for the ED.
- The ED had a separate room next to the resuscitation area that could be utilised for patients requiring

isolation. Staff were able to describe the procedure for use and provided specific examples of when they would use it including when patients had suspected measles or chicken pox.

- We saw that cleaning equipment such as coloured mops and buckets were available and stored correctly. Cleaning chemicals all had the appropriate instructions for storage and usage in line with Control of Substances Hazardous to Health national guidelines.
- Hand hygiene posters were on display next to all sinks to remind staff of the correct procedure for hand washing.
- Hand sanitising gel dispensers were available in corridors, waiting areas and clinical rooms. Staff were observed using hand sanitisers and personal protective equipment as appropriate. We did find that there were not any hand sanitiser units directly by the entrance to the majors' area.
- Personal protective equipment was available for staff (including gloves and aprons). We observed these being used appropriately to aid effective infection control.
- During our inspection, we observed that disposable curtains did not display the date they were installed or changed. IPC guidelines recommended that disposable curtains were changed twice a year or when they become soiled or contaminated. We highlighted this to the lead nurse during our announced inspection. During our unannounced inspection, all disposable curtains had been checked and dated.
- We observed that most nursing and medical staff observed the hospital's 'arms bare below the elbow' policy. However, we did observe three separate occasions where medical staff did not adhere to the policy and wore wristwatches while treating patients. Hand hygiene audits for the service showed 100% compliance in July 2016.

Environment and equipment

- Generally, the design, maintenance and use of facilities and premises did not meet all patients' safety needs. The maintenance and use of equipment generally kept people safe from avoidable harm. However, not all risks had been identified by the service and actioned.
- The ED did not meet current national guidance for compliance in facilities for accident and emergency departments (HBN 15-01: Accident and Emergency Departments, 2013). The majors' area was a temporary structure which was designed for two years use and there were challenges with access and flow through the department due to limited space. The trust told us that he majors' area was a temporary structure which was designed for two years' use. It had been raised in response to a growing demand for services within the ED. The trust board was currently considering a permanent structure as part of their five year plan.
- The temporary majors' area was accessed from the main ambulance streaming area via a ramp. Staff were required to push trolleys up the ramp and manage them safely on the way down. There was a risk assessment carried out for the area which highlighted the risk to staff and patients using the ramp. For staff, the main risk was the physical aspect of pushing the trolley up and the potential to lose control of the trolley on the way down. To mitigate this risk, the department had two electrical bed pushers; however, some staff told us that these were not always available as they were also used by the porter.
- We were not assured that adults or children presenting to ED with mental health conditions, who were at risk to themselves or others were being cared for in a safe or appropriate environment. The ED had no designated room for patients presenting with mental health conditions in line with Royal College of Emergency Medicine (RCEM) guidelines. The mental health risk assessment tool in use at the time of our inspection did not take into account all environmental and physical risks. During our inspection, we saw the notes from one patient who had an acute mental health episode; however, there was no mental health risk assessment in the patient's records and no description of the patient. From August 2015 to July 2016, there were two reported incidents of patients presenting with mental health illness and at risk of deliberate self-harm who had absconded from the department without staff knowing; on both occasions, other patients in the department had informed staff.
- During our announced inspection, the hospital was in the process of developing a dedicated mental health room that was due to meet RCEM guidelines in terms of the environment. We inspected the finished room during our unannounced inspection and found that it was not compliant with guidance. There were ligature points to the ceiling and furniture, moveable furniture with sharp edges, objects such as a bin that could be used as a missile and a lack of security and visibility to observe patients. We highlighted our concerns to the

hospital who immediately carried out a further risk assessment of the new room and confirmed that they still had improvements to make and planned for this to be completed by 4 November 2016. Following our escalation of this risk that the service had not fully recognised, the hospital provided us with updated guidance and risk assessments for all patients presenting with mental health conditions. This included environmental hazards checklist and clear flow chart that described the actions required by staff and level of care required for individual patients based on the risk assessment score.

- Space in the reception area was limited, with a lack of seating, and at peak periods, patients sometimes had to stand queueing, whilst waiting to be booked in, outside the main door to ED, on one occasion during our inspection we counted 20 people waiting in the queue. This meant that patients could be exposed to the elements of the weather and nursing and administrative staff were not able to see patients who were waiting to book in or readily identify if a patient waiting to book in was deteriorating. During our inspection, we did observe nursing staff were sent out to check on the queues.
- The children's ED was open 24 hours a day and accessed with a swipe card, which was installed after we highlighted the issue with security during our February 2016 inspection.
- There was a small children's waiting area in the main reception area that served both outpatients and ED patients. Younger adults who self-presented or children who were with their parents were seen at the main reception and sent to the main waiting area until they were called through to the children's ED. This was not in line with national guidelines 'Standards for children and young people in emergency care settings' Royal College of Paediatric Child Health (RCPCH, 2012) that recommend that children should be provided with waiting areas that are audio-visually separated from the potential stress caused by adult patients.
- The waiting area in children's ED had limited space and we observed parents standing and waiting with their children. The dedicated children's waiting area was not always observed by nursing staff which was not in line with national guidance 'Standards for emergency care settings for children and young people, 2012' which recommends that nursing staff should be able to see patients at all times to identify a deteriorating patient.
- During our inspection, we checked the resuscitation trolleys in all areas of the ED. The resuscitation equipment trolleys for adults and children were fully equipped, all equipment had been correctly stored and drugs and consumables were in date. However, we found that daily checks for resuscitation equipment was not always recorded on specific checklists in line with hospital policy. For example, in children's ED we saw that in September 2016, 11 out of 30 days had documented evidence of daily checks in line with the hospital's policy. We escalated this as a concern to senior staff and we were told that sometimes this information was recorded in the nursing daily communications book that was used at nursing handovers; however, this was not in line with protocol. The department had developed an action plan in February 2016, following our previous inspection, to ensure that the resuscitation equipment checks were conducted and that compliance with the protocol was 100%. This included the introduction of a daily checklist, weekly spot check and communicating the process to all relevant staff. After our inspection, we asked the hospital for an update on their action plan. Staff told us that they were still not achieving 100% compliance and had updated their process in November 2016 to allow the nurse in charge to have clearer oversight of the checks across the department.
- The systems and processes in place to ensure that equipment in ED was maintained were not effective. There were on-going issues since July 2016 within the IT system hospital wide, which meant that equipment due to be serviced was potentially not always identified. The electronic monthly report that detailed equipment that was due for service was not generated automatically due to a technical fault. At the time of our inspection, the data showed that a number of items had not received a service at the appropriate time; however, the staff told us that this was not accurate due to the IT issues. The hospital had put in a number of actions to mitigate the risk of equipment being used that had not been appropriately serviced. This included seeking further technical advice, reminding staff to check service dates before use and advising departmental leads to conduct random audit of devices. We saw no evidence during our inspection that these audits were conducted in ED at the time of the inspection.
- We checked equipment in the children's and adults ED and found that most equipment had been serviced and

had appropriate electrical equipment testing. However, we also found several items that were past their date for servicing. This included four wall suction units in the resuscitation area and a vital signs monitor (which was immediately removed from the department). In children's ED, we found a baby weighing machine (used for calculating medication doses) which was due for service May 2016, a tympanic thermometer and an ophthalmoscope which were out of date for service. We highlighted our concerns to the lead nurse and all equipment was immediately checked and replaced where necessary.

- The ED had an arrangement with another hospital and the local ambulance trust to transport all major paediatric trauma patients to another facility. However, some children with trauma may still attend the ED. During our inspection, we found that there were no paediatric chest drains and no stabilising collars for children over three years. Staff in the department could not locate the equipment, but thought that it was there. We asked senior staff about the equipment and after our inspection, we were told the chest drains were found in the department and collars had been ordered.
- There were arrangements in place to meet the Control of Substances Hazardous to Health Regulations 2002 (COSHH). COSHH is the legislation that requires employers to control substances which are hazardous to health.
- The arrangements for managing waste and clinical specimens were appropriate. This included the classification, segregation, storage, labelling, handling and, where appropriate, treatment and disposal of waste.
- There were clear guidelines for staff about how to respond to a sharps injury (needles and sharp instruments). This complied with the Safe Sharps Act 2013.
- Oxygen cylinders were stored appropriately in locked cupboards.

Medicines

- Generally, there were effective systems in place regarding the storage and handling of medicines.
- The hospital had a comprehensive medicines management policy and auditing process, which staff described to us during our inspection.
- Medicines were stored securely in line with hospital medicines' management policy. Fridge and room temperatures were regularly checked and temperatures recorded. Staff described what actions would be taken if medicines were stored at the incorrect temperature.
- Controlled drugs (CDs) were stored securely in designated areas with swipe or keypad access for authorised personnel. The department had recently worked with the pharmacy team and installed new CD cupboards that were accessed with electronic keys that digitally recorded the details of the individual staff member who used them. The nurse in charge of each area and the lead nurse held the keys.
- Staff knew how to report a medical incident and gave examples of when they would do this. We saw that incidents relating to medicines were communicated to staff through briefing newsletters and emails. A September 2016 'Pharmacy Matters' bulletin was displayed on a staff noticeboard which provided updated information on specific medicine issues from pharmacy.
- Nursing staff were aware of Nursing and Midwifery Council (NMC) standards for administration of controlled drugs and we saw that controlled drug records were completed appropriately.
- We reviewed 33 patients' records and found that any known allergies or sensitivities to medications had not been clearly documented in six of the patients' records and prescription charts to minimise the risk of patients being administered an incorrect medicine.
- Not all records we viewed were complete, and provided an account of medicines used and prescribed. We found two prescription charts where medicines such as antibiotics and analgesia had been prescribed but there was no signature or time stated for administration. This meant that there was not always an accurate record that demonstrated patients were always given medicines when necessary.
- Staff were aware of the hospital's local microbiology protocols for the administration of antibiotics and were able to access them through the hospital's internal website.
- Advanced clinical practitioners were independent prescribers and some senior nursing staff, such as emergency nurse practitioners (ENPs), were able to

administer medications using patient group directions (PGDs). These directions allowed authorised staff to give medicines to people in certain circumstances without the need for a prescription.

Records

- Patients' individual care records were not always written and managed in a way that kept patients safe. Records seen were not always accurate, complete, legible, and up to date. Patient records were not always maintained in accordance with hospital policy.
- Records were a mixture of paper based and electronic records. When patients initially attended the ED, a paper record was generated for use within the department. Requests for tests and diagnostics were made via the electronic system.
- We found that paper records were generally stored securely in areas that were only accessible to authorised staff. However, in minors' areas patients' records were often left for short periods in an open box outside treatment doors. The area was accessible to staff and public; this meant that patient confidential information could be accessed by unauthorised persons.
- We reviewed 33 sets of individual care records and found that 17 had been completed with appropriate information to describe the patient's care and treatment plan. The other 16 had information missing such as incomplete safeguarding referrals and lacked sufficient information to describe the patient's care pathway.
- We found that generally risk assessments had been completed in line with national guidance for patients at risk of falls, venous thrombolytic embolism (VTE) and pressure ulcers. However, in the emergency decisions unit we found one patient who was waiting to be admitted, had been in the department for over 24 hours and had no falls or skin integrity assessment completed; this was escalated to the nurse in charge.
- Audits of records were conducted monthly as part of the nurse sensitive indicators. The target for all documentation being legible, signed, dated and timed was 98%, in July 2016, the urgent care dashboard showed 93% compliance in this area and 100% for notes assessed as being in good condition and fit for purpose.

Safeguarding

- There were not effective systems and processes in place to ensure that patients were protected from the risk of abuse. We were not assured that all staff were aware of the processes or had had the required training.
- The department had a process for identifying and managing patients at risk of abuse; however, we were not assured that all staff were following it.
- During our inspection, we looked at 33 sets of patient records and found that in eight instances the safeguarding process was not always completed in line with the hospital policy or national guidelines. This included six instances including children and three of those with potentially suspicious injuries – we highlighted two of the instances to the safeguarding lead for the department. The other instance was highlighted to the senior management team as the patient had been highlighted on the system as having an 'alert' which meant that there should have been a referral made to social services or clearly documented in the patient's notes why this had not been done; however, this information had not been recorded . A referral was made immediately and an internal investigation showed that the clinician treating the patient had considered the information; however, this had not been recorded in line with the hospital's policy. We were told that safeguarding referrals were made by telephone to the local authority and a paper based form was also completed. Staff told us that any missing children's safeguarding referrals were picked up the next day by the registered nurse in children's ED: however this meant that a vulnerable patient could be discharged to a potentially abusive environment before a referral was made.
- The intercollegiate document 'Safeguarding children – Roles and competencies for healthcare staff' (RCPCH, 2014) provides guidance on levels of safeguarding training for different groups. The document states that 'All clinical staff working with children, young people and/or their parents/carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/child protection concerns' should be trained in safeguarding for children levels one, two and three'.
- We asked the trust for information regarding safeguarding training for nursing and medical staff prior to our inspection and we were not provided with it.

During our inspection, we were told that nursing staff compliance with safeguarding level three was 18% and that medical staff compliance was 29% against a hospital target of 85%.

- We highlighted our urgent concerns to the trust regarding the level of safeguarding training and the lack of compliance with the hospital's protocols regarding safeguarding. The trust immediately put in an action plan to address the training needs and we were supplied with updated data on 31 October 2016 that showed that 37% of nursing staff had completed safeguarding level three and there were planned training days throughout November 2016. We also saw that the trust had arranged for bespoke training sessions for staff in ED, which were to be delivered by the clinical lead for safeguarding. The trust told us that they would be conducting regular monthly audits and all safeguarding referrals would continue to be checked on a daily basis by a designated staff member of ED.
- At the time of our inspection, 87% of nursing staff and only 66% of medical staff had completed adult safeguarding (level two) training.
- Staff told us that information about unlawful restraint was covered in their Mental Capacity Act (2005) awareness training and they had not received specific training in restraint techniques, 76% of nursing staff and 53% of medical staff had received MCA training. The trust told us that staff attended conflict resolution training as part of their initial trust induction. After our inspection, the trust supplied us with evidence that staff were to attend bespoke training in de-escalation techniques and managing challenging behaviours.
- There was a designated member of staff for the children's ED who was the safeguarding lead. When they were on duty, they checked all of the safeguarding records from the previous day before they were taken to be securely stored. The individual member of staff worked closely with the local safeguarding authority, GPs, school nurses and health visitors to help develop the departments safeguarding processes.
- We saw that patients who were identified as 'at risk' were highlighted on the electronic system to make staff aware.
- There was information displayed in staff areas related to female genital mutilation (FGM) and staff that we spoke with understood the guidance and explained the flowcharts.
- Staff told us the hospital provided PREVENT training as part of the mandatory training in line with the government strategy to support people who may be at risk of radicalisation.
- Staff had access to a domestic violence liaison advisor who visited the department three days per week**.**

Mandatory training

- Staff did not always receive mandatory training in safety systems, processes and practices in line with the hospital's training programme.
- The hospital had a mandatory training programme that included basic life support, information governance, infection control, health and safety, fire safety, safeguarding children and adults, mental health act and mental capacity act, equality and diversity and manual handling.
- At the time of our inspection, the department was not meeting the hospital target of 85% compliance with mandatory training in all modules; the overall average was 73% for nursing staff and 55% for medical staff. This included non-compliance in infection control, fire safety awareness and risk management, which was 80% for nursing staff and 59% for medical staff in all three modules. Only 73% of nursing staff and 33% of medical staff had completed basic life support training for adults and 77% of nursing staff and 61% of medical staff had completed information governance training.
- The department had exceeded the 85% target for nursing staff in seven out of 22 modules including conflict resolution training, manual handling and collection and administration of blood components.
- Medical staff had met the target for manual handling, safeguarding adults level one and safeguarding children level one.

Assessing and responding to patient risk

- Risk management plans were developed in line with national guidance; however, comprehensive risk assessments were not always carried out for all patients using the service.
- Patients who self-presented to ED were booked in at the reception desk by a member of administrative staff. Patients then moved along the reception desk to a 'streaming' and 'triage' position (streaming is the

process of allocating patients to specific groups and/or physical areas of a department). Patients could be streamed to majors, children's ED, minors or GP (GP streaming was between the hours of 10am and 10pm).

- At the streaming position, a dedicated healthcare professional who was either a registered nurse (band 5 and above), advanced clinical practitioner (ACP – an ACP was an independent prescriber who could assess a patient and refer directly to other specialities, order scans and tests, provide front-line treatments such as intravenous antibiotics and analgesia) or pharmacist took details of patients symptoms. An initial rapid triage system (Manchester Triage System) was used to determine the priority of the patient waiting to be seen and identify any conditions that were potentially life/limb threatening. For example, patients with 'red flag' symptoms as defined by the Royal College of Emergency Medicine (RCEM, 'Triage position statement', 2011) such as crushing chest pains, severe bleeding or severe breathing problems were prioritised to be seen by a clinician. We were not assured that all staff that conducted the streaming were competent and equipped to identify a seriously ill or deteriorating patient; this was also highlighted on the departmental risk register. The hospital had a streaming competency framework book, however, no staff had completed this and the streaming policy document was undated with no author.
- The streaming time was recorded in patient's notes as an 'initial clinical assessment' that was normally recorded on the system within one to two minutes from arrival (booking in). This was not in line with RCEM or NHS England guidelines that state an initial clinical assessment should include a pain assessment, observation and recording of vital signs, brief patient history and immediate care plan. This also meant that patients were recorded as having had this done when this had not yet occurred. The hospital had not identified this as a risk prior to our inspection or recognised that the time recorded as an initial clinical assessment was incorrect.
- After streaming, all patients were then directed to the main waiting area and waited to be called for an actual 'initial clinical assessment' and this included patients with 'red flag' symptoms. The waiting area could not be clearly observed by staff in reception as there was a wall separating the areas. We asked staff about this and we were told that there was a closed circuit television (CCTV) camera in the waiting area, there were no signs on display telling people that there was a camera, this was not in line with government guidelines (CCTV code of practice, Information Commissioners Office, 2015).
- The ED had information on display that informed patients that they would be seen in order of priority and defined the prioritisation categories, which were one to five and based on Department of Health guidelines. Category one was for immediate life-threatening conditions where patients needed immediate intervention to save their life, category two was for serious conditions but not immediately life-threatening: the information displayed stated that these patients would be seen for an initial clinical assessment within 15 minutes. During our announced and unannounced inspection, we observed four adult patients present with 'red flag' symptoms and waited longer than 15 minutes for an initial clinical assessment. Clear systems were not in place to support this standard, which meant that we were not assured that the sickest patients were being seen first. We raised this as an immediate concern with the trust who took urgent actions to address this, which included a new operational policy that clearly defined which patients should be seen within 15 minutes. The trust immediately put in a process to audit the impact of the changes and provided evidence that an ED consultant had completed an audit at the end of October, which showed an immediate positive impact. The trust planned to continue monitoring and auditing the process until it was fully embedded and present the results to the hospital's quality governance group.
- The intercollegiate document 'Standards for Children and Young People in Emergency Care Settings, RCPCH, 2012' recommends that all children should have an initial clinical assessment (as described above to include pain score) within 15 minutes. The standards states that 'all children attending emergency care settings are visually assessed by a registered practitioner immediately upon arrival, to identify an unresponsive or critically ill/injured child'. Children who presented to the ED were recorded as having their initial clinical assessment at the streaming/triage position; this was not in line with the guidance. We observed two children waiting in excess of 15 minutes to attend the children's ED to have their observations taken.
- During our inspection, we observed some nursing staff using their skills and experience to determine if patients were safe to wait after being streamed. For example, a

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

- There was no effective process in place to ensure that patients waiting for up to three hours after streaming were safe to wait and that all patients with 'red flag' symptoms or category two patients were seen by an appropriate clinician for an initial clinical assessment within 15 minutes. After our inspection, we asked the trust for evidence that showed the initial time to clinical assessment and time to treatment for all patients that walked into the ED. The trust did not provide us with this data and told us that there was no national requirement to report this information for minors' areas. The trust told us that the process in place during our inspection was designed to ensure that majors' patients who self-presented were seen by an appropriate clinician within 15 minutes.
- The nurse in charge conducted two hourly rounding in all areas. This is a safety process whereby the nurse in charge would visit all areas in the department and assess the acuity levels of patients and the capacity in each area. The service provided us with an example of the record sheet for the day of our unannounced visit and we found that the record sheet had not been fully completed in accordance with the hospital policy. For example, the nurse and doctor in charge had not always signed the two hourly entries. Some of the entries gave a detailed description of current waiting times in all areas; however, this was not consistent.
- The Department of Health recommends that ambulance handovers be completed within 15 minutes of arrival at the ED to ensure that an initial clinical assessment is carried out in a timely manner.
- From April 2016 to September 2016, there were 15,604 ambulance handovers of over 15 minutes. This included 2,202 handovers of over 30 mins and 323 'black breaches'. A 'black breach' occurs when a patient waits over an hour from ambulance arrival at the emergency department until they are handed over to the emergency department staff. The trust had reported 'Nil' black breaches in the 12 months August 2015 to July 2016 as it had not understood the definition of a 'black breach'. Senior managers told us they thought a 'black breach' was defined as a patients waiting over 12 hours on a trolley in the ED.
- Between August 2015 and July 2016, there was a consistent picture of around 45% of ambulance journeys with turnaround times over 30 minutes.
- At the time of our inspection, the trust was in the process of formalising a handover policy with the local ambulance service to clarify the times of start and finish of ambulance handovers.
- From June 2015 to May 2016, the monthly median time to initial assessment for patients arriving at the ED by emergency ambulance was consistently worse than the England average. In October 2015, the median time to initial assessment was 10 minutes and in May 2016, it was 13 minutes.
- The ED had a dedicated ambulance streaming area with three bays. This had been introduced after our inspection in February 2016 when we raised serious concerns regarding the ambulance crews queueing in the corridors waiting to handover patients. Immediately after that inspection, the trust introduced an updated escalation policy and process for nursing in the corridor to release ambulance crews and ensure that patients were receiving appropriate care.
- The updated ED escalation policy was to provide clear actions and directions to manage periods of high demand, which all staff should have been fully aware of. This included opening up an extra area to avoid patients waiting in the corridor. During the inspection, not all senior medical staff in charge of ED not able to articulate the policy and the department did not always have the capacity to staff the area when it was necessary.
- Patients who attended the ED via ambulance underwent a streaming process at the time of ambulance handover. The area also provided a rapid assessment treatment process and clinicians were able to refer patients directly to other departments within the hospital. We observed this process generally worked well; however, when patients were waiting to be accepted by other specialities or receiving treatment, this had an impact on waiting times for ambulance crews waiting to handover their patients and the initial clinical assessment time. During our inspection, we observed delays of up to 90 minutes for patients arriving by ambulance waiting for an initial clinical assessment.

This meant that patients waiting to be seen remained on the ambulance trolley and waited in the ED corridor to complete a handover and an initial clinical assessment. This had a wider impact on the ambulance service as the crews were not made available to respond to 999 calls. We escalated our urgent concerns to the trust and after our inspection; we received an updated ambulance streaming process with set standards for key performance indicators, such as time to an appropriate initial clinical assessment as recommended.

- Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment is no more than one hour. The hospital performed better than the 60 minute time to treatment standard between June 2015 and January 2016. Between January 2016 and May 2016, performance against this standard showed a varying trend around and similar to the standard.
- A colour coded national early warning system (NEWS) was used in adults ED and a paediatric early warning system (PEWS) was used in children's ED in line with the National Institute for Health and Care Excellence (NICE) guidelines (CG50 Acute, illness recognising and responding to the deteriorating patient). We reviewed 33 sets of records and found that the correct use of NEWS processes for adult patients had not been followed for 10 patients. Evidence of appropriate escalation was not always followed in four instances, on two occasions NEWS had not been completed and on two occasions, the NEWS score indicated that more frequent observations were required but this was not done. Two of the patients were in the department during our inspection and we raised our concerns with nursing staff who ensured that appropriate actions were taken and provided feedback for staff involved.
- We found one patient who had been the department for over nine hours had an observation chart with only two sets of observations recorded, when we asked the nursing staff about this they returned with a second chart with a completed chart, staff were unable to explain why the patient had two separate charts. We found two sets of notes with no initial observations recorded.
- The department conducted local audits of the use of NEWS for adults and PEWS for children to ensure that staff were following guidelines and protocols. In July 2016, the urgent care dashboard showed that 88% of patients had their NEWS score calculated correctly and escalated appropriately against a target of 98%. Staff told us that they were due to have training in these escalation processes and this would be managed when the new practice development manager was in post in November 2016.
- The ED used Sepsis Six (UK Sepsis Trust, 2013, this is six steps to managing patients suspected of having severe sepsis, neutropenic sepsis or sepsis shock). We saw that the department was taking part in a CQUIN (Commissioning and Quality Innovation frameworks) audit related to sepsis. As of October 2016, 90% of all nursing and medical staff had received training in the recognition and management of sepsis. We looked at five sets of records where patients had been identified as potentially having sepsis, and we found that in each case an accurate record of their care and treatment had not been recorded including administration of antibiotics. We asked senior staff about this and we were told that as we were looking at past records (the previous days) the sepsis proforma was only a photocopy of the top sheet and did not include all the data which would have gone to the ward with the patient. We tracked two patients who attended during our inspection with suspected sepsis from their arrival in ED, one patient received most tests and antibiotics within the specified timeframe; however, hourly observations were not recorded in line with guidance or the escalation process. This patient was immediately brought to the attention of nursing staff who made sure the checks were completed. The second patient had been referred by a GP as potentially having sepsis: we saw that the sepsis six pathway had not been started and observations were not conducted in line with guidance. We immediately highlighted our concerns to staff as the patient was about to be discharged with antibiotics. The nurse in charge ensured that the patient's observations were taken and recorded and within normal limits.
- The department used a mental health risk assessment tool for patients presenting with acute mental health problems. There had been no implementation of an environmental risk assessment whilst the mental health room was being developed. Not all staff we spoke with had received training in the use of the tool. Some staff told us that patients with acute MH problems could be cared for in any adult area of the ED, whilst some staff thought there was a designated room. This meant that patients at risk to themselves or others may not be

cared for in an area of the ED that had been appropriately assessed. We highlighted this as an urgent concern to the trust and after our inspection we received an updated tool and environmental checklist to be used in the ED. We also received a flowchart which highlighted the specific areas in the ED that could be used whilst the mental health room was being developed and that they would monitor the use of the tool.

- The ED had an emergency decisions unit (EDU) for patients that attended ED and required a period of observation of no longer than 24 hours before they could be discharged. The EDU was put in place in May 2016 when the department had an expansion to the majors area. The EDU had specific criteria for patients that could be seen in the unit to avoid inappropriate use.
- In children's ED, there was an escalation process for children presenting with suspicious injuries who may have suffered abuse. Staff that we spoke with described the triggers for escalation and what their actions would be.
- An HCA or nurse and porter escorted patients requiring transfer to other wards or for tests.

Nursing staffing

- Staffing levels, skill mix and caseloads were planned and reviewed by the lead nurse so that patients received safe care and treatment in line with relevant tools and guidance. The lead nurse acted in a supernumerary capacity to provide co-ordination and point of escalation for the nurse in charge of areas.
- Actual staffing levels did not meet the planned levels at the time of the inspection. Staffing levels were checked on a daily basis and escalated to on-site managers to try and cover the shortfalls through agency cover or re-deployment of staff; this was also discussed at daily safety meetings and bed management meetings.
- During our focused inspection of the ED in February 2016, we highlighted that the staffing levels in children's ED were not adequate to meet the needs of the service. During this inspection, we found that the situation had not improved despite the trust having taken a series of actions after the last inspection.
- At this inspection, the vacancy rate for nursing staff in ED was 31%, which equated to 31.41 whole time equivalent (WTE) vacancies. The funded establishment for ED nursing staff was 101.57 and at the time there were 68.1 WTE staff in post (this included healthcare assistants).
- A business case had been submitted in February 2016 to match the increase in demand over the last five years. The lead nurse for ED had developed the business case based on National Institute of Health and Care Excellence (NICE) draft guidelines (2015). The recommendation was to have one registered nurse (RN) for every four patients in majors and minors, dedicated triage nurses and two RNs for the resuscitation area.
- On our unannounced visit, the department was staffed with ten registered nurses and five HCAs against a plan of 12 RNs and six HCAs. This was to cover 13 major bays, three children's ED bays, six minor treatment areas, six emergency decision unit (EDU) spaces, three ambulance streaming bays/corridor nursing and five resuscitation bays. This equated to three RNs and two HCAs to manage up to 13 patients in majors , two RNs and one HCA to cover minors, one RN and HCA to cover EDU, two RNs to cover resuscitation, one RN for ambulance streaming and one RN for children's ED.
- There was a high reliance on agency and bank staff to cover vacancies, sickness and annual leave. From April 2015 to February 2016, there were 1,056 shifts covered by bank and agency staff. We saw that the department had a local induction policy that covered local orientation and core responsibilities. Temporary staff had completed their inductions.
- There was funding for six WTE RNs (children's branch) in the ED staffing establishment to provide a 24 hour children's ED. An RN (children's branch) is a registered nurse who has specific training and competencies to be able to assess and care for children. The staffing establishment for paediatric competent nurses in ED was not sufficient to ensure that there was at least one RN (children's branch) on duty 24 hours a day. This was not in line with RCPCH guidelines or Royal College of Nursing (RCN) guidelines 'Defining staffing levels standards for children and young people services, RCN, 2013' that recommends a minimum of two such nurses. The trust told us they mitigated this by having adult RNs cover the area when there was no RN (children's branch) on shift; however, adult RNs who covered this area did not always have paediatric competencies. The lead nurse had developed a paediatric competency

framework in February 2016; however, staff that we spoke to told us that this was not monitored or signed off to show that staff were competent. On two occasions during our unannounced, we saw that the RN in children's ED did not have the necessary paediatric competencies in line with RCN guidelines.

- On our unannounced inspection, the children's ED was initially staffed with an adult RN and an HCA, which was according to the plan; however, due to capacity issues in other areas of the hospital the HCA was redeployed to another area leaving the RN alone to manage the department. We observed on two occasions that the RN had to leave the department unstaffed for brief periods – this meant that patients were left unattended. We highlighted this risk to senior staff who assured us that staff were frequently reminded not to leave the department unattended; however, this was challenging if there was only one member of staff in the department.
- The RN (children's branch) was required to attend the adult resuscitation area if a child was in cardiac arrest as that was where the children's resuscitation bay was located. This meant that if they were the only one on duty they would have to leave the department unattended whilst cover was found.
- At the time of our inspection, there was no dedicated senior nurse for children's ED. The trust had recently appointed a matron for children's ED who was due to start in November 2016. We highlighted our urgent concerns regarding the staffing levels in children's ED to the trust and immediately after our inspection we received an updated ED policy and revised rota plans to ensure that appropriately trained staff with sufficient cover, were in the children's ED at all times. The updated policy stated that the area was to be permanently staffed with a paediatric trained nurse and HCA and supported by a senior member of the medical staff. Any gaps in the rota would be identified in advance and appropriate cover arranged. Short notice cover would be an appropriately trained adult ED nurse or a member of staff from the children's ward. This was to be monitored daily by the nurse in charge on a two-hourly basis.
- We observed nursing handovers that were structured. The handovers involved staff that were starting and finishing their shifts in a group meeting and individual nursing handovers of patients in the department. Any safety issues were discussed in the group meeting and staff were allocated to their duties, we observed these team and individual handovers during our inspection.

Medical staffing

- Daily consultant cover did not meet national recommendations. Medical staffing cover for middle grade and junior doctors generally met the needs of patients.
- The proportion of consultants reported to be working at the hospital was lower than the England average. The proportion of junior doctors reported to be working at the hospital was higher than the England average.
- Medical staffing comprised of associate specialist doctors and speciality doctors (middle grades), senior house officers (SHO junior doctors) and advanced clinical practitioners (ACPs). ACPs were included in the medical staffing rotas as they were able to assess, refer, treat and discharge most patients autonomously. The department had 14 ACPs in post at the time of our inspection.
- The ED had one consultant on-site Monday to Friday 8am to 6pm (10 hours per day) and 8am to 2pm (six hours a day) Saturday and Sunday. Outside of these hours, a middle grade doctor who had access to an on-call consultant led the team. This did not meet the RCEM (2010) recommendations to provide 16 hours of consultant presence for EDs seeing 80000+ patients annually.
- At the time of our inspection, the ED had three WTE consultants with another vacancy due to be filled at the beginning of November 2016. The trust told us that they were working to have seven WTE consultants in post by January 2017 to meet the RCEM guidelines.
- During the week the plan was to have up to 11 middle graded and junior doctors (with a minimum of two middle grades on duty at any one time to provide supervision for junior staff) on duty from 8am to midnight and two ACPs. Cover at night was two middle grade doctors, two junior doctors and one ACP.
- National guidelines for emergency departments seeing 16000+ children a year state that there should be at least one consultant employed with sub-specialist training in children's emergency medicine. The lead consultant for the department had a recognised qualification in paediatric emergency care and the trust

told us the department had recently recruited another consultant with specific paediatric competencies who was due to commence employment in the ED in November 2016.

- The medical vacancy rate was 6% and the lack of consultants and middle grade doctors was highlighted on the risk register. As of August 2016, there were 52.55 WTE medical staff in post against a budgeted 56.08WTE. The department was actively recruiting staff at the time of our inspection and used long term locums to encourage consistency.
- The department used three locum doctors to cover vacancies. The hospital had a comprehensive corporate and local induction policy for bank, agency and temporary staff. This covered essential areas such as mandatory training, safeguarding and local orientation to departments/wards. We spoke with one locum doctor who told us that they had completed their corporate induction prior to joining the department.
- We observed effective medical handovers and saw that doctors discussed the acuity levels of the patients in the department and any issues or concerns highlighted from the shift.
- There were 13 medical staff trained in advanced paediatric life support and staff told us that they could also liaise with the children's wards medical staff for assistance if necessary.

Major incident awareness and training

- The hospital had corporate major incident and business management continuity plans.
- The ED had a departmental major incident plan that included action cards to describe the roles and responsibilities of individual members of staff. However, staff that we spoke with were not familiar with the policy and had not undertaken specific training or completed any exercises. Three members of staff in the department were unable to tell us where the major incident cupboard was located and the lead nurse directed us to it. We found that the major incident equipment cupboard was appropriately stocked and included items such as protective clothing and action cards for staff.
- The department had a business continuity plan, which described the process for managing the ED in the event of adverse weather affecting service delivery, severe staff shortages because of pandemic illness or any other unplanned reason and loss of power.
- The department had plans in place and an arrangement with a local hospital to access equipment to manage individual patients who had been exposed to chemical, biological, radiological or nuclear (CBRN) agents. We saw that specific members of staff had attended CBRN training.
- Staff in ED had access to on-site security services at nights between 8pm and 8am, seven days a week and outside of these hours, if they needed urgent assistance they were required to call the police.
- Staff in the main walk-in reception area had access to a panic button; however, due to the design of the desk and absence of a screen or barrier staff told us that they did not always feel safe if patients or visitors displayed aggressive behaviour. We saw that this was on the risk register and staff had been issued with handheld radios to request urgent assistance if necessary.

Are urgent and emergency services effective?

(for example, treatment is effective)

Inadequate

We rated the service for effective as inadequate because:

- Outcomes from audits were worse than expected. Clear action plans were not consistently developed in response to conducting audits or monitored or reviewed regularly to ensure that objectives were being met. There was a lack of action to drive improvements following national audits over time.
- There was not an effective cyclical audit programme to monitor the consistency of practice against evidence-based guidance. This meant that areas for improvement and opportunities for identifying best practice were not always identified to drive improvements following national audits over time.
- Care was not always delivered to national recommended guidance.
- There was inconsistency in pain scoring tools and recording of information. The department did not conduct an annual audit of pain management in children in line with Royal College of Emergency Medicine (2013) recommendations.

- Staff had not received bespoke restraint training and the service was not meeting the hospital target of 85% staff receiving Mental Capacity Act (2005) awareness training.
- There were not effective processes in place to ensure that all staff had the correct skills, knowledge and experience to undertake all the duties they were tasked with, for example, competency frameworks in children's ED and streaming area were not routinely checked or monitored.

However, we also found that:

- The department was a part of the Central England trauma network and took part in regular peer reviews.

Evidence-based care and treatment

- Care was not always in line with recommended national guidance for emergency departments and medicine.
- The ED did not meet the Royal College of Paediatrics and Child Health (RCPCH) intercollegiate document 'Standards for children and young people in emergency care settings (2012)'.
- The ED did not meet all of the standards of the RCEM guidance for minimum requirements for units that see less seriously injured people 'Unscheduled care facilities (2009)'. For example, there was a lack of safeguarding training and no effective processes in place to ensure that all patients were seen in a timely manner.
- The ED used specific pathways for patients presenting with head injuries, sepsis and fractured neck of femur. The department had recently updated their pathways for patients presenting with non-traumatic chest pains based on NICE guidelines (NICE CG95, 2016).
- The department used the 'sepsis six' care bundle and active cancer sepsis care bundle pathways in line with NICE (2016) guidelines and the UK Sepsis Trust (2013) for adults and children. These pathways are to aid those delivering care with the rapid recognition and treatment of severe sepsis. There were proformas in place for staff to record their actions within defined guidelines and the department had a dedicated clinical lead for sepsis.
- We saw that the department had a clinical audit programme that included audits based on Royal College of Emergency Medicine (RCEM), General Medical Council (GMC) standards and National Institute for Health and Care Excellence (NICE) guidelines. Clinical audits and reviews of updated guidance were discussed at divisional governance meetings. During our inspection, we attended a departmental meeting where nursing and medical staff discussed an update to the current protocol for patients presenting with chest pains.
- The department was conducting local audits to identify areas for improvement. For example, we saw that the department had undertaken an audit of the management of patients who presented to the ED that were in their first trimester of pregnancy and experiencing vaginal bleeding, based on NICE guidelines. Individual consultants took responsibility for specific audits.
- Policies were in place to ensure patients were not discriminated against, such as the hospital's equality and diversity policy. Staff were aware of these policies and gave us examples of how they followed this guidance when delivering care and treatment for patients.
- Staff demonstrated an awareness of the rights of people subject to the Mental Health Act (MHA) and the MHA Code of Practice.
- Staff had access to guidance, policies and procedures via the hospital intranet.
- Up to date clinical guidance was displayed in the resuscitation area. This meant that staff could visually see the necessary processes and treatments.
- All patients within the department were assessed for venous thromboembolism (VTE).
- As part of the urgent care improvement programme, the service had introduced a frailty and therapy team. The team consisted of occupational therapists, physiotherapists and they worked with community healthcare providers and social workers. The service was specifically introduced to care for patients over the age of 75 who may have complex needs.

Pain relief

- Pain was not always assessed and managed well. We reviewed records and found that four out of 33 records did not have pains scores recorded and had not been offered pain relief. We found two instances where patients had had their pain scored between five and 10 and analgesia was not prescribed for over 45 minutes. This delayed administration was not in line with the Faculty of Pain Medicine's core standards for pain management (2015) which state that patients with

significant pain should receive analgesia within 30 minutes. We found one children's record where pain was indicated and no analgesia was documented as being administered.

- The ED used pain-scoring tools for adults and children; however, it was not always clear from patient's records which tool had been used or how the score had been calculated. The pain-scoring tool on the patient's charts was between zero to three and we saw that staff were recording pain scores between zero and ten. We asked staff about the differences and we were advised that the score should be between zero and ten but they were using the old chart, as there was a surplus of them. The recording of pain scores formed a part of the urgent care dashboard nurse sensitive indicators. In July 2016, the dashboard showed that 78% of patients had their pain assessment score recorded against a target of 80%.
- The children's ED used a visual aid to help determine the level of pain in infants and small children. The tool was based on 'smiley faces' and asked children to point to the face that best described how they were feeling.
- The department did not have effective systems in place to meet the recommendations in the RCEM best practice guidance 'Management of pain in children (revised July 2013). There was no process in place to monitor if all children in moderate or severe pain had received pain relief within 20 minutes or that they had been re-evaluated within 60 minutes.
- In the 2014 CQC A&E Survey (published in March 2015), the service scored 5.66 for the question "How many minutes after you requested pain relief medication did it take before you got it?". This was about the same as other hospitals.
- The hospital scored 7.34 for the question "Do you think the hospital staff did everything they could to help control your pain?" this was about the same as other hospitals.
- All patients that we spoke to told us that they had been offered pain relief and there were signs in the waiting areas advising patients to seek help from a member of staff if they were experiencing pain.

Nutrition and hydration

- Patients nutritional and hydration needs were met within the department during our inspection.
- We saw that patients who were in the Emergency Decisions Unit were given appropriate food and drinks whilst they remained in the department for up to 24 hours for observation.
- Patient's records showed that fluid and food intake was monitored effectively when necessary using the Malnutrition Universal Screening Tool (MUST) which is a five-step screening tool to identify adults who are malnourished or at risk of malnutrition.
- In the 2014 CQC A&E Survey (published in March 2015), the hospital scored 6.75 for the question "Were you able to get suitable food or drinks when you were in the A&E Department?" This was about the same as than other hospitals.

Patient outcomes

- Outcomes from audits were worse than expected. Clear action plans were not consistently developed in response to conducting audits or monitored or reviewed regularly to ensure that objectives were being met. There was a lack of action to drive improvements following national audits over time.
- The Royal College of Emergency Medicine (RCEM) invites emergency departments to take part in national clinical audits annually that evaluate care based against agreed standards. We saw that the ED participated in relevant audits annually, which allowed them to benchmark their performance against national performance. We saw that the ED was identifying good practice and areas for improvement through participation in national audits; however, there was not always capacity or an effective process to support continued review of the effectiveness of the changes implemented.
- In the 2013/14 RCEM audit for asthma in children, the hospital performed worse compared to other hospitals for eight of the ten measures. This included seven measures relating to recording initial observations within 15 minutes. The hospital performed similar to other hospitals in regards to administration of medication and appropriate medication prescribed on discharge.
- In the 2013/14 RCEM audit for paracetamol overdose, the hospital was in the bottom percentage compared to other hospitals for two of the four measures, and in the upper percentage for two of the four measures. The hospital scored better for the percentage of patients

who received the recommended treatment and for patients who received the appropriate plasma test according to guidance. The hospital scored worse for two measures relating to the timeliness of treatment.

- In the 2014/15 RCEM audit for assessing cognitive impairment in older people, the hospital was in the lower quartile compared to other hospitals for two of the six measures and performed similarly to other hospitals in three measures. The hospital scored badly in using a structured cognitive assessment tool and communication of assessment findings with an admitting service although it should be noted that the sample size for both of these measures was very low at less than ten each.
- In the 2014/15 RCEM audit for initial management of the fitting child the hospital was in the lower percentage compared to other hospitals for one of the five measures and was in the between the upper and lower percentages for two of the five measures
- In the 2014/15 RCEM audit for mental health in the ED, the hospital was in the lower percentage for one measure and in the upper percentage for one measure compared to other hospitals. The hospital was comparable with others in England for all other measures. In the 2014 RCEM audit 'mental health in the ED', the service identified the need to improve their mental health risk assessment tool. We saw that an action plan was developed and a new tool was developed in line with RCEM guidelines.
- In the 2015 RCEM 'procedural sedation' audit, there were seven standards and five were classed as fundamental. The department scored worse than the England average in five of the fundamental standards. In the audit, it was identified that there was no documented evidence of patients having undergone a pre-procedural assessment in line with national guidance. In the action plan that the hospital developed in response to the audit, there were no further actions recorded as required in regards to ensuring that this information was documented. The hospital stated that they already had a proforma in place to capture all relevant information; however, the audit had shown that this had not been effective and there were no other plans to address this issue.
- In the 2015 RCEM 'vital signs in children' audit, the department scored worse than the England average and in the bottom 5% for the two standards relating to all children receiving an initial clinical assessment in 15 minutes. The department scored about the same or better for 'explicit evidence in the ED records that the clinician recognised the abnormal vital signs' and documented evidence that abnormal vital signs were acted upon. The action plan included recruiting more children's nurses and on-going training for nursing staff in recognition and prioritisation of children with abnormal vital signs. All actions were due to be completed by January 2017, with training highlighted as an on-going activity. The department planned to conduct a further audit against these standards in June 2017.
- In the 2015 RCEM 'VTE risk in lower limb immobilisation in plaster cast' audit, the department scored better than the England average in the standards relating to assessments and evidence that patients were given written evidence of the risk of venous thrombolytic embolism (a blood clot) after receiving treatment. They met the RCEM standard for written evidence of treatment having been administered, when required.
- In the 2013 RCEM audit 'severe sepsis and septic shock' the department scored worse than the national average for six out of twelve measures. This included the recording of vital signs in patient's records and the initiation of oxygen therapy treatment in ED.
- RCEM guidance states that EDs should work towards the standard of a consultant review for specified conditions prior to discharge; this is known as the 'consultant sign-off'. We observed that the ED was compliant with this standard in the 2013/14 audit. The conditions were updated in June 2016 to adults (over 30 years old) with non-traumatic chest pain, febrile children under 12 months, patients making an unscheduled return to the ED with the same condition within 72 hours of discharge from the ED and newly introduced standard of adults aged 70 years and over with abdominal pain. We saw that this information had been communicated to staff through the ED newsletter. The new standard was being audited at the time of our inspection and the data had not been published yet.
- From June 2015 to May 2016, the department's unplanned re-attendance rate within seven days of discharge was an average of 7% for the specified period. This was better than the England average for the same period, which was 9%, however this was below the

national standard of 5 %. Unplanned attendance rates were monitored on the urgent care performance dashboard on a weekly basis and were a part of the urgent care improvement plan.

- The department was a designated trauma unit as part of the Central England trauma network since 2012. Trauma networks are set up to deliver specialist treatment to patients with major trauma, such as severe head injuries, within a specified geographical area. A requirement of being a part of this network is to participate in peer reviews with other members of the network to improve and share best practice. The department must also submit data to the Trauma Audit and Research Network (TARN) on an annual basis.
- The department had undergone a peer review in July 2015 as part of their role in in the Central England trauma network. Serious concerns were identified in regard to the availability of suitably trained medical and nursing staff, lack of comprehensive network guidelines and that NICE guidelines for paediatric Computerised Topography (CT) scanning had not been embedded. During a further peer review in September 2016, the department had made improvements with establishing comprehensive network guidelines and embedding NICE guidelines for paediatric CT scanning. However, there were some concerns: the adult CT scanning guidelines were out of date and the department was still in the process of securing funding to have the sufficient amount of suitably qualified staff (these were not noted as serious concerns). The department were monitoring their collection of data and targets on a quarterly basis using a specific 'trauma unit' dashboard and had on-going plans to recruit suitable staff.
- The ED had undertaken a serious of audits relating to discharge letters and documentation based on GMC standards. This was in response to complaints from GPs and a lack of clinical coding (clinical coding is when medical terminology such as patient's medical symptoms/conditions is assigned a code and is used nationally to share information between professionals). In November 2013, the audit showed that 39% of discharge letters did not include appropriate information to meet GMC standards and 35% were coded incorrectly. A further audit was conducted in July 2015, which showed a 10% improvement in appropriate information included in discharge letters. There were a number of recommendations made including using a standardised format for discharge letters, conducting quarterly audits and 'naming and shaming' those staff members who were non-compliant; however, there was no action plan or continued regular monitoring to improve compliance, test recommendations or identify best practice.
- The audit related to first trimester bleeding was initially conducted in 2013, results showed that the department met one out of the six standards as set out in NICE (CG154 Ectopic pregnancy and miscarriage: diagnosis and initial management in early pregnancy of ectopic pregnancy and miscarriage, 2012) in regards to recording vital signs. A re-audit in 2015, showed that the department was still compliant with the same one out of six standards and identified areas for further improvement. One of the recommendations of the 2015 audit was to develop a flow chart and provide training to support staff in following the process within three months of audit. The department had developed a flow chart which was to be re-audited six months after implementation to monitor effectiveness; however, there was no evidence that actions outlined had been completed as per the action plan. The department had conducted a further audit in June 2016 which showed improvements from the previous two audits.

Competent staff

- We saw that there were some effective processes and systems in place to ensure that staff in the ED had the correct skills, knowledge, qualifications and competencies to do their jobs; however, this was not consistent throughout the department.
- The ED employed paramedics to work in the department. Staff in these positions worked through a comprehensive competency framework using their transferrable skills, which were checked, monitored and signed off by a senior clinician.
- There was also a paediatric competency framework for adult nurses working in the children's ED. However, at the time of our inspection, in the children's ED the paediatric competency framework for adult nurses was not being checked or monitored.
- Medical revalidation is the process that all medical staff have to undergo in line with General Medical Council (GMC) requirements to maintain their registration. All medical staff had up to date revalidation and 85% of medical staff had up to date appraisals.
- Revalidation is the new process introduced in April 2016 that all nurses and midwives in the UK need to follow to

maintain their registration with the Nursing and Midwifery Council (NMC) and allow them to continue practising. The department had guidance on display in staff areas, highlighting what the requirements were and how to register online. The department had recently made an internal appointment of a practice development matron for a six-month period and a part of their role would be to assist nursing staff with the revalidation process.

- Medical staff told us that they were given regular study days to increase their knowledge and gain new skills.
- The department had a number of middle grade doctors who were supported in achieving the Certificate of Eligibility for Specialist Registrars (CESR) with the GMC. Staff were given the opportunity to develop their skills and knowledge through practical and teaching sessions over a period of time. At the time of our inspection, five members of medical staff in the ED were undergoing this training.
- As of August 2016, 74% of nursing staff had up to date appraisals, this represented a 9% increase from the previous year and was highlighted on the departmental risk register. The department had developed a plan for a preceptorship programme and the practice development manager was to support band 7 nursing staff to conduct appraisals.
- Medical staff at all levels told us that they were given dedicated time for studying and development.

Multidisciplinary working

- We saw that the ED team worked with other teams within the hospital to assess, plan and deliver treatment for patients. We observed effective communications between nursing and medical staff when patients were transferred from ED for further care as in-patients.
- Staff told us that generally, they worked well with other specialities and we saw that any concerns regarding multi-disciplinary working was discussed at senior ED meetings and with the other departments throughout the hospital.
- The ED worked with physiotherapists and occupational therapists to provide a frailty service within the ED. This service allowed the team to identify patients who could be effectively cared for in the community reducing the need for admission.
- There was a GP unit from an external provider working with the department to care for patients with urgent care needs. Staff told us that they had good working relationships with the GP and they were able to provide care to patients who presented with minor illnesses.
- The ED was a part of the urgent care division which included some of the medical areas. We saw that the ED had developed pathways with the ambulatory care unit and medical observation unit to refer patients with specific conditions such as deep vein thrombosis (DVT) and access to oncology services for lung cancer patients.
- We observed effective working with ED and staff from other areas such as radiology and paediatric wards.
- The department was working with other external providers to develop urgent care facilities to develop local pathways to avoid unnecessary admissions.
- The ED had access to a psychiatric and acute mental health liaison team 24 hours a day, seven days a week; however, staff said that there were sometimes delays for the psychiatric liaison team to attend the ED. This was highlighted in the RCEM 2014 audit 'Mental Health in the ED' and similar to national performance. We saw that patients had access to services such as alcohol or substance misuse services through the psychiatric and mental health liaison team.
- Patients who were discharged from the ED had discharge letters sent to their GPs summarising the care and treatment they had received in the ED for continuity of care. The dedicated reception staff completed this on a daily basis.

Seven-day services

- The adults and children's ED was open 24 hours a day seven days a week. Our observations of patient records, discussions with staff and review of policies confirmed that the service met NHS England's seven-day services priority standards two, five and six.
- The department had a dedicated x-ray room that was staffed by colleagues from the radiology department at all times.
- The ED therapy team consisted of physiotherapists and occupational therapists to facilitate early discharge and integrated care in the community seven days a week from 8am to 430pm.

- The ED had access to on-site pharmacy support Monday to Friday from 8.30am to 6pm and Saturday 9am to 1pm. Outside of these hours staff had access to an on call pharmacist who was available to provide and support.
- The ED had access to an emergency and trauma theatre as per national guidance 24 hours a day, seven days a week.
- The ED had one consultant on-site between the hours of 8am and 6pm, Monday to Friday and 8am to 2pm on the weekends. Outside of theses hours consultants were available on-call, staff told us that if necessary consultants were able to return the hospital within 45 minutes.

Access to information

- Information needed to deliver effective care and treatment was generally available to ED staff in a timely and accessible way.
- The department had an electronic system where they could look at patients previous notes, including allergy statuses.
- When patients moved between teams or wards the appropriate information was not always shared. From August 2015 to July 2016, staff said there were a number of incidents reported where staff from different departments had said that the appropriate information, such as NEWS scores and falls risk assessments, had not been included. For example, in July 2016, there were 11 incidents reported on the electronic system related to lack of information on transfer from ED to other areas within the hospital.
- We saw that all relevant staff had access to the hospital's IT systems to receive information relating to diagnostics and test results.
- The ED used paper records for patients notes whilst they were in the department, the records were then electronically scanned onto the system. This meant that patients who had previously attended the ED had their details available for staff if they had to re-attend.
- We saw that the department was reviewing the way that they shared information with patients' GPs after discharge for continuity of care. An audit of GP discharge letters was conducted in 2013 and 2015 to establish if the ED was meeting GMC standards in terms of sharing information.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients' consent to care was generally sought in line with legislation and guidance. However, staff had not had sufficient training in the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and patients who lacked capacity to consent did not always have decisions made in line with legislation.
- At the time of our inspection, 76% of nursing staff and 53% of medical staff had received mental capacity awareness training. This was below the hospital target of 85%.
- Staff told us about an incident that occurred in December 2015 where relevant consent procedures had not been followed for a patient who lacked capacity. This had been investigated as an incident and identified the lack of mental capacity awareness in the department. From August 2015 to July 2016, there were two further incidents reported where patients who had potentially lacked capacity to consent to care were inappropriately discharged.
- Not all staff were able to describe instances when they would use 'best interest decisions' in line with legislation if the patient lacked capacity.
- Staff had had minimal training in restraint procedures and told us that they would ask for assistance from security staff or police. We asked the trust for the numbers of staff who had completed training in managing patients showing challenging behaviours. The trust told us that they had a comprehensive on-going conflict resolution training programme, which commenced at initial induction. Bespoke restraint training was planned to be included in mandatory training for doctors.
- We saw that the lack of MCA training had been discussed at departmental meetings. Senior staff told us that the lack of MCA awareness was a concern and this would be addressed with the introduction of the preceptorship programme and support from the practice development matron.
- Staff that we spoke with in adult and children's ED were able to demonstrate how Gillick competence and Fraser guidelines related to the consent process in their practice.

Urgent and emergency services

Are urgent and emergency services caring?

Good

We rated the service for caring as good because:

- Patients and those close to them were treated with respect in almost all interactions that we observed.
- All patients that we spoke to during our inspection told us that they had been treated with kindness and staff were friendly.
- Staff recognised when patients needed extra support to understand their care and treatment and adjusted their communication styles when necessary.

Compassionate care

- Patients and those close to them were treated with respect in almost all interactions that we observed.
- Reception staff were respectful, polite and compassionate to patients despite the limited space and restrictions of the environment.
- Staff took the time to interact with patients, relatives and those accompanying them in a caring manner.
- We saw staff treating patients and using humour to calm anxious patients.
- Patients we spoke with told us 'the staff are always smiling' and that the staff had introduced themselves by name.
- Staff took the time to interact with children and young people and those close to them in a respectful and considerate manner
- Privacy and dignity was generally maintained during all interactions and assessments with patients in areas visited. All staff showed an awareness of respecting their patient's privacy and dignity by closing curtains around all cubicles.
- The Friends and Family Test results for June 2016 and August 2016 (there were zero responses for July) showed that there was very low response rate of 1%, below the England average of 10%. 90% of patients that did take part would recommend the department. The department had leaflets on display for patients to leave feedback and staff told us that there were plans to ask volunteers to assist with gathering information about patient experiences. In September 2016, the department had introduced a new form and installed a postal box in the ED this saw a significant increase in responses for September 2016.
- The results of the Care Quality Commission A&E survey 2014 (published in March 2015) showed that the hospital scored about the same as other hospitals in all of the 24 questions relevant to caring.

Understanding and involvement of patients and those close to them

- Patients that we spoke to told us that they had felt involved with their care and understood the treatment they were receiving.
- All patients we spoke with told us they were informed of their treatment plan and potential diagnosis throughout their visit.
- Patients said doctors and nurses kept them informed of what was happening during their time within the ED.
- Relatives felt welcome and were able to sit with their family member. They were kept informed if the patient consented.
- Staff recognised when patients and those accompanying them needed additional support to help them understand their care and treatment; this included access to translation services.
- We observed staff changing their communication styles and speaking slower for patients who appeared to have difficulty understanding what was being said.
- We saw that staff actively directed patients, carers and relatives to access information about their care and treatment from the information leaflets throughout the ED.

Emotional support

- Staff showed patience and understanding when interacting and treating patients. We saw and were told by patients they provided timely support and information to help patients to cope emotionally with their care and treatment.
- With young patients and parents, we saw that staff were sympathetic and reassuring when they were nervous and this helped to put them at ease.
- Staff had good awareness of patients with complex needs and those patients who may require additional support should they display anxious or difficult behaviour during their visit to the service

Urgent and emergency services

- Staff directed patients and those accompanying them to services that provided counselling and support for patients with specific conditions.

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

Requires improvement

We rated the service for responsive as requires improvement because:

- Services were not always delivered in a way that took into account the needs of different people, in relation to age, gender, religion and disabilities. Reasonable adjustments were not always provided to accommodate patients when receiving care and treatment.
- There was clear criteria for patients that could be admitted to the EDU due to the facilities available and the staffing levels; however, we saw that the admission criteria was not always followed due to capacity issues throughout the hospital.
- The department did not have clear pathways in place to support patients with complex needs such as people with a learning disability and people living with dementia.
- The department was not consistently meeting national targets for service delivery but it had shown improvements in the last three months with performance against the national four hour target better that the England average. From July 2016 to October 2016, the average performance against the target was 88%.
- Performance against the monthly median total time in ED metric showed an overall trend of decline, with patients spending longer in the ED between June 2015 and May 2016. From June 2016 to August 2016, the ED performance against this standard was similar to the England average at 233 minutes.
- Not all necessary staff were aware of the organisation's escalation policy for capacity and demand for the ED.
- The waiting area in the children's ED had limited space, which meant that patients waited in the main waiting area and we observed those accompanying children standing in the children's waiting area.
- The percentage of patients waiting between four and twelve hours after a decision had been made to admit was worse than the England average.

However, we also found that:

- The department had introduced a frailty and therapy team to aid discharge for patients with complex medical needs and could be cared for in the community.
- From June 2015 to May 2016, the percentage of patients that left before being seen was consistently better than the England average for that period.

Service planning and delivery to meet the needs of local people

- Planning for service delivery was made in conjunction with a number of other external providers, commissioners and local authorities to meet the needs of local people. For example, the service worked with external partners to provide access to primary care services via the urgent GP service within the ED from 10am to 10pm. This was in line with RCEM guidance on how to achieve safe, sustainable care in emergency departments.
- We saw that the ED was working closely with commissioners and other external providers to increase the provision of urgent care facilities to meet the needs of the local population. The urgent care improvement programme, which had started in 2015, focused on a number of aspects including time to treatment, ambulance turnaround times, integrated discharge planning, patient flow and frailty services. The programme was on-going and included negotiations with the local authorities, other NHS trust and the CCGs.
- Senior managers within the ED recognised that the facilities were not adequate to meet the needs of the local people. Following discussions with the local commissioners, the ED had expanded the majors area by the installation of a temporary 'pod' in May 2016 that increased the number of cubicles in the majors area to 13. The ED also introduced the ambulance streaming bays to allow rapid access to treatment for patients. However, minutes from departmental meetings and conversations with staff at all levels confirmed that the children's ED area did not provide an adequate waiting area. There was limited space for seating and staff did not always have direct vision of children waiting in line with national recommendations. The risk related to staff

not having direct vision of patients was highlighted on the departmental risk register; however, the lack of space had not been highlighted. At the time of our inspection, there were no firm plans for increasing space in the children's ED, whilst staff at all levels acknowledged that more space was needed. Senior staff were aware of the requirements and we saw that a number of options were being considered at the time of our inspection to re-design the ED. This included relocating to another floor in the hospital or expanding the existing area.

- Information regarding the local population was used to inform plans to improve service delivery. For example, the business case for the increase to nursing staffing was based on the increase of attendances for the past five years and key demographics such as age and growing population rates.
- The service was working with the local ambulance NHS trust to develop pathways of care and working practices to improve ambulance handover times. This ongoing work also was to ensure that patients were taken to the appropriate care facilities such as hyper acute stroke units (for patients who have had a suspected stroke to receive thrombolytic treatment in a timely manner).

Meeting people's individual needs

- Services were not always delivered in a way that took into account the needs of different people, in relation to age, gender, religion and disabilities. Reasonable adjustments were not always provided to accommodate patients when receiving care and treatment.
- The department did not have a clear pathway for caring for patients with complex needs such as, a learning disability or those living with dementia. All staff told us that that there was a flagging function on the electronic records system which highlighted if a patient had specific communication needs; however, there was no system in place to ensure that these patients were prioritised and staff had no specific training in communicating with or caring for patients with additional communication needs. Some staff told us that patients with learning disabilities were sent to a specific ward in the hospital where staff were trained to meet the needs of this specific group; however, there was no standard operating procedure or flow charts that described this pathway.
- Not all staff were aware of the hospital's dementia strategy. Staff in the ED were not able to direct us to any specific 'distraction items' or tools used to support patients living with dementia. The department's urgent care dashboard in July 2016 showed that 25% of staff in ED had received dementia awareness training against a target of 80%.
- The main reception area for walk-in patients was not adequate to meet the needs of patients and those accompanying them. There was limited space for privacy and dignity to be maintained when patients were booking in. All staff that we spoke with were aware of this issue. We spoke with senior staff about this and we saw that various options had been considered to improve the area, which included relocation and/or redesign; however, there were no agreed plans for improvements in this area due to the longer-term plans being considered for the ED. There was signage at the main reception desk asking patients to stay back from the desk and behind a line to observe privacy; however, due to the close proximity, patients' personal information could be clearly overheard even when standing behind this line.
- The ED waiting area was a shared space with the outpatient clinics from 8am to 8pm Monday to Friday, outside of these hours the ED had sole use of the area. Patients that we spoke with told us that this was sometimes confusing as there were separate waiting times.
- The children's waiting area had limited distraction items for all ages and no access to a play specialist. The intercollegiate document 'Standards for Children and Young People, 2012' recommends that EDs that see 16,000 children a year should employ or have access to a play specialist to ensure that the environment is child-friendly. Staff told us that they did try to make the environment more suitable for children by designing their own artwork and decorations for the department.
- The ED had a designated therapy team from 8am to 8pm who were able to refer patients to external care providers and arrange community services for patients with complex medical needs.
- The department had access to language translation services and interpreters. Information on how to access these services was in all departmental policies and on display in staff areas. All staff we spoke with knew how to access the translation services.

- Staff had access to a range of appropriate leaflets for a variety of support services in the community, which they could give to patients and relatives if required.
- There was a small room available for relatives and staff that contained a microwave, small domestic refrigerator and tea and coffee making facilities. The room also served as a quiet room for patients and relatives who had received sensitive or upsetting news.
- There were snacks and refreshments available from a dispensing machine within the main ED waiting area and a water cooler for patients and visitors.
- The ED had a small kitchen area that could be used by patients or relatives if they were waiting for any length of time.
- There was a multi-faith chaplaincy service available on site Monday to Friday and Sunday, there was an on-call service available 24 hours a day, seven days a week.
- There was information throughout the department about the mental health services available at the hospital and through community and external providers.
- There was a room available for relatives who were with patients that were in a critical condition. The room was also used as kitchen facilities for staff and we saw that staff had raised charitable funds to furnish another room in the department for family.
- There was information available in the department regarding bereavement counselling services.
- The department was accessible for patients who used a wheel chair and a section of the reception desk for walk-in patients was lowered to accommodate wheelchair users.

Access and flow

- The Department of Health target for emergency departments is to admit, transfer or discharge 95% of patients within four hours of arrival at ED. From August 2015 to July 2016, the ED did not meet the target and was worse than the England average. We saw that the ED had been making improvements with compliance with this target since January 2016 when the performance was at 77%. We saw they had worked with commissioners and stakeholders to develop an action and recovery plan to improve performance in this area. This had included the extension of the majors area to provide a dedicated escalation area and the introduction of the ambulance streaming bays. From August 2015 to July 2016, the hospital did not meet the 95% target. The hospital's performance fell to 77% in January 2016 before climbing up to 91% in June 2016. During our inspection, we saw that the ED was regularly achieving above 80% performance since June 2016, better the England average. The department achieved 91% in September 2016. In October 2016, the average performance against the target was 88% which was better than the England average of 84%. However, they were not consistently meeting the national target.
- The Royal College of Emergency Medicine 'Crowding in the Emergency Department, 2012 (revised 2014)' recommends that EDs should have a hospital wide escalation policy to manage overcrowding in the ED. There was an escalation plan for this hospital that included action cards describing the triggers for various points of escalation and actions required by staff. During our inspection, we found that not all necessary staff were aware of the organisation's escalation policy and senior medical staff in charge of the department were not able to describe the triggers to implement the escalation policy.
- There were regular hospital wide bed management meetings to discuss the availability of beds throughout the hospital and the impact that would have on patients attending via ED who may need to be admitted. The hospital had a high bed occupancy rate and a high rate of patients who were medically fit waiting to be discharged with support in the community. This had a negative impact for patients who were waiting to be admitted to a ward after a 'decision to admit' was made and those attending for treatment.
- Between August 2015 and July 2016, the hospital's monthly percentage of patients waiting between four and 12 hours from the decision to admit until being admitted for this hospital was generally worse than the England average. Between December 2015 and March 2016, performance against this metric showed an improvement, falling below the England average. April 2016 saw a sharp increase to 35% and although this fell back to 13%, it still remained worse than the England average up to July 2016. From July to September, the hospital performance against this metric remained worse than the England average at 12%, whilst the England average was 7%.
- Staff in the ED told us that they did not feel as there was a whole system approach to managing overcrowding in the ED. The hospital used a live computerised system to monitor bed availability and staff told us there had been

discussions related to individual wards and specialities entering bed availability directly onto a live system to avoid delays and ensure that ED were aware when a bed became available; this was not in place at the time of our inspection.

- The ED used an electronic system to visually display how many patients were in the department, number of patients waiting to be seen and who was waiting for a bed. This was a good visual aid to ensure safe tracking of patients and that they could be treated in a timely way. The site managers also knew how to use this system.
- The ED had dedicated board rounds at least twice a day to discuss all the cases in the department with the focus on capacity, demand, and patient flow in the ED.
- From June 2015 to May 2016, the hospital's monthly median total time in ED for admitted patients was similar to the England average at around 150 minutes. Performance against this metric showed an overall trend of decline, with patients pending longer in the ED between June 2015 and August 2016. From June 2016 to August 2016, the ED performance against this standard was similar to the England average at 233 minutes.
- The ED had an emergency decisions unit (EDU) for patients that attended ED and required a period of observation of no longer than 24 hours before they could be discharged. This function meant that admissions could be avoided for patients where a definitive decision to admit or discharge could be made after a specified period time; for example, patients who had sustained head injuries and were stable but awaiting the results of an x-ray or CT scan.
- There were clear criteria for patients who could be admitted to the EDU due to the facilities available and the staffing levels; however, we saw that the admission criteria was not always followed due to capacity issues throughout the hospital. We saw that staff in ED had recorded five incidents from May 2016 to July 2016 related to inappropriate use of the EDU and during our inspection; we observed patients in the unit for longer than the 24 hours and patients waiting for a bed, which was not in line with the policy. We heard some staff referring to these instances as 'breach avoidance' for the ED targets. Minutes from the urgent care senior managers meeting June 2016 confirmed that this had been discussed and communications had been sent out to all divisions within the hospital reminding them of the purpose and criteria for admitting patients to EDU.
- The ED had clear pathways to admit patients to the ambulatory care unit for specific conditions such as chest infections and chronic obstructive pulmonary disease (COPD).
- From June 2015 to May 2016, the percentage of patients that left before being seen was consistently better than the England average for that period. The England average ranged between 3% to 4% and this hospital ranged between 2% and 3%.

Learning from complaints and concerns

- There was clear guidance on display in the ED for those using the service to make a complaint or express their concerns and leaflets available explaining how patients and those accompanying them could contact the Patient Advisory Liaison Service (PALS).
- During our inspection, we spoke with staff from the PALS team who had introduced a system of placing a stand throughout different departments on a monthly basis to encourage patients and visitors to give feedback and advising them how the complaints process worked, this had been implemented in November 2015.
- Staff told us that they responded to most complaints within 28 days in line with the hospital's policy unless the complaint required input from other wards or departments and then the response could take up to 90 days.
- The service had not met the trust's timescales for responding to complaints in the period August 2015 to July 2016, but following the introduction of a revised complaints' policy in July 2016, with longer timescales for a response, improvements had been made in responding to complaints with an average response timescale of 29 days (in the period April to September 2016). At the time of our inspection the department had six on-going complaints which were being investigated.
- Minutes from meetings confirmed that complaints were discussed at governance meetings to identify learning opportunities. There was some evidence of learning being used to make changes.

Urgent and emergency services

Are urgent and emergency services well-led?

Inadequate

We rated well-led as inadequate because:

- There was a lack of capacity in the leadership team to consistently embed learning from incidents and audits throughout the ED to drive improvements. There had not been sufficient improvement in areas of concerns highlighted during our February 2016 inspection. There was a lack of clear focus and support in the ED leadership up to board level. Quality and safety were not a top priority.
- The governance and risk management systems did not always operate effectively to support the delivery of safe patient care. Information used to monitor performance or to make decisions was unreliable and inaccurate.
- Processes in place to measure key aspects of quality patient care, such as ambulance handovers, were not in place. There was a lack of understanding in the leadership of the definition of 'black breaches' for ambulance handover times and effective time to initial clinical assessments for patients.
- There was not an effective system for identifying, capturing and managing risks at team, directorate and organisation level. There was not a holistic approach to the monitoring of safety and performance data, supported and informed by effective, ongoing clinical audits. Actions plans had not always been developed to address areas of risk or poor performance and those that were in place were not always effectively monitored.
- Significant issues that threatened the delivery of safe and effective care were not identified. Risk identified during our inspection had not been recognised by the service. Actions had not been taken to manage these risks. Risk registers were inadequate and not reflective of the current risks in the ED.
- Some staff said there was an emphasis on 'breach avoidance' to meet targets and that they were often required to move patients to an inappropriate area to meet a performance target or avoid a 12 hour breach in ED. Some staff told us that they sometimes felt that there was not a whole hospital approach to maintaining access and flow through the ED and if targets were not achieved it was an 'ED' problem.

However, we also found that:

- Staff said the local leaders of the department were visible and approachable.
- The department had made some improvements in response times and developed alternative pathways of care, such as the frailty and therapy team and emergency decisions unit, to improve admission avoidance.

Leadership of service

- There was a lack of capacity in the leadership team to consistently embed learning from incidents and audits throughout the ED to drive improvements. There had not been sufficient improvement in areas of concerns highlighted during our February 2016 inspection. There was a lack of clear focus and support in the ED leadership up to board level.
- The ED formed a part of the Urgent Care division that also included the medical assessment unit (MAU), Clifford ward (Observation Unit) and the ambulatory care unit (ACU) that was led by a general manager and a head of nursing. The lead nurse, associate general manager and interim consultant lead (this became a substantiated appointment after our inspection) led the ED at a local level.
- The deputy chief operating officer was visible in the department during our inspection and staff told us that this was a regular occurrence.
- The department had undergone significant changes in leadership since 2015 and the local leadership team had been working together for less than 18 months. Staff told us that their local leaders were visible and approachable and we saw good interactions between leaders and staff. Most staff told us that they felt confident to voice concerns openly and they would be listened to; however, the perception was that there would be minimal actions as a result due to lack of consistent support.
- At times when the department experienced high patient volume, we were told by staff that leaders were visible and worked as part of the team to maintain patient flow; this practice was observed during our inspection.

- The leaders of the department understood the challenges that they faced and were proud of the improvements that had been made since they joined the hospital and took on their roles. However, they also recognised that they still had significant work to do to achieve their vision and objectives, which was to ultimately deliver safe quality care through improvement and continued development of staff and processes.
- Staff at all levels told us that their local leaders had had a significant positive impact on staff morale and they had welcomed the changes they had made in the last 12 months.

Vision and strategy for this service

- The urgent care division had a clear vision and strategy to deliver key objectives that included an integrated service, which involved external health and social care partners.
- All staff that we spoke to were aware of the hospital wide values that underpinned the divisional vision which were 'Compassionate, Accountable, Respectful and Engaging' – CARE.
- The urgent care divisional strategy had been developed through contributions by each individual area that was a part of the division. Each individual area had developed individual strategies to meet the divisional overall objectives, which were integrated into an overall action plan for the whole division with timescales and identified leads for each area.
- The ED departmental strategy had been implemented in July 2015 and focused on 'Improving the quality of the patient journey by improving' and included the introduction of the ambulance streaming process, a frailty service through the ED therapy team, review and increase in staffing levels and increasing urgent care provision for minor injuries and illnesses. The strategy was on display in the staff communal area so that staff at all levels were aware and could comment on the plans.
- We saw that information about the department's strategy was displayed in staff communal areas and progress in key areas was discussed at weekly departmental meetings.

Governance, risk management and quality measurement

- The ED did not have effective policies or monitoring and quality assurance processes in place to support the delivery of the strategy and quality care. Risk identified during our inspection had not been recognised by the service. Risk registers were not effective and not reflective of the current risks in the ED.
- There was not a holistic approach to the monitoring of safety and performance data, supported and informed by effective, ongoing clinical audits. Actions plans had not always been developed to address areas of risk or poor performance and those that were in place were not always effectively monitored.
- There was a lack of understanding in the leadership of the definition of 'black breaches' for ambulance handover times and effective time to initial clinical assessments for patients.
- There was no clear process in place to monitor improvements and changes made as the result of identified risks or service improvements, which was integral to achieving the strategy. For example, the ED had developed an appropriate comprehensive paediatric competency framework to support adult nurses working in the children's ED; however, this was not monitored, checked or signed off.
- There was a lack of a systematic process of using internal audits to monitor, quality, adherence to hospital policies and protocols and to help identify potential risks. For example, we saw the ED had developed a local checklist for invasive procedures based on Royal College of Anaesthetists recommendations and in line with national guidance (National Safety Standards for Invasive Procedures – NatSSIPs, 2015); however, no audit of the effectiveness and correct use of the checklist had been conducted. During our inspection, we observed a patient was correctly intubated; however, the checklist had not been completed – this meant that there was no record that the procedure had been performed in line with national guidelines to improve safety.
- There was a lack of leadership oversight in relation to ambulance handovers. There had not been effective processes in place to validate or measure ambulance turnaround times for over 12 months and senior managers told us a dialogue with the local ambulance trust was ongoing.
- At the time of our inspection, the ED had a departmental risk register that was incorporated into the divisional risk

register. There were 19 risks on the ED risk register, the main risks related to inadequate staffing levels, lack of information governance training and lack of appropriate paediatric nursing cover.

- Identified risks were managed by individual members of staff and discussed at departmental clinical governance meetings. However, we were not assured that the risk management process was effective. For example, the risk register had a risk related to access and security for the children's area. It had been previously identified that the access into the children's ED was not secure and the touch pad to leave the area was too low and a child could leave unsupervised. We saw that appropriate actions had been taken to prevent unauthorised access into the children's area. A swipe card access and a CCTV camera had been fitted outside the children's ED; however, the mitigation for children being able to leave had not been achieved. Health and safety colleagues had advised the ED that they could not raise the touch pad to leave the department due to access in an emergency. The mitigation for this was to increase paediatric cover to ensure that the area was not left unstaffed; however, at the time of our inspection there were still insufficient staffing levels to ensure that the department was not left unstaffed and the risk was due to be removed after being noted at the governance meeting.
- There were number of risks identified during the inspection which were not highlighted on the register to allow effective monitoring at all levels. For example, the lack of an adequate mental health room, the inaccurate recording of initial clinical assessment time, lack of mental capacity awareness, lack of staff training for safeguarding level three, inconsistent equipment checking and lack of space and privacy in the reception area. The risks related to providing care for patients presenting with mental health problems were not highlighted on the departmental risk register. The limited space in reception and lack of privacy for patients booking in was not highlighted as a risk to patients' privacy and confidentiality on the departmental register.
- The department's lead nurse had raised the issue regarding the lack of safeguarding level three training for all staff in June 2016, however, there had been no action plan developed to address this and this was not highlighted on the departmental or divisional risk register at the time of our inspection.
- The lack of mandatory training was highlighted on the risk register and the department had an action plan to address the training needs, which included a preceptorship programme and the introduction of a practice development manager.
- The department was actively recruiting staff and senior staff told us that recruiting nursing staff at all levels was challenging and this had been highlighted on the divisional and corporate risk register since 2014.
- The lack of consultant cover was highlighted on the departmental risk register. The clinical lead for ED had worked with an academic facility and developed a programme to allow middle grade doctors to work towards consultancy at the hospital.
- After our inspection, the trust carried out a number of actions in regards to the urgent concerns we raised. This included reviewing their streaming model, reviewing the staffing arrangements in children's ED and updating their processes to allow better oversight in the waiting area. All actions taken were added to the urgent care improvement plan to allow monitoring at all levels.
- The service had a dashboard that was used to measure quality and performance in relation to national targets and nurse sensitive indicators at a departmental and divisional level.

Culture within the service

- Some staff said there was an emphasis on 'breach avoidance' to meet targets and that they were often required to move patients to an inappropriate area to meet a performance target or avoid a 12 hour breach in ED. We spoke to senior staff about this and they told us that the hospital had significant issues with bed capacity and sometimes patients were moved to temporary areas; however, this was about patient care and keeping the ED open for patients arriving. Staff were encouraged to record incidents where they felt that inappropriate moves had been made or patient care had been compromised because of a move.
- We found the culture of the department to be open and transparent during the inspection. Staff were comfortable with expressing concerns and voicing their opinions to us in an open environment.
- Staff told us that they felt valued and respected by their peers, colleagues within the ED and local leaders.
- Some staff told us that they sometimes felt that there was not a whole hospital approach to maintaining access and flow through the ED and if targets were not

achieved it was an 'ED' problem. For example, they felt that there was not emphasis on ensuring that bed availability was up to date and there were effective communication systems in place to convey this information.
- Staff were aware of the duty of candour and the hospital's specific policy related to openness and transparency.

Public engagement

- Patients and those close to them were given the opportunity to provide feedback through comment cards available in the ED.
- The hospital's public website encouraged people to leave feedback through comment cards, emails and written feedback.
- We saw that the ED had a very low response rate for the Friends and Family Test, (FFT) (this was not uncommon amongst EDs) and this had been discussed at departmental meetings.
- The patient advisory liaison service (PALS) had set up a patient steering group for the hospital to develop ways of receiving feedback from service users and relatives which included the presence of a 'listening booth' used throughout the hospital.

Staff engagement

- The local leaders of the department had an 'open door' policy and encouraged staff to give their opinions and suggestions about ways of improving and working together.
- In the ED newsletter, staff were encouraged to give feedback on new ideas and suggestions.
- We saw that the department planned meetings for staff at all levels; however, staff told us that they often had to attend these in their own times and often they were cancelled due to capacity issues.
- The service had developed an action plan in response to staff surveys, which included developing effective personal development and review processes to ensure staff understood their roles and responsibilities.

Innovation, improvement and sustainability

- The department had undergone a number of changes and improvements since the beginning of the year, which were still being embedded and improved. For example, the introduction of the ambulance streaming bay and frailty service run by the ED therapy team.
- We saw that staff were constantly exploring new ways of working and the department had been given two internal awards for improving performance and medical training through their CESR programme.
- The department had plans to increase their urgent care provision through working with local commissioners and other external providers.
- At this inspection, there had been some improvements noted since our inspection in February 2016. These included the introduction of the frailty unit, ambulance streaming bay, emergency decisions unit and an increase in majors capacity.
- There were areas highlighted where there had not been any changes since our inspection in February 2016. These included, inadequate staffing to meet the needs of adults and children attending ED, a lack of effective systems to ensure that ambulance handovers occurred in a timely manner and a lack of sufficient detail in patients' records to ensure all aspects of their care was clear.

Medical care (including older people's care)

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

Information about the service

The medical care service at Kettering general hospital provides care and treatment for cardiology, clinical haematology and immunology, endocrinology, gastroenterology, general medicine, geriatric medicine, medical oncology, nephrology, respiratory medicine, and stroke medicine. The service does not provide a hyperacute stroke service, which is provided by another hospital nearby.

There are 289 medical inpatient beds located in several wards including the endoscopy day-case unit, the bowel cancer screening centre, the cardiac centre, Oakley ward and the coronary care unit, the ambulatory day care unit, the medical admission unit (Middleton Assessment Unit), Clifford ward (medical short stay), elderly care (Naseby A and B wards), haematology (Lilford ward), respiratory (Harrowden A and C wards), endocrinology (HC Pretty A and B Wards), general medicine (Poplar ward), stroke (Cranford ward) and Twywell and Lamport ward (rehabilitation), the escalation ward (Fotheringhay) and the discharge Lounge.

We carried out the announced part of the inspection on 12 to 14 October and visited unannounced on 24 October 2016.

We spoke with 23 patients and 10 relatives and 87 members of staff, including doctors, nurses, ward managers, matrons, allied healthcare staff, pharmacists, health care support workers and domestic staff. We reviewed 48 patients' care notes and medical records and observed care being delivered on the wards. We reviewed information provided by stakeholders as well as information provided by the hospital.

Medical care (including older people's care)

Summary of findings

We rated the service as good for caring and responsive and requires improvement for safe, effective and well-led. Overall, we rated the service as requires improvement because:

- Nurses had not always followed the escalation process for high risk patients by informing a doctor when a patient's NEWS score was raised or when the patient's oxygen saturation showed a downward trend. There were NEWS charts which showed dates and times that were not clearly stated and some were not legible.
- Patients were exposed to the risk of receiving inappropriate care and treatment due to poorly written and incomplete care plans. For some patients, there were no individualised care plans; in some cases, the same written care needs were simply copied to a new sheet and changing needs had not been reflected or incorporated.
- Care plans did not always reflect the needs of patients and deteriorating patients were not always managed effectively. Patients' individual care records were not always written and managed in a way that kept patients safe. Patients' medical notes were mainly kept in lockable trolleys which were not locked when not in use and in some wards, they were kept on open shelves in the bays. This meant that confidential information was not always kept in accordance with the Data Protection Act 1998.
- There were not enough registrars and junior doctors to cover the medical wards out of hours, especially between 5pm to 9pm (Monday to Friday) and at weekends. Doctors told us there was no electronic handover system and no electronic list of priority patients to alert them to problems out of hours and at weekends in the medical wards. The hospital did not operate a multi-speciality hospital at night team. Working to seven day working in the service was variable.
- The coronary care unit had nurse staffing numbers that were below the recommended number stipulated by the British Cardiovascular Society.
- Entries on prescription charts had been cancelled without being signed and dated. Medicine reconciliations had not always been done. Patients had not always been assessed for needing prophylactic medication to combat venous thromboembolisms (VTEs).
- Outcomes for patients were variable. The hospital had produced poor results in two national audits that the hospital recently participated in. The Sentinel Stroke National Audit Programme (SSNAP) audit showed a poor score of D and E in all four quarters of the reporting year. The hospital participated in the 2015 National Diabetes Inpatient Audit: the hospital was worse for 13 out of 15 indicators than the England average.
- Discharges were sometimes delayed due to patients having to wait for ongoing care packages.
- Compliance with dementia awareness training was variable across wards
- The service had not met the trust's timescales for responding to complaints in the period August 2015 to July 2016, but following the introduction of a revised complaints' policy in July 2016, with longer timescales for a response, improvements had been made in responding to complaints with an average response timescale of 31 days (in the period April to September 2016).
- Ward dashboards referred to some local risks but these were not systematically escalated to the service risk register.
- Risks identified by the service were not being assessed, monitored and mitigated via an effective, comprehensive risk register. Risks we identified on inspection were not recognised by the service, including the failure to escalate deteriorating patients, poor junior doctor cover for medical wards, and the poor completion and storage of patients' records. We were therefore not assured staff at every level in the service had an effective understanding of all the risks to patient safety and were able to assess, mitigate and monitor all known risks.
- Not all staff were fully aware of the service's plans to remodel the beds in the service, which was designed to improve patient flow. Some staff described it as a 'stop, start' process with delays in the reconfiguration of beds and wards. Staff were not generally aware of the timescales for this reconfiguration.

However, we also found that:

Medical care (including older people's care)

- Staff treated patients with compassion, kindness, dignity and respect. Patients gave positive feedback about the care and service provided.
- Despite significant staffing pressures, generally patients' needs were met at the time of the inspection. Actual staffing levels were comparable to the planned levels for most of the wards we visited.
- Generally, the design, maintenance and use of facilities and premises met patients' needs. The maintenance and use of equipment kept people safe from avoidable harm. Appropriate infection control procedures were being followed.
- Arrangements were in place to safeguard adults and children from abuse that reflected relevant legislation and local requirements. Overall, the service was just below the hospital target of 85% for statutory and mandatory training at 83%.
- Pain of individual patients were assessed and managed appropriately. Patients' nutritional and hydration needs were appropriately assessed and the food and fluid charts were well maintained.
- Staff generally had the right qualifications, skills, knowledge and experience to do their job. A multi-disciplinary team approach was evident across wards
- The service had an effective escalation procedure in use for supporting demand for beds.
- Staff understood and respected patients' personal, cultural, social and religious needs, and took these into account and services were generally planned and delivered in a way that took account of the needs of different patients. The dementia strategy was being implemented and appropriate care was provided for patients living with dementia.
- Patient flow and bed capacity to meet demand had been a significant pressure for the hospital for a number of months. Senior managers were in ongoing discussions with commissioners and stakeholders regarding the most appropriate ways of managing the DTOC position as the medical care beds being used were placing a significant pressure on the effective patient flow through the service.
- Leaders within the service, of all levels, were generally visible and approachable. Staff told us that the senior leadership team, including both senior management and lead clinicians and nurses, were generally visible and effective.
- Staff felt involved in the hospital's CARE values which brought staff together to discuss ways to improve services and provide quality care to patients. Staff felt supported and able to speak with the lead nurse if they had concerns.
- There were a large number of volunteers from the local community working in various departments in the hospital.

Medical care (including older people's care)

Are medical care services safe?

Requires improvement

We rated the service for safe as requires improvement because:

- Care plans did not always reflect the needs of patients and deteriorating patients were not always managed effectively. Nurses had not always followed the escalation process for high risk patients by informing a doctor when a patient's NEWS score was raised or when the patient's oxygen saturation showed a downward trend.
- Patients were exposed to the risk of receiving inappropriate care and treatment due to poorly written and incomplete care plans. For some patients, there were no individualised care plans; in some cases, the same written care needs were simply copied to a new sheet and changing needs had not been reflected or incorporated.
- Patients' individual care records were not always written and managed in a way that kept patients safe. Patients' medical notes were mainly kept in lockable trolleys which were not locked when not in use and in some wards, they were kept on open shelves in the bays. This meant that confidential information was not always kept in accordance with the Data Protection Act 1998.
- There were not enough registrars and junior doctors to cover the medical wards out of hours, especially between 5pm to 9pm (Monday to Friday) and at weekends.
- Doctors told us there was no electronic handover system and no electronic list of priority patients to alert them to problems out of hours and at weekends in the medical wards. The hospital did not operate a multi-speciality hospital at night team.
- The coronary care unit had nurse staffing numbers that were below the recommended number stipulated by the British Cardiovascular Society.
- Entries on prescription charts had been cancelled without being signed and dated. Medicine reconciliations had not always been done. Patients had not always been assessed for needing prophylactic medication to combat venous thromboembolisms (VTEs).

However, we also found that:

- Despite significant staffing pressures, generally patients' needs were met at the time of the inspection. Actual staffing levels were comparable to the planned levels for most of the wards we visited.
- Generally, the design, maintenance and use of facilities and premises met patients' needs. The maintenance and use of equipment kept people safe from avoidable harm.
- Arrangements were in place to safeguard adults and children from abuse that reflected relevant legislation and local requirements. Overall, the service was just below the hospital target of 85% for statutory and mandatory training at 83%.
- Appropriate infection control procedures were being followed.

Incidents

- The service had systems in place to monitor an appropriate range of safety information. There was a monthly dashboard for ward areas that was used to set the targets for safety performance and nurse sensitive indicators such as compliance with infection control protocols and care associated risk assessments. The dashboard also included numbers of incidents and complaints, which was discussed at governance meetings.
- The service reported there had been no never events between August 2015 and July 2016 for the medical care service. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- In accordance with the NHS England Serious Incident Framework 2015, the service reported 18 serious incidents (SIs) which met the reporting criteria between August 2015 and July 2016. The most common category was suboptimal care of the deteriorating patient, for which there were 10 incidents, comprising 56% of the total serious incidents reported. Eight others were due to other causes. Action plans were in place in most wards to embed learning from these incidents.
- Staff said they used the hospital's online incident reporting system to report incidents. The hospital had a

process for ensuring all reported incidents were reviewed by a member of the risk management team; each incident was categorised and investigated by a designated member of staff.

- Staff understood the process for accident and incident reporting including the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR).
- A ward sister told us they had been asked to carry out the preliminary investigation and report back to the quality and risk manager before each incident was categorised and a root cause analysis was begun, if required. Another ward sister told us they usually checked the online incident reporting system to make sure staff had filled in the form correctly. A member of staff confirmed they received an automatic reply when an incident they had reported was logged and a summary email when the incident was resolved.
- Ward sisters we spoke with said lessons learnt from incidents had been cascaded down to frontline staff. Members of staff in the wards we visited confirmed lessons learnt had been discussed at team meetings.
- From November 2014, NHS providers were required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and reasonable support to the person.
- Staff had knowledge of the duty of candour and explained that they had to be open and honest with patients and their relatives when things had gone wrong in regard to care and treatment.
- Monthly mortality review meetings had been conducted to discuss each patient who had died in the preceding month, the causes of death and the care given. Records had had been reviewed to check if there was appropriate monitoring of the patient's deteriorating condition. The involvement of the family had been discussed, including their input in any decision not to resuscitate. There had been quarterly meetings to review mortality and morbidity in greater depth in Harrowden and HC Pretty wards and to discuss lessons to be learnt. For example, topics included the early treatment of sepsis and the occurrence and treatment of hospital-acquired thrombosis.
- The medical staff had regular lunchtime meetings on Mondays in the care of the elderly department where they gave case presentations and discussed lessons learnt from incidents and complaints.

Safety thermometer

- The NHS Safety Thermometer is an improvement tool. It provides a monthly snapshot audit of the prevalence of avoidable harm in relation to patient falls, pressure ulcers, new catheter-associated urinary tract infections and venous thromboembolisms (VTE).
- We reviewed NHS Safety Thermometer data regarding between August 2015 and July 2016. The hospital reported 74 pressure ulcers, 24 falls with harm and 74 catheter-related urinary tract infections. New pressure ulcers increased in prevalence from December 2015 onwards, whilst the prevalence of falls and UTIs remained fairly steady over this period.

Cleanliness, infection control and hygiene

- The wards we visited were visibly clean. Standards of cleanliness and hygiene were generally well maintained. Reliable systems were in place to prevent and protect people from a healthcare associated infection.
- Staff wore appropriate personal protective equipment (PPE) and followed 'arms bare below the elbows' guidance in clinical areas.
- We saw staff wearing PPE before giving personal care and these were changed in-between patients. Staff washed their hands before attending to patients.
- Four patients commented that the wards were kept clean.
- There were adequate hand washing facilities and hand gel for use at the entrance to the wards and in the bays and clinical areas. There was prominent signage reminding people of the importance of hand washing.
- Most equipment and clinical equipment trolleys were placed in main corridors; this equipment was visibly clean and labelled with a sticker to indicate it had been cleaned.
- We observed cleaning of endoscopes in the endoscopy decontamination room and noticed that endoscopes were leak tested and cleaned. Staff were wearing appropriate personal protective equipment during the process. The scopes were decontaminated in machines and track and traceability stickers and the chemical cycle was recorded in a book within the decontamination area.

- On HC Pretty ward, all the bays had hand basins with mixer taps. However, in one bay there was a problem with the hot water system. Work was in progress to address this problem. We noted that the curtains were made of fabric with no notice indicating when it had been changed.
- On Naseby ward, we noted clear signs at the entrance to a side room that was in use for a patient with an infection. This gave staff and visitors information on the precautions to be taken when entering the room. We observed that the correct infection control procedures were being followed.
- We saw domestic cleaners cleaning the bays in wards we visited at different times. One cleaner told us they were employed by the hospital and there were two cleaners assigned to the ward daily. We checked the shelves where equipment was kept and they were dust free.
- During our unannounced visit to Cranford ward, we observed three domestic staff carrying out deep cleaning. They were from a contractual company. The cleaners were conversant with the requirements for cleaning the area.
- We examined a sample of the cleaning audit data. The Ambulatory care unit had been audited monthly since April 2016. The compliance was 98%, exceeding the target of 95%. In the Middleton Assessment Unit (MAU), there had been a monthly audit since April 2016. The compliance was just below the target level of 95%. Clifford Ward had been audited weekly since May 2016 and had attained the target of 95%.
- A hand hygiene audit had been conducted on 16 June 2016. Lamport, Twywell, Fotheringhay, CCU and Oakley wards in the medical care service had not submitted data. Clifford ward scored 83%. The other nine wards in the service scored 100%.
- In the three months from April to June 2016, the service had had no cases of MRSA and five cases of c. difficle.
- In the Infection Prevention Control Committee (IPCC) meeting minutes of 15 July 2016, it was reported that Harrowden A Ward did not have any isolation rooms that were compliant with best practice guidance (HTM 04-01 Supplement 1 – Isolation Facilities for Infectious Patients in Acute Settings).
- All wards monitored staff training compliance for infection control and we saw, as of May 2016, 100% of staff in the endoscopy unit and Harrowden C had had infection control and prevention training, which was above the hospital target of 85%. As of June 2016, overall the service had a compliance rate of 75% for infection control training which was below the hospital target of 85%.

Environment and equipment

- Generally, the design, maintenance and use of facilities and premises met patients' needs. The maintenance and use of equipment kept people safe from avoidable harm.
- Some wards lacked appropriate storage space so equipment was stored in corridors: we saw that risk assessments had been completed where this was this case.
- Most wards were well maintained but others were in need of refurbishment: this was part of the hospital's ongoing estates' management plan. Whilst the decor may have needed improvement, we did not observe risks to patients on inspection posed by the environment. All wards carried out annual health and safety risk assessments (we saw that Harrowden A and C had completed a comprehensive risk assessment in April and May 2016).
- The entrance doors to the wards were installed with an intercom system. There was usually a ward clerk at the main reception desk who ensured that all visitors were greeted and that their identity was verified on entry. Staff used electronic swipe cards to gain entry to ward areas.
- Staff confirmed there was sufficient equipment available to meet the needs of patients receiving care. Equipment that was not available on the ward was provided in a timely manner.
- Equipment that required regular servicing was in date. There were systems in place to check and record equipment was in working order. These included annual checks of portable appliance testing of electrical equipment. The hospital had contracts in place with external companies to carry out annual servicing and routine maintenance work of other equipment in the premises in a timely manner.
- In HC Pretty A and B wards, we checked the volumetric pump, two vital signs machines, four glucose machines and a weighing scale. We found they had all been calibrated and were fit for use.
- We noted, in every ward we visited, the resuscitation trolley was visible and easily accessible in an emergency. The resuscitation equipment was stored on

the resuscitation trolleys on each ward. Each trolley had been checked daily by a trained nurse. We saw the daily log in the wards we visited and they had been completed appropriately and were up to date.

- There were systems in place for the segregation, storage and labelling of waste. We saw the appropriate disposal facilities in place in the clinical areas.
- There were arrangements in place to meet the Control of Substances Hazardous to Health Regulations 2002 (COSHH). COSHH is the legislation that requires employers to control substances which are hazardous to health.
- We found that the location of the haematology ward (Lilford) exposed ill patients to the risk of infection due to poor access. Patients, visitors and staff could only gain access through two separate wards. The service had risk assessments in place surrounding this issue.
- Since April 2016, the discharge lounge had been located in the basement of one of the outer blocks a fair distance away from the main hospital and facilities. In an emergency, patients would be at risk due to delay in receiving urgent medical care as the emergency team had a long distance to travel. The service had risk assessments in place surrounding this issue. Patients using the discharge lounge were medically fit for discharge.
- Patients' views about the environment were mixed: most were complimentary about the ward areas but one patient said that parts of the building were below standard. Another patient said they had to wait a long time for someone to fix a faulty drawer in a locker. One patient commented that the beds were so close that it was difficult to move another bed through and that there was a lack of storage space and another patient said that the conditions were cramped at times.

Medicines

- In most, but not all, wards visited, there were generally effective systems in place regarding the storage and handling of medicines.
- A small satellite pharmacy operated from the Middleton Assessment Unit (MAU) run by a team from the pharmacy department. This enabled medicines to be prescribed, checked, dispensed and available immediately for discharge. We were told that the waiting time for discharge medicines was around 30 minutes compared to two hours from the main pharmacy dispensary.
- A clinical pharmacist visited the coronary care unit (CCU) and Oakley ward daily. They were involved in patients' individual medicine requirements which helped identify medicine issues and therefore they could be dealt with immediately. We observed a pharmacist on CCU and on Oakley checking patients' drug history to ensure accuracy of the prescribed medicines. We looked at two prescription charts and found they had been completed correctly.
- Learning from medicine incidents was shared. We observed reminder posters were displayed to ensure all the correct checks were undertaken for the safe prescribing of warfarin (an anticoagulant).
- Medicines were stored securely with secure access limited to nursing staff. Controlled drugs, which required special storage and recording, were stored following good guidance procedures, including daily checks by two nurses on quantities and records. Medicines requiring cool storage were stored appropriately in locked medicine refrigerators. Daily temperature records for the medicine storage room and for the medicine refrigerator showed that medicines were stored within a safe temperature range.
- We visited the discharge lounge and found that delays in waiting for medicines sometimes increased the waiting time for patients' discharge. This was due to several factors, including waiting for medicines from pharmacy, patients' medicines sent back to the ward instead of discharge lounge or communication issues. There was a dispensing tracking system in operation, which enabled discharge lounge staff to check where patients' medicines were in the pharmacy.
- Staff in the discharge lounge told us they knew how to report a medicine incident. Learning from incidents was cascaded to staff with e-mails and staff meetings.
- On Naseby A and B wards, medicines were stored securely with access limited to nursing staff. Controlled drugs which required special storage and recording were stored following good guidance procedures including daily checks by two nurses on quantities and records. Medicines requiring cool storage were stored appropriately in locked medicine refrigerators. Daily temperature records for the medicine storage room and for the medicine refrigerator showed that medicines were stored within a safe temperature range.
- The ward was visited regularly by a pharmacist. We looked at 10 patients' drug charts. We found that medicine reconciliation was not always undertaken to

ensure the patient's drug history was correctly recorded. We also found that venous thromboembolism (VTE) assessment had not always been done (for five patients) and patients' weights had not always been recorded on patients' prescription charts. This could potentially lead to the incorrect prescribing of certain medicines that require a dose based on a patients' weight, in particular those for treating or preventing blood clots.

- We found one patient with the wrong medicines stored in their medicine bedside drawer. On investigation by the nurse in charge, we were informed that the previous patient's medicines had not been removed following their stay. Immediate action was taken when we pointed this out.
- The same patient had not been given their prescribed medicine for preventing seizures. They had missed three doses. We were informed that the medicine was not available to give, however the hospital's procedure had not been followed to obtain the medicine out of hours.
- We found that in seven out of 12 additional charts we checked, medicines had been crossed off without the cancellation being signed and dated by the doctor. In two of these charts, the dose had been changed but the alteration had not been signed and dated by the doctor.
- During our unannounced inspection on 24 October 2016, we checked eight prescription charts at random in Naseby A and B wards, six in HC Pretty A and B wards and five in Cranford ward. We saw that these patients' drug charts showed appropriate documentation of patients' known allergies, VTE prophylaxis and details of the patients' own medicines taken at home.
- We saw that oxygen required by patients had been prescribed and the doctors' written prescriptions were legible, dated and signed by the author. We saw that oxygen was prescribed with a target oxygen saturation clearly stated.
- We saw that antibiotics had been prescribed appropriately, in accordance with the National Institute for Health and Care Excellence (NICE) guidelines on the choice of antibiotics and the duration for which they were to be taken. We noted that no antibiotics had been prescribed for longer than they should.
- We observed the nurses' medicine rounds and noted patients were given their medicines on time. This was also evidenced in the drug charts we checked; the charts showed the nurse's signature against the date and time the medicines were given.

Records

- Patients' individual care records were not always written and managed in a way that kept patients safe. We reviewed 32 sets of patient records and saw that not all of these were accurate, completed, legible and up to date. We found that patients' confidential medical notes had not been maintained securely in accordance with the Data Protection Act 1998.
- In most medical wards, patients' medical record trolleys were kept in bays or corridors where staff were not always present. The record trolleys were found unlocked when not in use. In some medical wards, such as HC Pretty, the patients' medical and nursing notes were filed on open shelves above the hand basin in some bays in the wards. This meant that any visitor could gain access to patients' confidential information unnoticed, especially when staff were busy elsewhere.
- In Cranford ward, the medical record trolleys were kept in the doctor's office but it was not clear if the access door to the office was locked when not in use. We noted, however, that in Harrowden A and C, all medical notes were kept in a designated room in locked cupboards.
- We found that in some medical wards, patients' care plans were not individualised and had not been updated. In some wards the daily living assessments/ care plans lacked detail and the same information was transferred across to a new care prescription document nightly.
- During our unannounced inspection, we checked 24 sets of patients' medical and nursing records in three wards (Cranford, Naseby A and B and HC Pretty A and B). The medical notes we checked were legible and all entries were signed and dated by the author. The management plan, including the investigations and the treatment plan were clearly documented.

Safeguarding

- Arrangements were in place to safeguard adults and children from abuse that reflected relevant legislation and local requirements.
- The staff we spoke to understood their responsibilities and adhered to safeguarding policies and procedures. Staff were able to give examples of safeguarding concerns that had arisen when patients had been admitted onto the ward with evidence of neglect or

pre-existing pressure sores. They explained that they sought advice from the safeguarding lead if they were unsure whether a situation met the safeguarding threshold.

- Staff we spoke with said that they had received safeguarding training during their induction period. In Deene C, the matron confirmed all the nurses had attended safeguarding adults level 2 and all the HCAs had done safeguarding level 1. This was also the case in Cranford ward, Naseby, the MAU, and the other medical wards.
- From information provided by the hospital for June 2016, 94% of staff in the service had had safeguarding adults training level 2 and 93% had had safeguarding children's training level 2, which was better that the hospital target of 85%

Mandatory training

- Mandatory training covered a range of 10 topics, including health and safety, infection control, food hygiene, moving and handling, fire safety, basic life support, information governance, safeguarding (adults and children), Mental Capacity Act (MCA) and Deprivation of Liberty safeguards (DoLS). Staff told us they had received an induction period which included training in these topics. Staff told us they also had access to training topics through e-learning.
- As of June 2016, staff in the service were compliant in four of the modules (above the 85% hospital target), in line with the target for two modules (information governance and manual handling) and below the hospital target in four modules (fire safety at 77%, health and safety at 75%, infection control at 75% and risk management at 75%). Further training sessions were being planned. Overall, the service was just below the hospital target of 85% for statutory and mandatory training at 83%.
- In Deene C ward, the matron confirmed all the staff had received mandatory training during their induction and some had received refresher training as required. There was a rolling programme for staff to maintain their training requirements. All staff had received training on basic life support and some nurses (band 7, band 6 and a band 5) had attended a course on intermediate life support. We were told band 5 nurses had to work two years in the ward before undertaking the course.
- The ward sister in Naseby and the charge nurse in Cranford confirmed their staff had received mandatory training. Nurses and HCAs we spoke with confirmed they had received mandatory training. The activity co-ordinator, a recent recruit working in Cranford ward said they had attended mandatory training including safeguarding level 1.

Assessing and responding to patient risk

- Care plans did not always reflect the needs of patients and deteriorating patients were not always managed effectively. Patients were exposed to the risk of receiving inappropriate care and treatment due to poorly written and incomplete care plans. For some patients, there were no individualised care plans; in some cases, the same written care needs were simply copied to a new sheet and changing needs had not been reflected or incorporated.
- The National Early Warning Score (NEWS) chart was used to assess patients whose condition was deteriorating. We noted the NEWS chart was used for every patient in the medical wards. We randomly checked 15 NEWS charts in various medical wards and found in four of these charts, the date and time were not legible.
- We found that nurses had not always escalated cases and informed the medical team appropriately. For example, in HC Pretty B (female) ward, we saw a NEWS chart for a high risk patient which showed a downward trend regarding oxygen saturation; the last recorded reading at 5.45am on 13/10/2016 showed 88% oxygen saturation. The nursing staff had not escalated their findings to a doctor at the time. Further, the patient's vital signs had not been recorded preceding the consultant ward round at around 10am. A doctor confirmed the results documented in the NEWS chart had been noted during the consultant ward round and that the consultant had examined the patient and was satisfied that the patient was not unduly affected. We highlighted this to the ward sister who said that there was a ward emergency at the time and added that the matter would be reported using the hospital's incident recording system for investigation.
- In Naseby A, we found that a patient's condition had deteriorated overnight, but there was no nursing documentation to reflect this and whether action had been taken to inform the doctors. The NEWS chart stated a score of 4 on 12 October 2016. One nurse told

us the nurses at the time had made a decision not to escalate the case to the doctors because the doctors were already aware of the patient's condition: however, the records did not evidence this.

- For another patient in the same ward whose condition had deteriorated overnight, there was no nursing documentation to reflect the patient's condition and whether action had been taken to inform the doctors. Again, there was no nursing documentation to reflect when the patient's oxygen saturation had changed from the normal safe level.
- A nurse told us that they had initiated the escalation process the day before (23 October 2016), for one of these two patients who had felt unwell and who had a raised pulse rate; the patient was using their own cardiac monitor at the time. The nurse immediately informed the doctor who was in the ward and replaced the monitor with a 12 lead ECG monitor. We were shown the ECG trace that the nurse had taken. Following the escalation process, a doctor in the ward attended to the patient immediately and referred the patient to the cardiac outreach team. The patient was seen by the cardiac registrar the same morning. We saw the same patient resting in bed when we visited the following day.
- Ten nurse-sensitive indicators related to recording NEWS scores had been audited monthly for each ward since April 2016. We examined the results of the audit from April 2016 to July 2016. We looked at the percentage compliance for recording a full set of vital signs for every patient four hourly. 10 wards were 100% compliant, but in July 2016 Lamport Ward scored 95% and Oakley/CCU Ward 89%, against a target of 98%.The audit showed that:
  - For calculating the NEWS score correctly and taking appropriate action, seven wards were 100% compliant in July 2016, but compliance had decreased in a number of wards. Naseby A Ward scored only 40%, Naseby B Ward 85% and Naseby B Ward 85%, against a target of 98%.
  - For completing the fluid balance chart correctly with daily collation was only 15% compliant in Naseby B Ward in July 2016, 53% compliant in HC Pretty B Ward and 65% compliant in Naseby B Ward, against a target of 98%.
  - For providing a cumulative fluid chart, five wards scored 100% but Naseby B scored only 15%, HC Pretty A scored 82% and Deene C Ward scored 86% in July 2016, against a target of 98%.
  - For adjusting the frequency of observation according to a holistic view of the patient's health, all wards scored 100% in July 2016, except for HC Pretty Ward A, which scored 82%, against a target of 98%.
  - For recording a pain assessment, 11 wards achieved or exceeded the target of 80% in July 2016 but Harrowden A scored only 60%.
  - For using correctly for communication the 'situation background assessment recommendation' (SBAR) tool when a case required escalation, seven wards scored 100% in July 2016, but Deene C Ward and Oakley/CCU Ward each scored 93%, against a target of 100%.
  - For varying the frequency of observations following a specific intervention, such as a blood transfusion, compliance was generally 100% in July 2016 but HC Pretty Ward B scored only 94%, against a target of 98%.
  - For patients prescribed a target oxygen saturation, the results were particularly poor. In July 2016, only four wards met the target of 80%. Naseby B Ward scored 0%, Twywell 5% and Naseby A Ward 10%. Of the wards failing to meet the target, five scored worse than in the preceding month.
  - The percentage of staff who had completed the course in acute illness management (AIM) was generally around 9% and well below the target of 80% for all applicable wards except for Oakley/CCU, for which 100% of the staff had completed the course.
  - The percentage of staff who have had a blood transfusion competency assessment was generally around 60% in July 2016 and well below the target of 80%. However three wards met the target.
- The audit did not have an action plan or a schedule for completion. The data was highly variable and showed that compliance in this area had not been maintained.
- The NEWS chart had been recently revised to include an 'Adult Sepsis Screening and Action' tool. This provided a flowchart to determine if the patient had sepsis and, if so, its severity. The result was one of three categories: 'red flag sepsis', 'sepsis likely/present', or 'low risk of sepsis'. 'Red flag sepsis' was a critical condition needing immediate action, as part of the 'sepsis six bundle'. This set out six interventions staff had to undertake without delay and provided boxes to record the time of each intervention. 'Sepsis likely/present' indicated the need for treatment by the normal clinical route. 'Low risk of

sepsis' required only normal monitoring. Wards had access to antibiotics for suspected sepsis and the service was planning to introduce 'sepsis boxes' in wards.

- We reviewed four patient notes in the endoscopy unit and found that the World Health Organisation (WHO) checklist 'Five steps to safer surgery' was incorporated in the patients' care pathway and fully completed.
- On HC Pretty ward, we examined eight sets of patients' notes. We found that the patients' care needs had been documented under the twelve activities of daily living (ADLs). However, we found that changes in patients' care needs were often not recorded. The daily care prescription was simply copied unchanged every night and we could not find any individualised care plans. One patient's continence needs had not been reflected in the notes.
- One patient did not speak English. This communication need was recorded in the notes, but there was no mention of how the patient was going to communicate or how staff could support this patient. Certain members of staff were able to translate on an ad hoc basis. The hospital had an extensive translation service. Any actions to promote effective communication should have been recorded in the notes.
- It was recorded that another patient had difficulty speaking (dysphasia). There was no mention of how the patient could communicate in the notes. A patient was a smoker and had to request their cigarettes from the staff. This was not mentioned in the notes.
- However, in Lamport and Twywell, we examined the care plans of six patients with dementia and found that the care plans were individualised and covered the patient's communication needs, personal choices and consent. In one patient's care plan It was recorded that the patient had a pressure ulcer, which had been assessed and it was stated that it was improving.
- During our unannounced inspection on 24 October 2016, we checked 24 sets of patients' medical and nursing records in three wards (Cranford, Naseby A & B and HC Pretty A & B).
- The nursing notes had risk assessments carried out for patients on admission; there were risk assessments for falls, pressure areas using the Waterlow score, nutrition using the Malnutrition Universal Screening Tool (MUST tool) and susceptibility to healthcare acquired infection using the Kettering Infection Predictor Tool (KIP) and others.
- We chose 15 patients at random out of 29 who had bedrails attached to their beds. We looked at their nursing notes to see if risk assessments had been done prior to the use of bedrails. We found risk assessments had been done for all these patients affected in Naseby A, in Naseby B and in HC Pretty A and B. For example, in the case of one patient (Naseby ward) the bedrail risk assessment was done on 13 October 2016 and reviewed on 22 October 2016. The next review date was clearly stated. The ward sister told us there was a weekly review regarding the use of bedrails.
- There were other risk assessments carried out for these patients on admission, including falls, pressure areas using the Waterlow score, nutrition using the MUST tool and susceptibility to healthcare acquired infection using the KIP.
- During the unannounced inspection, we checked three wards to see if there were patients on percutaneous endoscopic gastrostomy (PEG) feeds. There were no patients on PEG feeds, however, in Cranford (stroke) ward, a doctor showed us the medical assessment notes for a patient who was waiting to be admitted for PEG tube insertion. We saw that the rationale for this invasive procedure had been documented clearly together with evidence of consultation and agreement with the patient and their family members.
- We saw the referral document and the nutritional assessment completed by the nutritional team, which confirmed that the request was appropriate; the patient had been seen by the consultant gastroenterologist prior to placing the patient on the list for the procedure to be undertaken. The medical notes included management advice and admission procedures to be undertaken, such as checking that the consent form was signed, taking the full blood count and checking the international normalised ratio (INR) regarding the usage of anticoagulation before the procedure.
- Staff told us that they made psychiatric referrals if patients' mental health and wellbeing deteriorated.
- In the medicine service performance report for June 2016, completion of VTE assessments were at 100%, above the target set of 95%.
- We observed cohort nursing care practice in some of the medical wards to reduce the risk of falls. In HC Pretty A (Male) ward, patients with the greatest risk of falling were placed in the same bay with continuous supervision, usually by an HCA. There was a cohort nursing care guide displayed by the entrance to Bay 2.

The bay had five beds and one HCA was assigned to provide continuous supervision and support to four patients. We noted a second HCA providing one to one care to a fifth patient who lived with dementia and had behavioural problems.

- In the geriatric ward, Naseby A (male) and B (female), we observed an HCA providing continuous supervision to a group of four patients primarily because they were prone to falls; some of these patients were also confused and lived with dementia. There was a care rota and an HCA was present in this section of the ward throughout the day. A member of staff told us this new care approach had reduced the number of falls and since May 2016, there had been no fall incidents in Naseby B but there had been one in Naseby A in September 2016. There had been no falls in October 2016.
- Patients who developed pressure areas were managed appropriately by staff, with support and advice from the tissue viability nurse. Patients who were prone to pressure areas were nursed on pressure relieving mattresses. We noted two patients with a pressure area were receiving appropriate care and treatment and were improving.

Nursing staffing

- Despite significant staffing pressures, generally patients' needs were met at the time of the inspection. Actual staffing levels were comparable to the planned levels for most of the wards we visited.
- There were arrangements were in place to escalate concerns regarding staffing levels. Ward managers attended a safety huddle every morning where they went through every ward and asked if staffing numbers were sufficient. The service had a staffing escalation policy and process in place whereby any unfilled shifts were escalated to a matron or the clinical site supervisor at nights. Management staff flexed permanent staff from ward to ward to cover vacancies where possible.
- As at August 2016, in the service, there were 319.08 nursing whole time equivalents (WTE) and 227.46 other clinical WTE.
- As at August 2016, the hospital reported a staff turnover rate of 8.2 % in the service. The majority of medical wards reported no turnover; of those that did, the highest reported turnovers were in the Naseby Ward (6.8 WTE), Oakley Ward (5.7 WTE) and Cranford Ward (5.6 WTE). Cranford also reported one of the largest rates proportionally (16.7%).
- As at August 2016, the hospital reported a sickness rate of 4.3 % in Medical care. Proportionally, the highest rates were reported by the Cardiac Centre (7.2%), Harrowden A Ward (6.3%) and Cranford Ward (6.2%).
- During our unannounced inspection, we found that the CCU and Oakley ward had staffing numbers that were below the recommended number stipulated by the British Cardiovascular Society. During the day, there were usually nine nurses covering the morning shift and the late shift. The nurses were supported by four HCAs. The hospital information provided showed there were usually five nurses allocated to the 12 bed CCU and four nurses covering Oakley ward (16 beds). There was a nurse in charge of both wards.
- We found that during the night Oakley ward had three nurses and two HCAs and in CCU the number of nurses had been reduced to three with one of the nurses being the nurse in charge of both wards. This meant that one nurse was looking after four patients in CCU.
- Staff told us the night staff had to cover each other for breaks which lasted 30 minutes. This meant that CCU was left with two nurses for 1.5 hours when one nurse had their half hour break. Therefore during break times, one nurse had to look after six patients in CCU and if the nurse was the nurse in charge, they had to cover six patients in CCU as well as Oakley ward, the step down ward for 16 patients. Patients in these wards and especially in CCU were potentially at risk due to an insufficient number of trained staff at certain times. Staff reported feeling under pressure due to the work intensity.
- The British Cardiovascular Society (BCS) guideline, 'From Coronary Care Unit to Acute Cardiac Care Unit – the evolving role of specialist cardiac care' 2011 (p.23) endorsed the standard of the British Association for Critical Care Nursing (BACCN). 'The BACCN standard for nursing in a critical care environment such as an Acute Cardiac Care Unit is that the nurse patient ratio should not fall below one nurse to two patients.' and 'The BCS do not therefore support any variation in staffing levels between day and night in an acute cardiac care unit.'

- The BCS also recommended (p.30) that 'where nurses have additional responsibilities … staffing levels should be organised to reflect these additional roles.' The hospital had not followed the guidance from the BCS.
- In the medical wards, the ward sisters said they had used the safer nursing tool to assess staffing levels and skill mix but they did not consistently achieve the level of staffing indicated by the tool.
- For example, in HC Pretty A and B wards, the planned staffing number was six nurses but in practice there were only four nurses (band 5s) on duty and one of them was an agency nurse. They were supported by six health care assistants (HCAs). There was a ward sister (band 6) in charge of both wards. On the day of our visit, HC Pretty was full with a total of 35 patients. Additional HCAs had been used to cover the cohort nursing bays; there was one to one supervision for a patient in HC Pretty A (male) ward.
- Ward sisters had also carried out acuity assessment of patients' needs and they were responsive when they identified the need for additional staff. This was evident in the wards where additional staff were used to provide continuous supervision of patients living with dementia and in the bays where cohort nursing care was implemented for high risk patients who were prone to falls.
- We were told 50% of the staff working in HC Pretty were agency nurses. Most of the agency nurses worked regularly in the ward. On the day of our visit, there was an agency nurse working in HC Pretty A who told us they had worked in the other wards within the hospital but it was the first time they had worked in HC Pretty. We observed patients were calm in the wards and staff interacted well with patients in their care.
- The charge nurse in Cranford ward, for patients who suffer from stroke, reported there were nine nurse vacancies and the ward was dependent on agency staff. Attempts had been made to organise recruitment days but with no success.
- Staff on wards visited were aware of the hospital's induction policy and we saw that agency staff inductions were being recorded. This meant that there was record that an induction had occurred for the agency staff across the service
- We examined the Integrated Governance Report for June 2016. The vacancy rates for medical care and specialty medicine were 24% and 14% respectively. In Cranford ward, 25% of the nurses were temporary during the day and 51% at night. In HC Pretty A and B wards, 28% of the nurses were temporary during the day and 46% at night.
- The matron (band 7) for the specialty ward, Deene C, (a 29-bed gastroenterology ward) said there had been no vacancies for nurses since September 2016. The staffing and skill mix was adequate on the day of our inspection. There were four nurses (band 5s) and one ward sister (band 6) on duty and they were supported by four HCAs. One of the two ward sisters had been deployed to cover Fotheringhay and Observation Bay ward for two weeks. The matron told us agency staff were used only to cover maternity leave and sickness.
- In Deene C, the matron said an acuity audit had been done and this was ongoing to ensure safe care. A risk assessment was carried out daily. If the staffing level was unsafe due to high acuity, the lead nurse would be notified, who usually approved the deployment of additional staff.
- Nursing staff in the discharge lounge worked from 8am to 8pm. The HCA had to take the role of the porter out of hours to fetch patients from the medical wards since there was no porter out of hours. Staff said they had to walk a long distance to collect medication for the patient waiting to be discharged.
- Handovers occurred at shift changes and staff discussed the reason for admission, any progress since admission, any action plans and any relevant medical history. Staff told us that they received adequate information at handover.
- We attended a nursing handover in HC Pretty A and B wards. Routinely, staff in each ward had a brief handover by the nurse in charge of the night shift. Each member of staff was given a list of patients in the ward and was assigned to certain bays and patients. Following the brief handover, there was a bedside handover in the relevant bays by the night staff to the day staff for that bay. However, on the morning of our visit, there was an emergency situation and the handover period was slightly disrupted but staff carried on with bedside handovers.

Medical staffing

Medical care (including older people's care)

- As at August 2016, the hospital reported a vacancy rate of 11 % in medical care. The highest vacancy rates were reported by cardiology (3.77 WTE, 13% of total staff), acute medicine (3.7 WTE, 29%), and diabetes/ endocrinology (3.5 WTE, 28%).
- As at August 2016, the hospital reported a turnover rate of 37% in medical care. With the exception of dermatology (0% turnover), all units reported turnovers of between 20% (ear, nose and throat) and 78% (diabetes/endocrinology).
- As at August 2016, the hospital reported a sickness rate of 1.1 % in medical care. Sickness rates were almost entirely equal to or below 1%; the exceptions were stroke (1.5%) and geriatric medicine (4.3%).
- Patients were reviewed by the consultant and registrars through the day until 5pm. The consultants covering the medical wards conducted a daily consultant board round usually from 9am to 9.30am followed by two ward rounds daily with their team of registrars and junior doctors. However, in Naseby ward (A and B), each of the four consultants carried out two ward rounds per week and on Wednesdays, there was a registrar ward round for each ward. This had ensured all the patients were seen daily. We saw a registrar conducting a ward round with three medical students as part of a practical teaching session in Naseby B.
- We observed a consultant's board round in Naseby B and this was followed by a ward round together with a registrar and five junior doctors. We noted patients were involved in the discussion about their care and treatment.
- There were not enough junior doctors to cover the medical wards, especially between 5pm to 9pm (Monday to Friday) and at weekends. Staff told us the medical staffing consisted of only one registrar and one junior doctor covering 10 medical wards (some having separate A & B wards) and these doctors also covered medical patients using outlier wards such as the surgical and orthopaedic wards. However, there was a registrar and two junior doctors to cover the two acute medical wards. The CCU had its own medical cover, consisting of one registrar and one junior doctor.
- Clifford ward (medical short stay) and the MAU had a team of doctors (two registrars and three junior doctors) during the day and these doctors also saw medical patients in the emergency department on a rota system. The doctors were supported by the respective consultants covering the ward during the day. There was a consultant of the week to cover out of hours and weekends. However, the number of junior doctors was reduced to two out of hours for these areas. The registrar also had to cover the13 other medical wards after 9pm in rotation with other registrars out of hours.
- There was a second team of doctors covering the other 13 medical wards and medical outlying patients. In the geriatric medical wards, such as Naseby A (20 beds) and B (20 beds), the medical team for each of these A and B wards consisted of a registrar and two junior doctors during the day. There were two consultants for each of these wards during the day. The consultant of the week supported the doctors out of hours, at night and at weekends. However, there were only two junior doctors covering these 13 wards and medical outlying patients after 9pm.
- The registrars and junior doctors told us there was an insufficient number of junior doctors to cover out of hours, especially between 5pm and 9pm. The doctors at all levels confirmed there were only two junior doctors to cover 13 medical wards, including at least three medical outlier wards (the gynaecology ward and Barnwell B and C, the orthopaedic surgical wards).
- Doctors told us the handover from the day shift to the night shift was at 9am and from the night shift to the day shift was at 9pm. There was a handover in two parts with an initial meeting for all medical doctors at 9pm, then separating into distinct handovers for the MAU and Clifford ward teams and the rest of the medical care wards team.
- We observed a handover and only a selected group of patients were discussed and the handover team had to prioritise the patient list to handover as the patients were from all wards. There was no consultant presence at evening handovers and handovers were led by registrars.
- The hospital did not operate a multi-speciality hospital at night team and handover was focused on medical care wards. There was a senior nurse supporting the junior doctors at night. Their role was to hold the bleep for calls to the medical team and to triage calls and escalate to the doctors when required. Doctors reported this had reduced the number of calls at night from 60 to an average of 20 per night. Doctors said the service was looking at the introduction of a multi-specialty hospital at night team, but no defined timescales for this.
- The hospital had not yet implemented the recommendations for improved, standardised handover

protocols as detailed in the Royal College of Physicians "Acute care toolkit 1: handover" dated May 2011 but were planning to do so but doctors were not able to give any timescales for this.
- Doctors told us there was no electronic handover system and no electronic list of priority patients to alert them to problems out of hours and at weekends in the medical wards.
- In patient's notes, we saw the documented notes of a registrar's ward round with junior doctors which demonstrated good teaching and supervision of junior doctors.
- The discharge lounge had no medical staff assigned. The nursing staff had to contact the ward the patient had been transferred from. During the week of the inspection, there had been two incidents where blood tests for INR level for two patients on warfarin had not been done before these patients were transferred from the wards to the discharge lounge. Staff had to contact the doctors from the respective wards to take blood. The patients had to wait over an hour to see the doctor and then had to wait for the blood results before they could go home.
- In some wards, such as HC Pretty (A and B) there were locum doctors on long term contracts. Arrangements were in place governing the use of locums and the required checks had been undertaken. As part of their induction, locum doctors were given an induction leaflet, which set out their duties, the facilities the service provided, advice on referrals, discharge summaries and handover information.

Major incident awareness and training

- There was a hospital-wide major incident plan, reviewed regularly. A copy was available on the intranet under hospital wide policies, accessible in the hospital library. Staff told us they had seen the emergency and evacuation plan folder which was kept by the nurses' station in Naseby ward.
- Staff were aware of the fire alarm system. A continuously ringing bell indicated a fire in the present area and that immediate evacuation was needed. There was a fire action plan in place and the fire team leader would carry out necessary actions when evacuation was needed. An intermittently ringing bell indicated that a nearby area had a fire but immediate evacuation was not required. Staff were expected to be aware, however, that evacuation may become necessary at some point.
- Ward sisters we spoke to were able to tell us what arrangements were in place to respond to emergencies and major incidents.
- Evacuation routes within the wards were free of obstacles and kept clear.
- For the service, 77% of staff had completed their mandatory fire training, below the target of 85%.

Are medical care services effective?

Requires improvement

We rated the effectiveness of medical care as requires improvement because:

- Outcomes for patients were variable. The hospital had produced poor results in two national audits that the hospital recently participated in. The Sentinel Stroke National Audit Programme (SSNAP) audit showed a poor score of D and E in all four quarters of the reporting year. The hospital participated in the 2015 National Diabetes Inpatient Audit, the hospital was worse for 13 out of 15 indicators than the England average.
- Patient's care and treatment was generally being planned and delivered in line with evidence-based guidelines. However, nursing care plans were not always person centred.
- Working to seven day working in the service was variable.

However, we also found that:

- The hospital was accredited by the Joint Advisory Group on Gastrointestinal Endoscopy (JAG).
- Pain of individual patients was assessed and managed appropriately. Patients' nutritional and hydration needs were appropriately assessed and the food and fluid charts were well maintained.
- Staff generally had the right qualifications, skills, knowledge and experience to do their job.
- A multi-disciplinary team approach was evident across wards
- Generally, nursing staff said all the information needed to deliver effective care and treatment was available to in a timely and accessible way.

Evidence-based care and treatment

Medical care (including older people's care)

- The hospital followed national guidelines from professional healthcare bodies such as the National Institute for Health and Care Excellence (NICE), the Royal College of Physicians and other medical specialty organisations and the Royal College of Nursing (RCN). Guidelines and policies were often in line with national guidance.
- Assessment tools for patients were generally comprehensive and did cover all health needs (clinical needs, mental health, physical health, and nutrition and hydration needs) and social care needs. Patient's care and treatment was generally being planned and delivered in line with evidence-based guidelines. However, nursing care plans were not always person centred.
- Assessments were carried out for the potential for skin damage and we found that all required assessments (included the national Waterlow score) and documentation was in place to provide staff with the appropriate guidance to manage patients' skin care needs effectively. Appropriate pressure relieving equipment was in place and we saw that wards had access to the tissue viability nurses.
- The hospital had not followed the guidance provided by the British Cardiovascular Society in regards to nurse staffing levels in the coronary care unit, where the nurse to patient ratio of 1:2 had not been followed in practice. Further, the hospital's document, 'Cardiac Care Unit and Oakley Ward Operational Policy', Policy 7.2, was not in line with the BCS's guidelines in regard to nurse staffing for coronary care.
- The medical care service regularly carried out a number of local audits, including hand hygiene, cleaning and records.
- The service had implemented a dementia care bundle in line with the implementation of the National Dementia Strategy (Department of Health 2009, 2010). A care bundle is a structured way of improving the processes of care and patient outcomes: a small, straightforward set of evidence-based practices, generally three to five that, when performed collectively and reliably, have been proven to improve patient outcomes.
- The service had recently implemented a revised sepsis care pathway in line with the national 'sepsis six' care bundle.
- Ambulatory care bundles had been implemented following national guidance and included specific care pathways for first seizure, new onset atrial fibrillation, painless jaundice and suspected pulmonary embolism.
- The national stroke care pathway was followed by the occupational therapist, the physiotherapist and the speech and language therapists before patients were transferred to rehabilitation units.

Pain relief

- Pain of individual patients were assessed and managed appropriately. We saw evidence in nursing records and NEWS charts of pain assessments being completed and pain relief being administered where required. The Abbey pain scale was used for those patients unable to vocalise their pain.
- In the Middleton Assessment Unit (MAU), three patients said they had been prescribed paracetamol for pain and felt that if they needed painkillers the nurse would give them. One patient said that during the drug round the nurse usually asked them if they needed tablets for pain. The drug chart showed the medicine was prescribed to be taken 'as required'. One patient was waiting for their medicines before going home.
- A patient told us their pain was under control. Another patient said that staff were working with him to get the pain control right but were not there yet.
- We observed patients in the wards we visited and they were comfortable as they rested in bed.
- We found that the pain assessment section of the NEWS chart we checked had been completed appropriately.

Nutrition and hydration

- Patients' nutrition and hydration needs were being assessed and met.
- We found that all patients in the medical wards we visited had been given a nutrition risk assessment on admission using the Malnutrition Universal Screening Tool (MUST).
- We saw that the nutritional and fluid charts were correctly filled in for patients whose food and fluid intake were being monitored and the fluid charts were maintained for patients on intravenous drips.
- In Cranford ward, the charge nurse told us that patients on PEG feeds or patients requiring nasogastric tube (NGT) feeding had been assessed by a dietician, who

prescribed the feeding regime for each patient. The patients' feeding regime had been reviewed regularly to ensure their nutritional and hydration needs were being met appropriately.

- We saw the written nutrition prescription chart with the prescribed feeding regime for a patient who required NGT feeding. The prescriptions were dated 3 October 2016 and assessed on 11 October 2016. The nasogastric feeding pump had been adjusted in accordance with the instructions from the dietician. The nutrition and fluid balance charts had been appropriately maintained and kept up to date.

Patient outcomes

- Information about the outcomes of patients' care and treatment was routinely collected and monitored. The information showed that the intended outcomes for people were variable.
- The hospital's Hospital Standardised Mortality Ratio (HSMR) performance was better than the England average. The HSMR is an indicator of healthcare quality that measures whether the mortality rate at a hospital is higher or lower than you would expect. The national expected HSMR score is 100. For the 12 month period from January 2015 to December 2015, HSMR was as expected with a value of 94 (compared to 100 for England) and 971 deaths compared to an expected 1,028 deaths. The weekend HSMR was within expected range for this time period. This means that the hospital had a lower mortality ratio than expected, meaning that there were fewer deaths in the hospital than expected.
- The hospital also participated in the Summary Hospital-level Mortality Indicator (SHMI). The SHMI is a nationally agreed hospital-wide mortality indicator that measures whether the number of deaths both in hospital and within 30 days of discharge is higher or lower than would be expected. For the 12 month period from January 2015 to December 2015, the SHMI was as expected with a value of 1.08 (compared to 100 for England) and 1,587 deaths compared to an expected 1,475 deaths.
- The hospital participated in the Sentinel Stroke National Audit Programme (SSNAP), the Lung Cancer Audit, the Heart Failure Audit, the National Diabetes Inpatient Audit (NaDIA) and the national Myocardial Ischaemia National Audit Project (MINAP) audit. The hospital did not provide a stroke thrombolysis service (this is a treatment where drugs are given rapidly to dissolve blood clots in the brain), as this was provided by another local NHS hospital.
- The hospital was participating on an ongoing basis in the SSNAP. An SSNAP level is assigned of A to E, A being the best. For the last audit, covering the period from January 2016 to March 2016, the hospital scored E. In the three preceding quarters, the hospital scored D or E. The hospital scored particularly poorly in team-centred key indicators. Patient-centred key indicators were poor for the stroke unit and multidisciplinary team working. Part of the service's plans to address this poor performance was a stroke nurse specialist who worked on Cranford ward (stroke ward) five days a week (Monday to Friday) to support patients; the nurse specialist also supported staff to provide appropriate care to patients.
- The hospital's results in the 2015 Heart Failure Audit were better than the England and Wales average for three of the four of the standards relating to in-hospital care, and slightly higher for the proportion of patients receiving an echo. The hospital's results were better than the England and Wales average for four of the seven standards relating to discharge, worse for two and the same for one. In comparison with the England and Wales average scores, the hospital performed best for input from specialists at 99% compared to the England average of 78%. The lowest score were for the referrals to cardiology follow-ups at 59%, which was better than the England average at 54%.
- The hospital participated in the 2015 NaDIA. The hospital was better than the England and Wales average for two out of 15 indicators and worse for 13, including medication errors at 44%, worse than the England average of 38% and patients having a foot risk assessment during the hospital stay at 14%, worse than the England average at 34%.
- The hospital participated in the MINAP audit in 2012/13 and 2013/14. In both years, the hospital scored better than the England and Wales average for all three indicators. Thrombolytic treatment time was not submitted as KGH is a tertiary cardiac centre and the treatment of choice is PCI and no patients were thrombolysed during the stated period.
- The hospital participated in the 2015 Lung Cancer Audit and the proportion of patients seem by a cancer nurse specialist was 91%, which was better than the audit

minimum standard of 90%. The 2014 figure was 93%. The proportion of fit patients with advanced non-small cell lung cancer (NSCLC) receiving chemotherapy was 80%, this was significantly better than the national level. The 2014 figure was 85%. The proportion of patients with small cell lung cancer (SCLC) receiving chemotherapy was 53%, this was not significantly different from the national level. The 2014 figure was 56%.

- Between March 2015 and February 2016, patients at the hospital had the same as expected risk of readmission for non-elective admissions and a lower than expected risk for elective admissions. Among the top three elective specialties, clinical haematology had the closest to expected risk of readmission, while medical oncology and general medicine showed a lower risk, closer to 80% of the expected risk.
- The service had an annual audit programme as part of the hospital's ongoing annual cycle of audits and progress against timescales was monitored. During 2015/16, 38 national clinical audits and five national enquiries covered relevant health services that the hospital provided. During that period, the hospital participated in 84% of national clinical audits and 100% of national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.
- The service was not an outlier for any mortality indicators.
- The hospital was accredited as the maximum grade A by the Joint Advisory Group on Gastrointestinal Endoscopy (JAG). This meant the endoscopy unit and its staff was assessed and monitored for quality performance and clinical safety against established international benchmarks. JAG accreditation was monitored through quality checks annually.
- Endoscopy and bowel screening services achieved very positive outcomes and strongly positive patient feedback. The bowel screening service was one of the first wave bowel scope centres. The diagnostic performance for endoscopy procedures delivered 99% of test results within 6 weeks.

Competent staff

- Staff generally had the right qualifications, skills, knowledge and experience to do their job.
- The service had mechanisms in place to ensure appropriate levels of formal supervision of all staff.
- There were clinical nurse specialists within the hospital to support the delivery of care to specific groups of patients, such as patients with pressure sores, patients living with dementia and patients who had had a stroke.
- Cranford ward organised training for staff in the care of patients on PEG feeds and patients requiring nasogastric tube (NGT) feeding. The training was provided by a nutritionist and the stroke nurse specialist.
- We saw the records for a new nurse (band 5) who commenced competency training in regard to NGT insertion and the care of a patient with an NGT. The competency training commenced on 18 October 2016 and was completed on 24 October 2016. The training was given by the charge nurse.
- Nurses working in medical wards had attended study days for venous puncture training and blood transfusion training, which were given by a practice development nurse. The nurses booked the topics they wished to attend following staff development discussion during staff appraisals.
- Staff said they had received regular appraisals and clinical supervision. Ward sisters confirmed the majority of their staff had received staff appraisals. In Deene C ward, the appraisal rate for August 2016 was 88% and in September 2016, it was 92%. Across the service in June 2016, appraisal rates were below the hospital target at 85% at 79%.
- Doctors and nurses underwent revalidation, as required by regulation.
- Junior doctors said there was good clinical teaching by consultants and registrars and on Fridays there was a grand round and teaching by consultants. On Wednesdays, there was medical teaching organised by the Deanery and mandatory teaching on Tuesday afternoons.
- Junior doctors said they had plenty of opportunities to learn new skills such as mental capacity assessments, identifying safeguarding cases and complex discharge planning.
- Nurses who were appointed as nurse in charge of a ward had competency training. We met a nurse in charge (band 5) who was currently undergoing six months development training provided by the ward sister (band 6), ward matron (band 7) and the lead nurse (band 8) before taking up the post as a ward sister (band 6).

- Staff undertook mandatory training as well as other relevant clinical training on topics such as tissue viability, falls management and prevention, and dementia care.
- Staff said they had had training on complaints' management and the importance of local resolution and the importance of Duty of Candour. Staff were trained to give assurance to complainants that they would not be treated differently because they had raised concerns.

Multidisciplinary working

- A multi-disciplinary team (MDT) approach was evident across wards. We observed effective MDT working in the wards we inspected. MDT meetings took place on the wards on a regular basis to review the progress of each patient towards discharge
- All the medical wards held their own internal MDT meeting every morning (9am to 9.30am). We attended one of these meetings in HC Pretty ward which was led by one of two consultants. Among those who attended were the registrar and the junior doctors, a ward staff, the occupational therapist and the physiotherapist and, on this occasion, the safeguarding lead. Matters discussed were patients on the prioritised list due to changes in their care and treatment and patients due to be discharged. There was a comprehensive discussion about patients, the assessments they needed and the plan for their discharge.
- Staff said there was good multidisciplinary working with doctors, other internal services and external organisations, including social services, the ambulance service, other healthcare providers and the Admiral Nurse.
- Complex discharge planning required good internal and external MDT working with medical specialists, allied healthcare professionals, social workers, patients, and family members.
- In the endoscopy unit, three staff nurses and a bowel cancer screening nurse told us that there was a good working relationship between consultants and nurses.

Seven-day services

- Working to seven day working in the service was variable.
- The medical wards had consultant cover during weekdays and had out of hours access to consultants. The medical care service arranged consultant of the week cover for out of hours and at weekends. Most, but not all, staff felt the consultant cover was adequate. Consultants were on call at weekends.
- Senior staff said the service was looking at ways to fully adopt a seven-day a week working practice for doctors. Newly admitted patients were seen by the on call consultant at weekends as required, but there were not generally full ward rounds at the weekends.
- Patients had access to the physiotherapist and the occupational therapist daily and they were based in the wards. The speech and language therapist (SALT) attended to patients by referral only. Dieticians were available and attended to patients through referrals by the ward staff. Therapists were on call out of hours.
- There was a pharmacist available for the medical wards. The charge nurse told us Cranford ward had a pharmacist allocated to the ward daily.
- There was a consultant on call 24 hours a day, seven days a week to respond to urgent cases of gastro-intestinal bleeds.
- Diagnostic services were available over the weekend and out of hours.

Access to information

- When patients moved between teams and services, including at referral, discharge and transfer the information needed for their ongoing care was generally shared appropriately, in a timely way and in line with relevant protocols.
- Generally, nursing staff said all the information needed to deliver effective care and treatment was available to in a timely and accessible way.
- There was access to a range of information on the hospital's intranet.
- Staff had access to information, clinical guidelines and hospital policies through the hospital library intranet. They also received a newsletter on current developments in the hospital and updates through emails.
- Information was communicated and shared through ward meetings and multidisciplinary meetings.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff we spoke to generally understood the relevant consent and decision-making requirements of

legislation and guidance, including the Mental Capacity Act 2005 (MCA). We saw evidence that mental capacity assessments had been undertaken for almost all patients who required this.

- The service showed 91% compliance with MCA training in June 2016, which was better than the hospital target of 85%.
- Patients told us staff asked their permission before providing care and treatment. Consent was taken from patients appropriately. We saw documents were in place for consent to treatment and interventions.
- Patients were supported to make decisions. We saw posters displayed providing contact details for Independent Mental Capacity Advocates (IMCA) for patients who lacked capacity and supported and represented the patients in the decision making process.
- A Deprivation of Liberty Safeguards (DoLS) authorization had not been completed for a patient on Cranford ward for 10 days and a mental capacity assessment had not been done. We raised this as a concern and the nurse in charge took action urgently to resolve this matter.
- For another patient, we saw that appropriate measures were taken; a mental capacity assessment and a DoLS application and authorisation to support the care plan required. Staff had complied with the MCA 2005 in this case.
- In Naseby wards, we saw that three people had DoLS applications completed appropriately.
- We checked the medical and nursing records for four patients who were living with dementia on Naseby A and Naseby B. We noted these patients had Mental Capacity Act (MCA) assessments completed and the behavioural charts for all four patients had been updated daily reflecting their capacity to make decisions.
- In the endoscopy unit, when we asked regarding asking consent of patients for a CT scan post sedation, we were told that consenting prior to the endoscopy procedure incorporates consenting to a possible CT scan if a malignancy is suspected.

Are medical care services caring?

Good

We rated the service for caring as good because:

- Staff treated patients with compassion, kindness, dignity and respect. We observed that staff were friendly and interacted well with patients.
- Patients gave positive feedback about the care and service provided. They said that they were very happy with the standard of care and would be happy to use the facilities in the future.
- Patients reported that staff were kind, respectful and gentle in their approach. They said the doctors explained things to them in a gentle way and that they were well informed before treatment was agreed.

Compassionate care

- Patients and those close to them were treated with respect in almost all interactions that we observed.
- Patients told us that the nursing care was excellent. They said the staff worked hard and were kind, gentle and courteous. A patient commented they were always treated with respect and dignity.
- Patients said the staff were always polite in their approach and unfailingly keen.
- A patient commented the doctors were wonderful and spoke in a gentle way.
- Patients all said they were very happy with the standard of care at the hospital and would be happy to use the facilities in the future.
- Patients felt respected and their dignity was maintained. They said that the curtain was always drawn when patients were given personal treatment.
- We observed doctors drawing the curtains before they examined a patient and nursing staff drew the curtains before personal care was provided.
- During lunchtime, we saw an HCA cutting up fish fillets to assist some patients. A patient commented they should not have ordered chips since they had difficulty chewing but added that they love chips. The patient confirmed they were given a menu to choose from.
- Patients felt the healthcare assistants were very helpful and said they were always around to lend a hand. In one ward, we observed an HCA answering a call for help and

the HCA was seen assisting a patient to get out of bed to go to the toilet. The HCA was patiently encouraging the patient, prompting and guiding the patient to hold on to the walking frame before walking to the toilet.

- Four patients told us that staff always responded to the call bell when they rang for help. One patient said 'the staff saw us struggling to sit up and they came over without us calling for help'.
- We observed an HCA assisting a patient to lie in a more comfortable position in one ward without the patient calling for help.
- However, a patient told us there was an agency nurse who had difficulty speaking English and that the person was unhelpful. Another patient said they had raised a concern about an agency staff and later found that the agency staff had gone off site.
- The response rate for the Friends and Family Test between August 2015 and July 2016 was 19%, which was worse than the England average of 26%. The response rate analysed by wards varied from 2% for Ambulatory Care to 59% for Clifford Ward and Lilford Ward. The percentage of respondents saying they would recommend the service was in the range 90-100% for the Cardiac Centre, Clifford Ward and Lilford Ward. The other wards had lower scores but were mostly above 70%. The lowest scores were reported by Ambulatory Care and Naseby Ward B.
- The nature of the responses had been analyzed further for all responding inpatients in quarter 1 2016/2017. 74% of responses were positive. 3% related to delays in treatment; 5% related to poor communication; 1% related to poor patient care; and 17% were other comments.
- We saw staff respecting patients' privacy and dignity, for example by knocking on doors to consultation rooms. However, on one occasion we saw staff did not provide care in a way that respected patients' dignity on the cardiac unit; the curtain was not drawn around a female patient who was having treatment that required her to partially undress and there was a male patient in the area at the time. We raised this with staff and they promptly pulled the curtain. When we went back to the hospital on the unannounced inspection, staff had been briefed on the importance of maintaining patient privacy and the manager of the cardiac unit had ordered curtains that closed together with magnets to ensure patients' dignity was maintained.

Understanding and involvement of patients and those close to them

- Patients that we spoke to told us that they had felt involved with their care and understood the treatment they were receiving.
- Patients said doctors and nurses gave them full information in a clear and unhurried way.
- They said the doctors were thorough in taking down all the information needed from the patients. Most patients knew the name of their doctor.
- A patient told us the doctors gave them the success rate of a procedure and informed the patient of the possible complications. Another patient said the doctors spoke concisely and responsively.
- We observed staff changing their communication styles and speaking slower for patients when required to help them understand what was being said.
- We saw that staff actively directed patients' relatives to access information about their care and treatment from the information leaflets throughout the wards.
- In patients' notes we reviewed, there was documented evidence of discussions held with patients and their family members regarding a patient's treatment or the progression of their illness and any discharge planning or end of life decisions, including whether the patient wished to be resuscitated in the event of a cardiac arrest.

Emotional support

- The medical services had a number of clinical nurse specialists who gave additional support to people living with specific conditions such as stroke and dementia. We saw that patients living with dementia were supported by the hospital's Admiral Nurse.
- Staff monitored patients for signs of anxiety and depression.
- Staff told us patients would be referred to the confidential counselling service if required.
- Staff showed patience and understanding when interacting and treating patients.

Medical care (including older people's care)

Are medical care services responsive?

Good

We rated responsiveness for medical care as good because:

- The service had an effective escalation procedure in use for supporting demand for beds.
- Staff understood and respected patients' personal, cultural, social and religious needs, and took these into account and services were generally planned and delivered in a way that took account of the needs of different patients. The dementia strategy was being implemented and appropriate care was provided for patients living with dementia.
- The ambulatory care unit included a consultant-led service to provide suitable patients with fast access to an assessment or intervention, without the need for an overnight stay in hospital.
- Patients with a learning disability were well supported by the specialist nurse.
- Information was available in different languages and interpreters were available to support patients.
- Patient flow and bed capacity to meet demand had been a significant pressure for the hospital for a number of months. Senior managers were in ongoing discussions with commissioners and stakeholders regarding the most appropriate ways of managing the DTOC position as the medical care beds being used were placing a significant pressure on the effective patient flow through the service.
- Since April 2016, the trust had consistently delivered six of the seven cancer targets demonstrating sustainable improvement.

However, we also found that:

- Discharges were sometimes delayed due to patients having to wait for ongoing care packages.
- Compliance with dementia awareness training was variable across wards.
- The service had not met the trust's timescales for responding to complaints in the period August 2015 to July 2016, but following the introduction of a revised complaints' policy in July 2016, with longer timescales for a response, improvements had been made in responding to complaints with an average response timescale of 31 days (in the period April to September 2016).

Service planning and delivery to meet the needs of local people

- The service generally understood the different needs of the patients it served and acted on these to plan, design and deliver services. As well as the general medicine and speciality wards, the service had an ambulatory care service to cater for patients who required treatment but did not need to be admitted overnight. Patients on the unit received the same medical treatment as inpatients but this service reduced the amount of overnight stays.
- Planning of the delivery of the service was coordinated at daily safety huddles where ward leadership met to discuss staffing levels, potential discharges, outliers and bed moves.
- Commissioners, other providers and relevant stakeholders were involved in planning services. The service did not provide a hyper-acute stroke service as they did not carry out thrombolysis, which is where blood clots are dissolved by infusing an enzyme into the blood. Patients requiring this treatment were transferred to another local NHS hospital.
- Staff working in the medical care service felt they had worked well with local GPs, the local authorities, other healthcare providers and local charitable organisations, such as Dementia UK, to meet the needs and improve the health of the local community. Staff felt the communication within the multidisciplinary team was effective.
- Information leaflets were available in different languages, representing local cultural groups. The menus were in different languages and included cultural dishes reflecting the needs of the local community.
- The Ambulatory Care Unit provided a consultant-led facility for suitable patients to have advanced assessments and interventions that could safely be completed in a day, without the need for an overnight stay in hospital. This service was appealing to patients because they were able to make an appointment to see their consultant and have the assessment or

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

- Treatments that had been provided in the unit included ultrasound imaging for deep vein thrombosis, the assessment of respiratory conditions and draining fluid from the lungs. Patients were provided with a pager and could wait anywhere in the hospital, such as the cafeteria, and be called when the consultant was ready. The unit also housed a nurse-led clinic for venesection and intravenous infusion, used by regular patients. This area had two trolleys and six chairs to accommodate eight patients.
- The Cardiac outreach was operating a 24/7 service and had been since August 2016.

Access and flow

- Patient flow and bed capacity to meet demand had been a significant pressure for the hospital for a number of months. Bed occupancy was reported as 104% and the hospital had 82 Delayed Transfer of Care (DTOCs) patients on the day of our unannounced inspection. The DTOC patients comprised of 47 patients for further medical rehabilitation, 19 patients waiting for social care assessments and 16 patients awaiting further input from both health and social care. Senior managers were in ongoing discussions with commissioners and stakeholders regarding the most appropriate ways of managing the DTOC position as the medical care beds being used were placing a significant pressure on the effective patient flow through the service. The service was in the process of carrying out a bed remodelling exercise designed to improve patient flow.
- The service had an effective escalation procedure in use for supporting demand for beds and at the time of the unannounced inspection, 23 escalation beds were being used. Staffing was flexed to these areas in accordance with the deflation procedures and the clinical site supervisors ensured all patients needs could be appropriately met in these escalation areas and had been risk assessed by their relevant consultants.
- At times, medical care patients were placed in 'outlying wards' (such as the surgical wards): we saw effective policies and admission criteria in place governing this process. At the time of the unannounced inspection, there were nine medical outlying patients. Staffing and facilities were appropriate to meet those patients'' needs.
- We observed the site supervisors bed capacity meeting during one evening and saw that there was a clear, structured focus on patient safety and ensuring that appropriate staffing levels and skill mix were in place despite significant pressures on bed capacity, due to a significant number of new admissions that day. The hospital was using a bed predictor model to forecast bed demand and capacity and the senior manager on call and clinical site supervisors liaised with all relevant wards and the emergency department to ensure patient flow and safety was maximised.
- Patients needing medical care were admitted through the emergency department. They were transferred either through the Middleton Assessment Unit (MAU) or directly to a medical ward or a specialty medical ward. This provided flexibility for the service but also resulted in several moves for some patients.
- The number of moves depended on the patients' medical conditions and the type of specialist care needed. Between July 2015 and June 2016, 75% of individuals did not move wards during their admission, and 25% moved once or more. These figures were hospital wide. Separate data was not available for medical care. The number of bed moves after 10pm in July 2016 for the service was 146, which equated to about five patients being moved at night each day of the month. However, we did not have a breakdown of how many of these patients had been moved to clinical reasons, as opposed to bed capacity pressures.
- Some patients needed to be located in a different ward, called an 'outlier ward' because of shortage of beds. A patient from HC Pretty ward was placed in Barnwell C ward. The nurse in charge told us that it was common to receive such patients; it is generally the more stable patients that were transferred to the outlier ward. The doctors from HC Pretty ward attended to such patients.
- All acute stroke patients were transferred to the another local NHS hospital's stroke unit for thrombolysis in accordance with the national stroke pathway. These patients usually stayed for two to three days before being transferred back to Cranford ward. The

repatriation list was discussed at the morning board round daily in relation to whether there were beds available when these patients returned after two to three days.

- We were told occasionally patients were placed in an outlier ward. If this was the case, the stroke specialist nurse would review the patient and if the patient was medically fit for rehabilitation, the patient would be transferred to a bed at a local community hospital Wellingborough and Market Harborough. Otherwise, patients would be moved back to Cranford ward as soon as a bed was available. However, patients and families often refused to travel long distances to rehabilitation centres in Wellingborough and Market Harborough. This blocked medical beds for new admissions. On the day of our visit, Cranford ward had 12 patients considered to be medically fit for discharge (MFFD) but they were still waiting to be discharged.
- Lamport and Twywell wards provided rehabilitation for patients waiting to be discharged into the care of the community services. The ward sister told us the average length of stay was 48 hours, although two patients had been there for over 30 days. The flow was constrained by the need to arrange care packages, particularly for patients who came from outside the county.
- The ward sister in Naseby ward showed us the comprehensive form that had to be filled in for a patient needing funding for continuing nursing care when discharged. The care package had yet to be drawn up but this took time especially when the patient was out of area. The patient was medically fit for discharge but may have had to wait a week or more for transfer. The delay meant that the bed occupancy level was affected.
- Discharges were generally handled efficiently and a comprehensive care package was drawn up for patients due for discharge. From Monday to Friday, there was a daily ward MDT meeting attended by the consultant and their team of doctors, allied healthcare therapists, a senior nurse and the discharge co-ordinator to discuss each patient's progress and the plan for patients due to be discharged. The discharge lounge had referral criteria and staffing met patients' needs during the inspection.
- A junior doctor explained the discharge summary forms they filled in, signed and dated, giving their grade. A copy of each patient's form was sent to their GP following their discharge.
- Between April 2015 and March 2016, the average length of stay for medical elective patients at the hospital was 5.4 days, which was worse than England average of 3.9 days. For medical non-elective patients, the average length of stay was 6.5 days, which was similar to England average of 6.6 days.
- In the endoscopy unit, staff said that where a malignancy was suspected post endoscopic procedure, patients were referred to have a CT scan on the same day.
- The cardiac unit facilitated the flow of patients through the department by storing patients' medications To Take Away (TTAs) in a locked cupboard in the treatment room on the unit. This meant that patients who were fit for discharge could have their prescribed TTAs checked by two nurses and dispensed from the ward without going through the pharmacy, therefore minimising how long they had to wait.
- The trust recognised that performance against the nationally mandated cancer pathways was not as it should be. In January 2016, this became a key focus for improvement and a recovery programme was initiated. Since April 2016, the trust had consistently delivered six of the seven cancer targets demonstrating sustainable improvement. The outstanding target to be achieved was 86.7% against a 90% trajectory.

Meeting people's individual needs

- Staff understood and respected patients' personal, cultural, social and religious needs, and took these into account and services were generally planned and delivered in a way that took account of the needs of different patients.
- The hospital worked closely with Dementia UK who provided an Admiral Nurse (a dementia specialist nurse) to assist patients and their families, and support and advise staff in the care of patients living with dementia. The "This is Me" assessment booklet was used to support staff's understanding of the needs of patients.
- In Naseby ward, we observed patients living with dementia were encouraged to get involved in therapeutic activities. The ward had an activity co-ordinator who organised social and therapeutic activities for people living with dementia and older people in the ward who wished to join in.
- Group activities were held in Naseby A either in the ward area or in the activity room depending on the type of

activities held. Patients from Naseby B would share in the group activities. The activity co-ordinator also arranged to take individuals for walks in the hospital grounds as they preferred.

- In Harrowden A, there was a designated activity corner for patients living with dementia. This had memory pictures and items for the patients to explore.
- Compliance with dementia awareness training was variable across wards. According to the nurse sensitive indicators for June 2016, Harrowden C had no staff that had had training with the hospital target being 80%, whereas Twywell ward showed 100% of staff had had this training.
- In the wards we visited, we observed appropriate one to one care was provided by staff for patients who had delirium or who were living with dementia and who demonstrated extreme behavioural problems.
- Reasonable adjustments were made so that disabled people could access and use services on an equal basis to others. In the endoscopy unit, we were told that carers were allowed to sit with learning disability patients until their procedure time. This meant that patients were kept calm and anxiety was reduced prior to their procedure. Staff were able to articulate how they managed patients with dementia and learning disability. We were told that if patients were known to have either dementia or learning disability, their time slot would be prioritised.
- The ward sister in Lamport and Twywell told us patients with a learning disability were well supported by the clinical nurse specialist in learning disability. The specialist nurse followed these patients through their journey. Staff said they would contact the specialist nurse when they admitted a patient with a learning disability.
- There was a translation service provided 24 hours a day over the telephone. Patients also had access to face to face translation which staff could arrange if required. Charts were provided in which patients could point to what they needed in their own language. Patients confirmed they were aware of this service. Information leaflets were available in different languages, representing local cultural groups. The hospital had between 30 to 40 members of staff who were multilingual and who would help to translate for patients if required.
- Patients who suffered from depression or mental health conditions would be referred to the psychiatric team for assessment.
- We found that in some wards, such as Clifford ward (medical short stay), there was no room set aside for private discussions with family members.
- There was a bereavement counselling service available for patients' relatives.
- We were told assistance was provided for believers of most faiths. There was access to a chaplaincy service. The chaplain provided services and was assisted by many lay ministers including 60 chaplaincy volunteers and 48 ward-based volunteers.
- Wards had protected meal times to ensure that patients received adequate nutrition and hydration. Posters were on display to remind visitors of this.
- During our visit, we saw staff encouraging patients to drink plenty. Jugs of fresh water were seen on patients' lockers and hot drinks were served regularly. We observed tea, coffee and biscuits being offered to patients post procedure in the endoscopy recovery area.
- Eight patients commented the food was of a high standard and plenty of choices were provided; for dinner, there was a choice of three hot meals, two salads and two kinds of sandwiches. There was a choice of three cereals for breakfast. Patients commented they were impressed with the food. They said they had large portions and the food was well presented. Drinks were refilled often and there was a choice of drinks. The menus were in different languages and included cultural dishes reflecting the needs of the local community.
- There was not always enough space to ensure care was provided in a single sex area on the cardiac unit and we saw a male patient nursed in a side room within a four bedded female bay. The hospital had a 'Same Sex Accommodation Pledge' stating that they aim to care for patients in same sex areas but that there may be occasions when clinical needs outweigh all else and mixing sexes may be unavoidable for a short period of time. Staff told us that the male patient we observed in a female bay would be moved as soon as they had the facilities to do so. When we returned to the cardiac unit on our unannounced inspection, single sex accommodation was maintained.

Learning from complaints and concerns

- Patients who used the service knew how to make a complaint or raise concerns. Information for patients

and visitors about how to make a complaint was available on the hospital's website and the wards had contact details for the patient advice and liaison service (PALS).

- The service had not met the trust's timescales for responding to complaints in the period August 2015 to July 2016, but following the introduction of a revised complaints' policy in July 2016, with longer timescales for a response, improvements had been made in responding to complaints with an average response timescale of 31 days (in the period April to September 2016).
- The complaints policy was updated in quarter 1 of 2016/17, together with supporting publicity materials, such as a leaflet, an easy read leaflet and a poster. All public materials would be reviewed by the Patient Experience Steering Group before publication.
- A lead nurse told us that the hospital's target was to respond to complaints within 25 working days. The complainant received an acknowledgement within 3 working days.
- Staff who managed complaints received external training on complaints management and other complaint resolution techniques. Senior ward staff were able to call upon the hospital complaints' team to help resolve issues as close to the point of care as possible and offered differing routes for resolution including meetings, telephone conferences and a formal investigation with a written response.
- All written responses were subjected to scrutiny to ensure that all key lines of enquiry had been dealt with and that details were given of how improvements could be made where necessary. The written responses were then signed off by the Chief Executive Officer.
- Complainants were encouraged to return to the hospital if they were dissatisfied with any aspect of the hospital's investigation and response. Complainants were made aware of their right to approach the Parliamentary and Health Service Ombudsman. Complainants were sent a questionnaire post resolution so that the hospital could assess how accessible the complaints procedure had been and where improvements could be made in its management of complaints.
- Lessons learnt from complaints and concerns raised were reported on via Patient Experience Reports to the Patient Experience Steering Group and the Governance Committee. The hospital's 'Learning Leaflet' included learning points from complaints so that all staff could benefit from lessons learnt and improve their service.
- Over the period from April 2016 to June 2016, there had been 14 complaints in medical care and eight in specialty medicine. All complainants had been offered an informal resolution process. Otherwise the formal process had been followed, which included a personal letter from the Chief Executive Officer.
- In medical care, the majority of the complaints related to nursing care. Other themes were delays, discharge and communication. Key action and learning from the complaints included revised training on discharge and more effective communication with the patient and family. Where members of staff had been identified as giving poor nursing care, the matter had been fed back to ward areas by matrons.
- In specialty medicine, the main concern had been treatment by medical staff and more specifically diagnosis. In all instances, the consultants in question found that guidelines had been followed. Where there were difficulties, the cases had been referred to an external consultant.
- From April 2016 to June 2016, the number of complaints taken to the Parliamentary and Health Service Ombudsman had been two in medical care and two in specialty medicine.

Are medical care services well-led?

Requires improvement

We rated the service for well led as requires improvement because:

- Risks identified by the service were not being assessed, monitored and mitigated via an effective, comprehensive risk register. Risks we identified on inspection were not recognised by the service, including the failure to escalate deteriorating patients, poor junior doctor cover for medical wards, and the poor completion and storage of patients' records.
- Many of the risks on the risk register did not have sufficient assurance that mitigating actions were being

monitored. We were therefore not assured staff at every level in the service had an effective understanding of all the risks to patient safety and were able to assess, mitigate and monitor all known risks.
- Ward dashboards referred to some local risks but these were not systematically escalated to the service risk register.
- Not all staff were fully aware of the service's plans to remodel the beds in the service, which was designed to improve patient flow. Some staff described it as a 'stop, start' process with delays in the reconfiguration of beds and wards. Staff were not generally aware of the timescales for this reconfiguration.
- Staff felt they were not always listened to and there had been few changes about staffing issues raised.

However, we also found that:

- Leaders within the service, of all levels, were generally visible and approachable. Staff told us that the senior leadership team, including both senior management and lead clinicians and nurses, were generally visible and effective.
- Staff felt involved in the hospital's CARE values which brought staff together to discuss ways to improve services and provide quality care to patients.
- Almost all staff were proud of their wards and teams and spoke positively of the 'friendly' working environment at the hospital. Staff felt supported and able to speak with the lead nurse if they had concerns.
- Patients were encouraged to be involved and had attended trust board meetings.
- There were a large number of volunteers from the local community working in various departments in the hospital.

Leadership of service

- Leaders within the service, of all levels, were generally visible and approachable. Staff told us that the senior leadership team, including both senior management and lead clinicians and nurses, were generally visible and effective. Local ward leaders were known within teams and appeared to communicate well with staff. Generally, we saw effective team working and evidence of positive working relationships between staff and the ward leadership.
- The Director of Nursing and Quality and the Medical Director were visible in some areas of the service.
- The leadership team were looking at ways to enhance joint working with another local NHS hospital, and had set up joint mortality review meetings for the two hospitals.
- Staff said members of the executive team were visible in the wards and the hospital was open and transparent in sharing relevant information to enhance its performance.
- Most staff said matrons were approachable and played a lead role in managing day to day pressures on the wards.
- Junior doctors felt well supported by consultants and registrars and found them approachable and helpful.
- Nursing staff including HCAs felt able to speak with the matron or lead nurse if they had concerns about practices, staffing issues and other concerns. However, staff felt there was little changes in regard to staffing issues raised.

Vision and strategy for this service

- The hospital's vision was to provide excellent and convenient care in new ways to transform people's health for the better. The hospital had four principal strategic objectives:
  - To provide appropriate and high quality care to individuals, communities and the local population.
  - To be a clinically and financially sustainable organisation.
  - To maintain a fulfilling and developmental working environment for the staff.
  - To be a strong and effective partner in the wider health and social care community
- The hospital was implementing a new dementia strategy to ensure patients with dementia had a better patient experience.
- The hospital was participating in a wide-ranging extended clinical collaboration with another local acute NHS hospital and other partners in the local health economy, stretching across all clinical specialties. The transformation project was planned to take place from 2016/2017 to 2020/2021 and would deliver better health services to patients at lower cost to the taxpayer.
- Staff had been encouraged to develop good teamwork and communication skills and to acquire attitudes conducive to caring treatment through the CARE

initiative. The CARE acronym refers to compassionate, accountable, respectful and engaging care. A number of workshops had been held and the topics had been introduced at a number of regular meetings.
- Most staff were aware of the CARE values and some had been involved in workshops to devise them.
- Most staff on the wards were aware of the localised service plans and vision for the future, and were able to explain what was going to happen and how this would improve the service.
- Not all staff were fully aware of the service's plans to remodel the beds in the service, which was designed to improve patient flow. Some staff described it as a 'stop, start' process with delays in the reconfiguration of beds and wards. Staff were not generally aware of the timescales for this reconfiguration.

Governance, risk management and quality measurement

- The service risk register was not comprehensive and some risks had been on the registers for up to two years. There were 29 risks on the register and there was not a timescale in place for the resolution of any of the risks. Whilst control factors (mitigations) were evident for all risks, the registers only contained positive assurance (how the progress in managing the risk was being monitored) in 13 cases. Risks did not have a unique reference number.
- For example, one risk was recorded was that patient monitoring not available on Oakley Ward (cardiac ward) as the portable telemetry monitors only fed into the screens on CCU making detection of issues difficult and ongoing monitoring problematic. The risk was entered on the register on 1/4/2015 and the mitigation of the risk was 'Approval of business case to purchase equipment' but this was not dated. Many of the risks did not have sufficient assurance that mitigating actions were being monitored.
- The areas for improvement identified by the nurse sensitive indicators and ward dashboards had no direct correlation to the service risk register. Ward dashboards referred to some local risks but these were not systematically escalated to the service risk register. Poor completion of NEWS charts, poor compliance with mandatory training, poor compliance with dementia training on some wards, variable outcomes from stroke audits (SSNAP) and poor completion of MUST assessments on some wards within 24 hours were examples of risks to patient safety and the quality of care and treatment that had not been reflected in the service risk register. Risks identified by the service were not being assessed, monitored and mitigated via an effective, comprehensive risk register.
- Risks we identified on inspection were not recognised by the service, including the failure to escalate deteriorating patients, poor junior doctor cover for medical wards, and the poor completion and storage of patients' records. We were therefore not assured staff at every level in the service had an effective understanding of all the risks to patient safety and were able to assess, mitigate and monitor all known risks.
- The clinical governance indicators, including the nurse sensitive indicators, were compiled each month into a comprehensive Integrated Governance Report, which was presented to the monthly Integrated Governance Committee.
- Senior staff attended various meetings regularly including the lessons learned forum, matrons forums, risk management meetings and quality meetings to discuss clinical practice and to improve patient care and experience.
- The hospital had made it a major initiative to reduce falls. The falls policy had been reviewed to make risk assessments and care planning more effective. A practice improvement facilitator nurse had been appointed to champion falls prevention work.
- The work of the falls prevention steering group had been reviewed to increase the focus on the prevention of falls. Equipment had been reviewed with a view to preventing falls. There had been a review of how patients at risk of falling are cared for by the nursing staff. Training on falls prevention had been enhanced.
- Another of the hospital's initiatives was to develop an effective system and processes to reduce avoidable pressure ulcers.

Culture within the service

- Staff at all levels were enthusiastic about their work and team working was evident during our visit. Almost all staff were proud of their wards and teams and spoke positively of the 'friendly' working environment at the hospital, despite the ongoing work pressures most staff reported.

Medical care (including older people's care)

- Staff told us that despite a shortage of permanent staff in some wards, they felt deeply committed to offering the best care they could to patients.
- Staff felt they were not always listened to and there had been few changes about staffing issues raised.
- There had been no concerns raised about bullying, harassment and whistleblowing. Staff knew how to access the hospital intranet library for relevant policies and procedures if they felt a need to raise an issue.
- All staff said they had received training in duty of candour during the induction period and they could get access to the hospital's policy on duty of candour on the intranet. This ensured that if a significant adverse incident occurred the patient or their relatives would be informed within 10 days, following the correct formal procedure.
- The policy on duty of candour had been reviewed and completed in May 2016. A translation service was available for this policy. The Interpretation/Translation Policy, Guidance for Staff (I55) was available on the hospital library intranet under hospital wide policies.

Public engagement

- The local community had been involved in a number of engagement events held to find out if each specialty could modify the service provided to better meet patients' needs.
- Patients were encouraged to be involved and had attended trust board meetings. Patients had attended board meetings to present their patient stories.
- The Patient Experience Steering Group met regularly, was well attended and reviewed themes arising from complaints to consider changes in services to improve the patient experience.
- There were a large number of volunteers from the local community working in various departments in the hospital. They included 21 meet and greet volunteers and 29 volunteers providing individual support to patients.

Staff engagement

- Staff felt they had been involved in projects to improve services for the local community.
- Staff had been encouraged to be fully engaged through the CARE project, which commenced in July 2016.
- This project brought staff together to discuss ways in which communications among staff and between staff and patients could be improved to deliver a top quality service.
- Ward managers commented that their frontline staff were enthusiastic to improve care and that they supported each other to do so.
- Doctors felt that they had a good team of experienced HCAs who were an asset.

Innovation, improvement and sustainability

- The clinical collaboration programme involved Kettering general hospital, another local acute NHS hospital and other partners in the local health economy working together to a massively increased extent to provide a better service to patients and lower cost to the taxpayer. This programme was a key element of Northamptonshire's Sustainability and Transformation Plan (STP), which set out to implement a five-year plan for a sustainable service for health and social services in the county.
- The collaboration focused initially on 10 specialties, but others would be added later. Patients would be referred or triaged by a county service and then treated close to home.
- A number of engagement events were held to find out if each specialty could modify the service provided to better meet patients' needs.
- The hospital had developed new treatment pathways to make better use of available staff, not just consultants but also specialist nurses and GPs with specialist skills.

Surgery

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

Information about the service

The Kettering General Hospital NHS Foundation Trust has 13 main operating theatres covering general surgery, medical oncology, urology and trauma and orthopaedics, and two gynaecology theatres, across the one hospital site. The hospital also had five surgical wards, a surgical day case unit and treatment centre.

Kettering General Hospital had 24,682 surgical spells from April to 2015 to March 2016. A hospital provider spell refers to the total continuous stay of a patient using a hospital bed on premises controlled by a health care provider during which surgical care is the responsibility of one or more consultants. Emergency spells accounted for approximately 25% of stays, 60% were day case spells, and the remaining 15% were elective. Almost 40% of spells were in ophthalmology or trauma & orthopaedics.

All patients admitted were treated under the direct care of a consultant and a senior house officer supports surgical care 24 hour a day, seven days a week. Patients are cared for and supported by registered nurses, care assistants and allied health professionals such as physiotherapists employed by the hospital.

We visited the hospital as part of our announced inspection on 13, 14 and 15 October 2016 and carried out an unannounced inspection on 24 October 2016. As part of the inspection, we visited the pre-assessment clinics and emergency acute assessment unit, the operating theatres, the theatre recovery area and the surgical wards.

During the inspection, we spoke with 40 staff at different grades, including ward and theatre managers, nurses, therapists, consultants, healthcare assistants, pharmacists and housekeepers. We spoke with five patients and their families, observed care and treatment and looked at 17 patient's medical records. We received comments from people who contacted us to tell us about their experiences, and reviewed performance information about the hospital.

Surgery

Summary of findings

We rated the service as good for effective, caring and well-led and requires improvement for safe and responsive. Overall, we rated the service as requires improvement because:

- The hospital had not provided data for referral to treatment time (RTT) for admitted performance for surgical services since November 2015. The service had a RTT recovery programme and was exceeding its trajectory of 77% by the end of November 2016. Private providers had been contacted to support the treatment to some of their patients.
- Nursing staffing was not appropriate on Ashton ward whereby registered nurses left the ward unattended during the night shift at times. We raised this as a concern with the trust and they took immediate action to ensure a registered nurse was on this ward at all times.
- Infection control precautions were not always effective. We observed staff on Geddington and Deene B wards not decontaminating their hands after being in direct contact of care with patients. Clinical waste bins were conveyed through the maxillofacial service. These frequently leaked which meant there was a risk of infection control putting both staff and patients at risk. The breast pre-assessment clinic had fabric chairs and privacy curtains. The chairs and curtains had no date when last changed or cleaned which meant there could be a risk of cross infection due to inappropriate cleaning. Nursing staff did not adhere to the handling of food safely guidance. Theatre staff did not adhere to the hospital and national standards by wearing of cover gowns and footwear when leaving and entering the theatre area.
- The environment within the maxillofacial service area was cramped and not conducive to patients who were partially sighted, hard of hearing or disabled. They had limited to no access to the x-ray room due to the entrance being too small for a wheelchair. This contravened the Equality Act 2010. The service had a business plan in place for the relocation of this area.
- Medicines were not always stored or handled appropriately. Medicines were stored with sterile instruments, on open shelves within the maxillofacial service. Medicine clinical rooms (Geddington, Barnwell B and C, DASU and the surgical day case unit) had temperatures above the recommended 25º celsius which were detrimental to some drugs. We found topical medicines and liquids which had been used with no date of opening.
- Patient records on DASU and Geddington ward were left unattended during our visit. Also on Geddington ward, records were kept in an unsupervised, unlocked room.
- The environment of Barnwell wards B and C were found to be visibly dirty and very dusty. This was brought to the attention of senior staff. During our unannounced visit on 24 October 2016, the ward had undergone a deep clean and it was visibly clean.
- There were mixed patient outcomes and not always an action plan to ensure improvements. Examples included the hip fracture audit and the bowel cancer audit. This had not been identified on the surgical and anaesthetist risk register as an area of concern.
- The service had not met the trust's timescales for responding to complaints in the period August 2015 to July 2016, but following the introduction of a revised complaints' policy in July 2016, with longer timescales for a response, improvements had been made in responding to complaints with an average response timescale of 33 days (in the period April to September 2016).
- Staff had little awareness of the new CARE values introduced by the hospital.
- Routine audits and monitoring took place across the service. However, not all audits had actions or outcomes to improve performance.

However, we found that:

- Staff understood the importance of reporting incidents and had awareness of the duty of candour process. The team meeting minutes identified shared learning from incidents.
- There were clear processes and procedures in place regarding the completion of the Five Steps to Safer Surgery checklist.
- Nursing handovers were well structured and comprehensive.

Surgery

- Training levels met the recommended target set by the hospital and staff understood their roles and responsibilities around the Mental Capacity Act 2005 and had an awareness of the Deprivation of Liberty Safeguards. The appraisal rates were just above the hospital target at 86% for the service. There were competency frameworks and induction programmes for staff in all surgical areas.
- Patients received care according to national guidelines such as the National Institute of Health and Care Excellence (NICE) and the Royal College of Surgeons.
- Medical and nursing staffing was appropriate across almost all the surgical wards and in theatres. There was effective multidisciplinary team working that delivered coordinated care to patients. Staff had access to patient related information when required.
- Patients were supported, treated with dignity and respect and were involved in planning their treatment and care. Feedback from patients and those who were close to them was positive about the way staff treated and cared for them.
- The cancer 62 day standards showed the hospital had met 92% of its urgent GP referrals.
- The 'butterfly' scheme was used to discreetly identify patients living with dementia. Staff had access to an Admiral Nurses to provide support when required.
- There was a clear governance structure in place within the surgical clinical business unit to review areas such as; infection control, incidents, health and safety, estates and policies.
- Generally, there was a clear governance structure in place within the surgical clinical business unit to review areas such as; infection control, incidents, health and safety, complaints, estates and policies.
- There was a positive culture within the teams and staff felt supported by their managers. Staff confirmed the senior management team was visible, conducted daily walkabouts and often visited the ward and theatres to observe practices.

Are surgery services safe?

Requires improvement

We rated the service as requires improvement for being safe because:

- Infection control precautions were not always effective. We observed staff on Geddington and Deene B wards not decontaminating their hands after being in direct contact of care with patients. Clinical waste bins were conveyed through the maxillofacial service. These frequently leaked which meant there was a risk of infection control putting both staff and patients at risk. The breast pre-assessment clinic had fabric chairs and privacy curtains. The chairs and curtains had no date when last changed or cleaned which meant there could be a risk of cross infection due to inappropriate cleaning. Nursing staff did not adhere to the handling of food safely guidance. Theatre staff did not adhere to the hospital and national standards by wearing of cover gowns and footwear when leaving and entering the theatre area. The trust took actions to address this.
- Medicines were not always stored or handled appropriately. Medicines were stored with sterile instruments, on open shelves within the maxillofacial service. Medicine clinical rooms (Geddington, Barnwell B and C, DASU and the surgical day case unit) had temperatures above the recommended 25º celsius which were detrimental to some drugs. We found topical medicines and liquids which had been used with no date of opening.
- Nursing staffing was not appropriate on Ashton ward whereby registered nurses left the ward unattended during the night shift at times. We raised this as a concern with the trust and they took immediate action to ensure a registered nurse was on this ward at all times.
- Patient records on DASU and Geddington ward were left unattended during our visit.
- The environment of Barnwell wards B and C were found to be visibly dirty and very dusty. During our unannounced visit on 24 October 2016, the ward had undergone a deep clean and it was visibly clean.

However, we also found that:

- Staff understood how to record incidents, which were discussed at staff meetings so shared learning, could take place. The service had procedures for reporting all new pressure ulcers, and slips, trips and falls.
- We observed processes and procedures in place regarding the completion of the Five Steps to Safer Surgery checklist.
- Nursing handovers were well structured and comprehensive.
- Training levels met the recommended target set by the hospital. Staff understood their responsibilities regarding safeguarding procedures to protect the safety of vulnerable adults and children.
- Pre-operative assessments were carried out in line with National Institute for Health and Care Excellence (NICE) guidelines.
- Medical staffing was appropriate in almost all areas. Consultants worked throughout the week within the surgical services with support by specialist registrars during the weekend.

Incidents

- Staff understood their responsibilities to raise concerns, to record safety incidents and near misses and to report them internally and externally. Incidents were discussed at staff meetings so shared learning could take place, which was confirmed by staff we spoke with.
- The surgical team had identified systems, processes, and practices that were essential to services to keep patients safe from avoidable harm.
- There had been two strategic executive information systems (STEIS) reportable 'never events' from August 2015 and July 2016 relating to surgery. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- One never event occurred when a swab was inadvertently left inside a patient. The hospital had revised its "swab policy" as a result of learning from this incident . A further checking procedure was in place to ensure the incident did not re-occur. Staff were aware of these new systems.
- The other never event related to a patient receiving a left knee implant on their right knee. The review identified no adverse effect or harm for the patient. The hospital had instigated actions to prevent a re-occurrence. The service had implemented another "stop and check" process in addition to the one performed as part of the World Health Organisation (WHO) checklist. During our visit to theatre, we observed this procedure in place.
- We saw the list of incidents from August 2015 to July 2016. During this period, there had been 1,061 incidents of which 16 were classed as major, 180 as minor and 37 as moderate. There were no identified themes in relation to the incidents. Incidents were analysed at quality governance meetings to ensure that lessons were learned. Serious incidents were investigated by staff with the appropriate level of seniority, such as clinical leads. All lessons learnt were cascaded to the team during ward and theatre handovers and staff meetings. Staff confirmed this during our inspection.
- The hospital had implemented its own information dashboards. Senior staff confirmed they used information dashboards to support lessons learned from incidents and to increase knowledge of patient safety issues. The dashboards were on display within the services visited and staff showed awareness of the content.
- From November 2014, NHS providers were required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person. We saw guidance within the service, which staff could refer to. The records showed the Duty of Candour had been utilised regarding the two never events and staff showed awareness and understood their responsibilities of when it would be used.
- The mortality meeting minutes for May 2016 included case reviews and root case analysis of all deaths with any recommendations and actions. Examples included; "disseminate National Early Warning Score (NEWS) escalation policies to medical and nursing staff" and "general measures of skin checks after plaster applications". Information gathered from meetings was shared as lessons learnt and distributed to staff.

- There were systems in place to manage safety alerts relating to patient safety, medicines and medical devices. These alerts were cascaded to staff across the surgical services.
- All national safety alerts were discussed during the surgery safety group meeting. The minutes for July 2016 addressed the management of safety alerts. To ensure staff had the most up to date information lunchtime workshops commenced in September 2016. Areas included were: the importance of intravenous (IV) and the switch to oral medicines and the safety involved with vancomycin (an antibiotic used to treat a number of bacterial infections) prescribing. Medical staff spoken with confirmed they often attended these workshops and were a good source for additional information.

Safety thermometer

- The NHS safety dashboard is a tool for measuring, monitoring, and analysing patient harms and 'harm free' care. Data is collected on a single day each month. The safety dashboard looked at risks such as falls, pressure ulcers, nutritional wellbeing, medicine incidents and deteriorating patients.
- Information relating to the safety dashboard were clearly displayed in the ward areas we visited. There were 38 pressure ulcers, three falls with harm and 22 catheter urinary tract infections between August 2015 and August 2016. There had been no falls reported since December 2015.
- To reduce skin damage the tissue viability specialists created a training and education programme based on one and-a-half hour drop-in sessions designed for staff. The training took staff through the fundamentals of how to measure patients, how to fit the products and how to recognise when the products needed changing. The tissue viability specialists also provided a skin guide, for staff, which covered essentials such as how to clean patients' skin and what barrier products to use. Staff confirmed they found this very useful in helping to reduce pressure ulcers amongst patients. Staff carried out venous thromboembolism (VTE) screening on admission to the hospital. VTE is a condition where a blood clot forms in a vein. We found no issues or concerns in the 17 records seen.
- The records showed that patients received a re-assessment within 24 hours of admission for risk of VTE and bleeding. This was in line with NICE QS3 Statement 4 guidelines.

Cleanliness, infection control and hygiene

- There were not always reliable systems in place to prevent and protect patients from healthcare-associated infections.
- The April 2016 environmental walkabout reports for Deene B ward outlined what was looked at, who was responsible and the action taken. However, during our visit to Barnwell wards B and C we found the environment to be visibly dirty and very dusty. This was brought to the attention of senior staff. During our unannounced visit on 24 October 2016, the ward had undergone a deep clean and it was visibly clean.
- Most staff followed the hospital's policy on infection control. Hand hygiene audits carried out across each department showed the service was 97% compliant. However, during our visit on 12 October 2016, we observed many nursing staff on Geddington ward who did not decontaminate their hands immediately before and after every episode of direct contact of care. This contravened National Institute for Health and Clinical Excellence (NICE) QS61 Statement 3 guidance. This was brought to the attention of senior staff. During our re-visit on 13 and 24 October 2016, we did not see any issues or concerns.
- Housekeeping audits conducted during September 2016 showed the surgical services achieved 93%, which was below the 95% national target for high-risk areas. The service investigated the reasons for this audit outcome and outlined the actions to be taken. These actions included new supervisors being retrained in the process of conducting audits and working alongside experienced member of the supervisory team to ensure they were professionally competent to conduct audits.
- The hospital had a 'Hazard Analysis of Critical Control Points' (HACCP) system in place as part of their food safety system which included meal delivery schedules. HACCP is a system that helps food operators look at how they handle food and introduces procedures to make sure the food produced is safe to eat. However, although catering supervisors monitored ward food quality audits, this was on an ad-hoc basis with approximately five wards per month being reviewed. The recommendation by the environmental health officers is for meal service times to be recorded on HACCP forms at the start and on completion of the last patient meal served. We did not see this form in use during our visit to the wards.

- During our inspection, we observed staff not adhering to the Food Safety Act 1990 and the Food Hygiene (England) Regulations 2006 (Temperature Control Schedule 4- EU Regulation No.852/2004). For example, staff handled cereals and toasts with their hands without the use of gloves. The guidelines stipulate that foods must always be handled for example; using serving tongs. This was brought to the attention of senior staff who also confirmed they would arrange to have serving tongs made available to staff.
- Standards and Recommendations for Safe Perioperative Practice 2011 by the Association of Perioperative Practice stated there must be arrangements made to ensure that there is a sufficient supply of clean cover gowns available and footwear worn in theatres should be for that use only. We observed lack of compliance by some theatre staff with regard to the correct use of theatre attire. Cover gowns and overshoes were provided but not always worn or changed into when leaving and re-entering the theatre areas. This was also a contravention of the hospital's principles and practice outlined in their operating theatre policy and the theatre standard operating procedure, which stated, "theatre scrubs are not to be worn as general hospital uniform and must only be worn within the specific perioperative environment". This was brought to the attention of senior staff during our visit on 13 October 2016. This had also been addressed in the weekly hot topics leaflet dated September 2016, which highlighted that there were hazard lines at the entrances to theatre to reduce the number of unnecessary entries into theatres with inappropriate footwear.
- During our visit on 14 October 2016, senior staff confirmed they had addressed our concerns and we saw notices requesting staff to adhere to the correct guidance. We saw there were sufficient cover gowns and overshoes available. However, during our unannounced visit on 24 October, we observed theatre staff visiting Barnwell B and C wards and not complying with the appropriate standards and hospital policies. This meant there was a risk of cross infection to patients due to the wearing of inappropriate theatre clothing.
- Clinical waste bins in the maxillofacial service were conveyed weekly through the department. Staff confirmed there were frequent fluid leakages from the bins, which were absorbed by the carpet at the entrance to the department. We did not see an action to manage the clinical waste bins, which meant there was a risk of infection putting both staff and patients at risk. Staff confirmed they were aware of the concerns but due to the location and shortage of space, they were unable to address this matter. However, the maxillofacial business plan, a copy of which we saw, highlighted the concern and how the matter would be resolved with the relocation of the service. This concern had also been identified on the surgery and anaesthetic local risk register.
- The breast pre-assessment clinic located within the treatment centre had fabric chairs and privacy curtains. There was a risk of cross infection due to the fabric chairs not being able to be cleaned appropriately. There was no date on the curtains and therefore we could not ascertain when they were last changed. This was brought to the attention of senior staff during our visit to the assessment unit.
- The hospital had infection control policies available on the hospital intranet, including management of patients with MRSA and an infection outbreak. We saw these policies had been reviewed and were in date.
- The healthcare associated infection figures from April 2016 to June 2016 for the surgical wards showed there had been two cases of MRSA from clinical specimens and one of Clostridium difficile across the service. Senior staff confirmed they had processes in place and staff described the procedures in the event of an infection outbreak.
- Patients being transferred from Deene acute surgical unit (DASU) and Geddington ward to Deene B ward underwent a decolonisation treatment to reduce the carrying of MRSA. Staff said this had assisted in their current rate of not having any MRSA cases within the service since June 2016.
- During the pre-admission appointment, patients were swabbed to assess if they had MRSA. Where results were found to be positive the admission date was deferred if necessary, and the patient provided with a treatment pack to use at home. A further appointment for the patient was rearranged once a clear swab result was received.
- The anaesthesia business and governance meeting minutes for June 2016 identified a case of pseudomonas. Pseudomonas is a bacterium that can affect the lungs. We saw the hospital had implemented

processes to manage the infection, which included heat and chemical disinfection. The September 2016 minutes identified the matter had been addressed with no further outbreak identified.

- We observed staff complying with 'arms bare below the elbow' policy across the services visited.
- Staff were observed wearing personal protective equipment, such as gloves and aprons, while delivering care.
- The surgical site infection surveillance report from January 2016 to March 2016 from Public Health England for breast, hip and knee replacement summarised the surveillance data collected. The report provided data on the operations and surgical site infections (SSI) that occurred during the inpatient stay, on readmission and post-discharge. During this period there had been one SSI identified which referred to a superficial incision. The systems, processes and practice regarding SSIs, reflected the NICE CG74 guidance.
- Housekeeping staff had clearly defined roles and responsibilities for cleaning the environment. We observed they used different coloured mops and buckets for clinical and non-clinical areas. A checklist was used to ensure all aspects of required cleaning were met. This was in line with national guidance and best practice.
- Where cleaning was required urgently, the housekeeping staff on duty would be informed and asked to respond immediately to the request. Any areas, which required a rapid response, staff, were able to contact the housekeeping team via infection control or the housekeeping supervisors. Patients identified with specific infections out of hour's staff could contact the infection prevention and control team who would request a terminal clean of the area. However, ward staff were unaware of this service and nursing staff informed us they often cleaned the wards and beds in the event of an infection.
- The patient led assessment of the care environment (PLACE) results for 2016 regarding cleanliness showed a satisfaction level of between 91% and 96%. For example maxillofacial achieved 91% whilst Ashton and Geddington wards achieved 95% and 96% respectively. The PLACE assessments is undertaken by local people who go into hospitals as part of a team to assess how the environment supports patient's privacy and dignity, food, cleanliness and general building maintenance. It focuses entirely on the care environment and does not cover clinical care provision.

Environment and equipment

- The design of most areas and the maintenance of the facilities and electrical equipment ensured the safety of patients. There were systems and arrangements in place to review and check equipment.
- The ventilation system within the theatres had been on the risk register since September 2014. The risk register identified that the main theatres ventilation system were only partially compliant to June 2016. During our visit, we found no issues or concerns highlighted with the ventilation system within theatres and saw copies of tests undertaken which confirmed compliance. The service had identified this risk and there were arrangements in place to re-locate the theatres as of December 2016.
- We reviewed the medical device audit completed in July 2016. The audit randomly chose wards and theatre clinical areas in order to determine the condition of the medical equipment. For example, the results for DASU did not highlight any issues or concerns with the equipment, which had been categorised, and risk assessed.
- An incident occurred within the breast pre-assessment clinic whereby the call bell system did not work. This resulted in staff dialling for emergency response. The call bell system was fixed as a result of the incident. However, on talking to senior staff they confirmed the matter had not been resolved as the call bell system required additional sounders. A business case was in the process of being developed for consideration. This meant that there was a continued risk that the call bell systems could fail within the service.
- The service undertook routine checks of anaesthetic equipment in accordance with recognised guidance by the Association of Anaesthetists of Great Britain and Ireland (AAGBI), 'Checking Anaesthetic Equipment' 2012 guidance. We observed that checks were completed and recorded.
- Daily equipment checks of essential equipment such as anaesthetic and resuscitation equipment in operating theatres and wards were completed and recorded. This meant that we were assured of the safe management of operating theatre equipment.

- Resuscitation trolley records within the wards visited showed no issues or concerns with the daily checking of equipment.
- Equipment was visibly clean and well maintained. Staff told us that all items of equipment were readily available and any faulty equipment repaired or replaced in a timely manner. There was sufficient equipment to maintain safe and effective service, such as anaesthetic equipment, theatre instruments, blood pressure, and temperature monitors, commodes and bedpans.
- The equipment and appliances viewed during our inspection had been appropriately electrically tested which meant we were assured they were safe to use.
- Single use sterile instruments were stored appropriately and kept within their expiry dates. Although the amount of storage space within the theatres was small, surgical procedure packs, implants and consumable items were appropriately stored in a tidy and organised manner.
- Staff both on the wards and in theatres confirmed they had access to bariatric equipment and had no difficulty in obtaining them when required.
- Both the wards and operating theatres had appropriate arrangements for managing waste. We saw that waste was correctly segregated, labelled and disposed of. For example, containers were available for the disposal of sharp medical instruments.
- We saw copies of the Control of Substances Hazardous to Health (COSHH) risk assessments within the wards visited which included guidance on the handling and storage of items such as disinfectant. The risk assessments also covered the precautions for safe handling, which included well-ventilated areas and the use of personal protective equipment.

Medicines

- There were not always reliable systems in place to manage the storage and disposal of medicines.
- Due to the lack of space within the maxillofacial unit, medicines were stored with sterile instruments in a storage room on open shelves. The room could not be secured as it was in regular use and access was only available through a treatment room. Also within the treatment, room was a locked cupboard where FP10 prescription pads were kept. FP10 prescriptions pads are the forms used to write an individual's required medicines. This meant that patients undergoing treatment were often disturbed whilst undergoing treatment. The pharmacy had risk assessed this room in April 2016, but cupboards had not been ordered due to the "unavailability of a compliant location for fitting one. We found no other mitigations in place regarding the storage of medicines, which meant we could not be assured there were systems in place to manage the security and administration of medicines. This concern was identified in the local risk register for surgery and anaesthetics.
- Ambient temperature of medicine' storage rooms and fridges were recorded on the ward and operating theatre department. Across the service we found clinical rooms (in Geddington, Barnwell B and C wards, DASU and the surgical day case unit) recording temperatures above the recommend room temperature of 25º Celsius which were potentially detrimental to some stored drugs. Temperatures ranged between 28º and 30º across the service.
- There was a procedure to follow should temperatures fall out of the defined range, which staff explained during our inspection. This had also been discussed at the quality governance steering group meeting in September 2016. The outcome showed that for those areas where air conditioning was not feasible, medicines with a shortened expiry date were issued. The pharmacy was supplying medicines with a short expiry date of up to six months.
- Staff informed us and we saw guidelines on the temperature checklist, which stated that medicines were to be kept for a maximum of six months in order to manage the deterioration of medicines. However, we found no risk assessment or action plan regarding the management of these medicines within the service. Staff informed us it was the responsibility of the pharmacy staff to monitor medicines. This meant we could not be assured there were systems in place to manage the deterioration of medicines in order to provide safe care and treatment
- On Geddington ward and DASU, we found topical medicines and liquids, which had been used with no date of opening. This meant there was a risk that patients may receive topical medicines and liquids, which may be detrimental to their health. This was brought to the attention of senior staff who disposed of the medicines appropriately.
- On the wards, there was a pharmacy communication book, which was reviewed daily. However, during our visit to Barnwell B ward we found an omission of medicine for one patient for four days. The request for

nerve pain medicine was requested in the communication book on Thursday 20 October 2016. During our unannounced visit on 24 October, we found the medicines had not been received. Senior staff informed us they had reviewed the communication book and on seeing the shortfall had immediately chased up the required medicine. We noted the additional request was reflected in the communication book. However, this meant that we could not be assured there were procedures and systems in place to manage the care and welfare of patients who required urgent medicines.

- Improving the feedback to junior doctors involved in prescription errors was identified as an area of concern in the medicine audit in August 2016. To overcome this, junior doctors' feedback training was arranged during Wednesday lunchtime training sessions. Doctors spoken with confirmed they had received updates regarding medicine errors within the hospital.
- There were effective arrangements for the receipt, storage, dispensing and disposal of unwanted medicines, which was managed by the pharmacist.
- The 17 patients' records seen showed that patients had their recommended oxygen saturation rate and oxygen therapy prescribed which was in line with the British Thoracic Society guidance.
- During the last inspection, a compliance action was issued for poor medicines management on Deene wards. However, during this inspection, we found no issues or concerns.
- The hospital produced a medication safety group newsletter. This looked at medicine incident themes. For example, the August 2016 issue looked at incidents across the hospital relating to an antiseptic hand-washing preparation used to help prevent the spread of bacteria). The newsletter looked at the background, what happened, what went wrong, together with key messages of ways to improve. This meant that staff had up to date information to support the management and care and welfare of patient's medicines.
- Medicines were contained in locked cupboards. Medicine cupboards in anaesthetic rooms were left unlocked while the associated theatre was in use. This was in line with hospital policy. We found no issues or concerns during our visit.
- We reviewed the controlled medicines cabinets and booklets and the service has safe systems in place to manage the storage and administration of controlled drugs.
- We did not observe the administration of medicines during our inspection. We looked at the medicine charts for 17 patients, found these to be complete, up-to-date, and reviewed on a regular basis. Allergies were clearly recorded on the patients medicine chart and in their records. We observed that known patient allergies were discussed at the daily huddle, which meant nursing staff had the appropriate information to manage the patient's medicines.
- Nursing staff were aware of and were able to seek guidance from the hospital's medicines policy and British National Formulary (BNF), which was the latest up to date edition. The BNF is a pharmaceutical reference book and contains advice on prescribing and pharmacology.
- The medicine audit for August 2016 showed improvements in the following areas:
  - Controlled drugs quarterly audits showed 100% compliance.
  - Approximately 60% of discharge prescriptions were dispensed over 24 hours in advance to ensure an effective discharge with limited delay.
  - The introduction of the pharmacy technicians had reduced the time spent by nursing staff looking for and ordering medicines.
  - Improved staff satisfaction with the pharmacy service (100% of ward staff surveyed strongly agreed that they were satisfied with the service).

Records

- We found that patient's individual care records were written, managed in a way that kept patients safe.
- The hospital used a paper-based system for recording patient care and treatment, which included a record of the initial consultation.
- The records contained information of the patient's journey through the service including pre assessment, investigations, test results and the treatment and care provided.
- Some patient records were kept at the end of their beds, which included care plans and fluid balance charts. These were found to have been completed and up-to-date. Records were accurate, complete, legible and up to date.

- We looked at 17 sets of patient's records within the service. These included day case patients and inpatients and we found them to have been appropriately completed. They were formatted with a standard layout to allow ease of access to relevant information.
- In surgical wards and theatres, the patient notes included assessments for patients treated in operating theatres. Within the patient's notes, there were detailed and comprehensive pre-assessment records documented within a pre-assessment pathway booklet for patients prior to admission. The wards had care plans to identify what care should be given to patients. This meant that staff had access to information on how to care for a patient.
- We observed patient records being left unattended during our visit to the wards. For example, on DASU and Geddington ward, we saw records left unattended behind the reception desk, which could be accessed by members of the public. Also on Geddington ward records were kept in an unlocked room. We were able to walk into the room unobserved which meant there was a risk of patients' records being available to unauthorised people. This was brought to the attention of senior staff who confirmed that they were aware of the problem and lockable cabinets had been ordered.

Safeguarding

- The training records showed that staff within the surgical team had achieved the hospital target of 85% for both children and adult safeguarding training with the exception of medical staff who only achieved 64% for their adult safeguarding level 2. For example, the registered nurses had achieved 100% for their level 3 children's safeguarding training and 93% for adult safeguarding level 2 training. Heath care assistants had achieved 90% for level 2 children's safeguarding and 93% for their adult's level 2 training.
- The records showed that none of the surgical staff had undertaken Prevent training. The purpose of Prevent is to identify when a vulnerable person is at risk of radicalisation, how to raise concerns and what a proportionate response looks like. Senior staff confirmed they were aware of the shortfall and were arranging for staff to attend e-learning sessions regarding the additional training required.
- We reviewed the safeguarding planner for 2016, which included safeguarding knowledge training and safeguarding children documentation audit.
- There were arrangements in place to safeguard adults from abuse that reflected relevant legislation and local requirements. They service had an established link with the local safeguarding teams both within the hospital and the local authorities. Staff knew who the hospital's safeguarding lead was and how to contact them.
- Staff understood their responsibilities and knew how to identify potential abuse and report safeguarding concerns. Staff completed training on safeguarding through electronic learning and had a good understanding of their responsibilities in relation to the safeguarding of vulnerable adults.

Mandatory training

- We found staff received effective mandatory training the safety systems, process and practices.
- The clinical business unit monthly performance report for June 2016 showed the service was 87% compliant with its statutory and mandatory training for both the anaesthetic and surgical teams. This was above the hospital target of 85%. However, the records showed that both teams had not quite achieved their target for infection control and manual handling averaging 83% compliance. Plans were in place to provide further sessions.
- Training timetables were on display so staff could clearly see what training was outstanding. The ward manager confirmed they followed up staff members who had failed to complete their training, or were having difficulties.
- Mandatory training was discussed during induction for all new starters. Staff said they had undertaken mandatory training relevant to their role.
- Staff explained they received mandatory training to ensure safe care was provided. Examples included adult basic life support, consent and equality and diversity training. Most of the mandatory training was completed through e-learning. Some training such as manual handling was provided through onsite training. Staff on the surgical wards confirmed they had recently undertaken conflict resolution training.
- Staff received training in recognising and responding positively to equality and diversity issues through its equality and diversity training programme. This was delivered at induction and every three years thereafter.

- The hospital had launched an education programme on the early detection of and management of sepsis. This was in line with the national sepsis guidelines (March 2016) and pathway to ensure staff were aware of these.

Assessing and responding to patient risk

- The trust assessed and responded to patient risk by undertaking comprehensive risk assessments, and surgical safety checklists. However, the completion of the NEWS charts was inconsistent across the service as well as the review of patients on the maxillofacial waiting list. The trust informed us that all patients on surgical waiting lists are reviewed at patient tracking list meetings and clinical harms reviews are performed for all patients waiting for 46 weeks or longer. However, staff within the maxillofacial service were unaware of these procedures and we did not see processes in place which meant that there could be delays in responding to a deteriorating patient or a patient not being informed of any consequences to having to wait for treatment.
- We saw the nurse sensitive indicators from April 2016 to July 2016. The records identified patients having NEWS scores calculated and escalated as per the trigger algorithm. This included four hourly observations unless stated otherwise which included; heart rate, respiratory rate, temperature, blood pressure and oxygen saturations.
- We reviewed 17 patient charts. Of the 17 charts, seven had incomplete NEWS information. This concern was brought to the attention of the ward managers who confirmed they were currently reviewing the completion of NEWS records monthly due to the NEWS July 2016 audit highlighting the incompletion of these charts. They also confirmed the NEWS was discussed at ward meetings and additional training was being provided to staff as required. Staff spoken with confirmed they had received additional training in the completion of the NEWS charts.
- During our visit to Barnwell wards of the four records viewed, none had been fully completed. However, during our unannounced visit on 24 October, we reviewed a further four records and found no issues or concerns.
- The NEWS audit and action plan for July 2016 identified the concerns with the completion of the following:
  - The recording of the date of the observations taken was consistently bad across the hospital
  - Poor inclusion of the date and time in all entries in the patient's notes
  - The taking of observations at a minimum of four hourly intervals, in accordance with hospital policy was variable across the service
  - Appropriate escalation of the frequency of observations and the recording of the observation frequency in the patient's notes was variable across the service
- The result of the audit was provided to all ward manager with actions, which included for example; the monitoring of fluid balance charts. The dissemination of the results and key recommendations was via the executive nursing group, which enabled co-ownership of any quality improvement plan. The audit also proposed the introduction of a revised NEWS chart, which offered the opportunity to provide guidance to the staff on the correct completion of the chart. Senior staff confirmed they were currently using a revised NEWS chart and were conducting monthly checks on the completion of these.
- The hospital had a sign up to safety campaign with five key pledges. The aim was to ensure patient safety by reducing avoidable harm and to make public their goals and plans. The campaign incorporated the following areas: hospital associated infections, pressure tissue damage, falls, preventable deterioration, risks associated with surgery and medicines. This was linked to the "I will keep you safe" campaign and staff directed us to the relevant information and showed us the posters linked to the scheme.
- A pre-admission assessment was completed for all patients prior to their admission to hospital. Not all patients attended a pre-assessment clinic before their admission for surgery. Patients were assessed according to their clinical needs by completing a pre-operative questionnaire. On receipt of the questionnaire, patients were triaged by senior nurses or doctors to determine who required a face-to-face or a telephone consultation.
- The quality steering group minutes for October 2016 identified that a sepsis screening tool and pathway was being rolled out to all clinical areas with ongoing training. A sepsis nurse had been recruited and was due to start shortly. This was in line with the Commissioning for Quality and Innovation (CQUIN) framework for 2016/17 regarding sepsis. Sepsis is a common and potentially life-threatening condition where the body's immune

system goes into overdrive in response to an infection, setting off a series of reactions that can lead to widespread inflammation, organ damage and blood clotting.

- All patients having a planned major surgery, for example, a hip replacement, attended a pre-operative assessment clinic. Any pre-operative investigations, for example; blood tests were carried out during the clinic visit. Pre-operative assessments were carried out in line with the National Institute of Health and Care Excellence (NICE) guidelines. If there were any concerns about a patient's condition or fitness for surgery during the assessment, the pre-assessment team would liaise with the consultant anaesthetists.
- An anaesthetist and surgeon, also additionally assessed patients with underlying medical conditions, or those deemed at risk of developing complications after surgery, on the day of surgery.
- The consultant who explained the procedure and the risks saw patients, who were planning to undergo surgery. Patients spoken with confirmed this.
- Staff explained that during pre-assessment they recorded base line observations such as temperature and blood pressure. They checked the patients' understanding of the treatment they were being admitted for, discussed discharge arrangements, and completed a range of risk assessments such as; falls and pressure ulcers.
- The hospital used nationally recognised risk assessments such as Malnutrition Universal Screening Tool (MUST) and Waterlow score. MUST is a five-step screening tool to identify patients, who are malnourished, at risk of malnutrition (under nutrition) or obese. The Waterlow score gives an estimated risk for the development of a pressure sore in a patient. Patients identified at risk were placed on care plans and were monitored more frequently by staff to reduce the risk of harm.
- Patients with known allergies wore a bracelet, which acted as an alert to any staff providing care or treatment.
- The National Early Warning system (NEWS) tool was used on surgical wards, the surgical day case unit and DASU in order to identify the deteriorating condition of patients. This system alerted nursing staff to escalate patients for review if routine vital signs were out of safe parameters.
- The recovery suite did not use the NEWS scoring system as intra-operative anaesthetic drugs/techniques could affect the scores postoperatively potentially raising the score for each patient to critical. We saw the anaesthetic recording chart was in use in recovery to record observations. Ward staff described how they were provided with details of the patient's observations during handover from the recovery staff.
- We saw Situation, Background, Assessment and Recommendation (SBAR) communication records in use. SBAR is a communication tool to share patient information in a clear, complete, concise and structured format.
- The World Health Organisation (WHO) 'Five Steps to Safer Surgery' checklist was used. We attended a safer surgery briefing and observed the checklist being completed appropriately. The briefing sessions included for example, checking that all ordered equipment had been received, staffing arrangements and allocated responsibilities were understood. The WHO checklist was included in the pre-list huddle and post-list debrief which theatre staff attended.
- Operating theatre records included the "Five Steps to Safety Surgery" checklist, which had been appropriately completed. The 'Five Steps to Safer Surgery' checklist was audited, the results of which showed 100% compliance.
- Theatre staff had safety huddles before procedures commenced. During these huddles, staff discussed elective cases and order of patients along with flow and any necessary escalations. There was a standard operating procedure to support this process, which ensured continuity.
- The re-development business case for maxillofacial identified 594 patients on the oral surgery waiting list, including 35 waiting over 46 weeks. We asked senior staff how they managed the risk and potential harm to patients on the waiting list. They confirmed they were unaware of how the patient list was being reviewed but due to the length of time, confirmed patients may require other or additional treatment. This meant there was a risk of patients not being informed of any consequences to having to wait for treatment. The service were aware of the issue and taking steps to prioritise patients on the waiting list.
- Surgical staff completed the "inadvertent perioperative hypothermia" audit form. Compliance is met if the patient's temperature is maintained between 36º to 38º

celsius. The temperature recordings from May 2016 to September 2016 showed an average body temperature of 36º Celsius which was in line with the guidance from the British Journal of Anaesthesia and NICE pathway.
- If a patient became unwell after treatment, there were arrangements for the patient to be seen promptly and where reassessed by the admitting consultant or anaesthetist.
- If changes to an operating list had to be made, there was a process understood by operating theatre and ward staff. Once a change had been agreed with the consultant, the original list was destroyed and a different revised list was issued. This process was used to ensure staff worked to the same list to reduce risks to patient safety.
- Five patients confirmed nursing staff told them what to do if they felt unwell following their discharge home.
- There were pre-arrangements in place for visitors to theatre. Medical representatives visited the theatres by pre-arranged appointments. The surgeon and the theatre manager checked their identities. We saw the confidentiality policy, which provided the service with guidance on representatives visiting theatre.
- Staff escalated key risks that could impact on patient safety, such as staffing and bed capacity issues. There was daily involvement by the ward and theatre managers and the director of clinical services to address these risks.
- Intentional rounding by care staff was completed throughout the patients' stay. Intentional rounding is a structured process where nurses carry out regular checks with individual patients at set intervals, typically hourly. During these checks, they carry out scheduled or required tasks. This meant staff visited patients regularly for example; hourly to check if call bells and a drink were in reach, if the patient had pain or had any other requests.

Nursing staffing

- The hospital had systems and processes to assess, plan and review the staffing levels and skill mix to ensure patients received safe care and treatment.
- The hospital used a staffing tool, which was in line with the National Institute for Health and Clinical Excellence (NICE) staffing guidelines and helped the hospital to support safe staffing acuity levels based on the patients' needs. The number of nurses and health care assistants (HCA) required for each shift were calculated following the staffing tool guidelines. Additional staffing could be implemented to support patients with increased need for example; living with dementia or at high risk of falls. Daily huddle meetings discussed staffing levels with areas of risk identified and escalated as appropriate to the matron in charge.
- The hospital had details of daily required and actual staffing levels displayed on a notice board in the main ward corridor for relatives and visitors to see. In most areas we visited, staffing levels met patients' needs.
- Contracted staff worked flexible hours to cover the rota and a separate team of bank and agency staff met any identified gaps. Senior staff on the wards confirmed most shifts were covered by either bank or agency staff. The ward manager explained they strived to keep agency use to a minimum and tended to use bank staff at weekends when the occupancy and dependency levels were lower. We reviewed staffing rotas and these reflected the explanation provided.
- Recruited agency staff came from specific agencies with which the hospital had a preferred provider arrangement. This ensured temporary staff met key requirements such as having completed mandatory training such as manual handling and competencies to safely administer medicines.
- The ward areas had systems in place to manage the induction of agency staff. This included a tour of the ward, introduction to staff and details of the equipment used. We saw completed templates used for this process. Agency staff confirmed that this always happened, even if they had worked on the wards previously.
- During our visit to Ashton ward (upstairs), the night staffing levels was one registered nurse (RN) and two HCA's for 12 patients during the night shift. The ward did not have controlled drug facilities or refrigerated medicines, which meant the RN, had to leave the ward and access medicines from Ashton Ward (downstairs). This meant a walk down three flights of stairs and leaving the upstairs part of the ward unattended. The service had not recognised this as a risk to patient safety. This was brought to the attention of the hospital as an immediate concern. During our unannounced inspection on 24 October 2016, we observed that Ashton Ward (upstairs) had increased their RN staffing to

two during the night shift. Staff confirmed they felt that the ward was much safer since the implementation of additional staff and that there was now always an RN on the ward at all times.
- The hospital undertook elective (planned) surgery, which meant the number of nursing and care staff required on any particular day could be calculated and planned. During the inspection and unannounced visit, planned staffing numbers were met for each department.
- The hospital had increased the number of emergency surgical nurse practitioners to support out of hours and weekend working.
- As at August 2016, the hospital reported a vacancy rate of 14.7 % in surgery (13.6 WTE) and the Barnwell B and C ward (12.1 WTE). DASU reported the third highest vacancy rate (7.6 WTE). Consistently, the greatest vacancy rates were reported in urology (32.4%), general surgery (20.6%) and DASU (18.31%). However, urology and general surgery reported relatively small staffing bodies.
- Handovers took place between each ward shift where information was disseminated to the staff team. We observed a handover and it was detailed and succinct.
- There was an on-going programme within the hospital, which ensured that all registered nursing staff maintained their revalidation. Staff confirmed support was available if required with the revalidation process.

Surgical staffing

- The hospital had systems and processes to assess, plan and review the staffing levels and skill mix to ensure patients received safe care and treatment.
- A team of consultant surgeons and anaesthetists carried out surgical procedures. At the time of our inspection, the service, which included theatres and the pre-assessment team, had 119 qualified medical staff and 21unqualified medical staff. An additional 47 medical staff either had been offered a position and were waiting to commence their role or were new starters. The records as of July 2016 showed a vacancy rate of 39% for medical staff across theatres.
- The 2014 inspection identified insufficient junior doctors cover out of hours and at weekends was minimal across the surgery and orthopaedic wards, which meant some duties were delayed or not completed. As a result of the inspection, the service had increased the number of emergency surgical nurse practitioners to support out of hours and weekends. The hospital was in the process of recruiting to additional junior doctor posts. Junior doctors spoken with said they did not have any concerns or issues with the number of junior doctors in post and felt this was not detrimental to the patient as the emergency surgical nurse practitioners were supportive.
- Junior doctors completed an audit in August 2016 regarding handovers. The result was based on 20 responses, which included both night and day shifts. Areas identified for improvement were:
  - Better room, as often difficult to fit whole team in
  - To update the list in correct bed order
  - To explicitly mention on handover sheets any issues and highlighted urgent jobs
  - Allowing time for the night foundation doctor (FY1) to hand over to the non on-call day FY1s
  - Bleep free to minimise interruptions
- We saw the recommendations from the audit, which included presentation of the findings at surgical meetings, and a further audit in three months' time.
- There was a registrar and a senior house officer (SHO) on duty covering the surgical wards at night, the emergency department, GP referrals and attendance at theatre. This meant that if the registrar was called to theatre with a patient, a SHO was covering the care of both general and specialised surgical patients without any direct support. Staff confirmed they, on occasions, had to wait for registrar support due to them being held up in theatre. There had not been any reported incidents due to the lack of clinical support and senior staff confirmed this did not have any impact on the care of the patient. However, this meant there could be a risk of patients, who may be deteriorating, not receiving the appropriate treatment in a timely manner.
- To ensure effective planning and continuity of service, consultants were required to provide the hospital a minimum of six weeks' notice of leave such as holidays. We found systems in place to manage this with no identified concerns.
- There was an on-going programme within the hospital, which ensured that all medical staff maintained their revalidation. Doctors and surgical consultants confirmed no issues or concerns with the revalidation process.
- The records seen showed that patients saw their consultant after surgery as well as seeing medical staff

during ward rounds daily. Patients confirmed they had seen the consultant after surgery and saw a doctor every day and were happy with the service provided and had no issues or concerns.

Major incident awareness and training

- The hospital had a service contingency plan in place for staff to use in the event of interruption to essential services such as electricity and water supply.
- We saw regular testing of generators occurred in case there was a failure of the electricity supply to the hospital.
- Staff were aware of the procedures for managing major incidents, winter pressures and fire safety incidents.
- The surgical service completed annual health and safety assessments. We saw the June 2016 assessment, which included staff understanding what they should do in the event of a fire and how to use equipment to raise an alarm such as: accessing control panels and remote alarms. Staff spoken with confirmed they were aware of the procedures in the event of an incident.

Are surgery services effective?

Good

We rated the service for effective as good because:

- Patients received care according to national guidelines such as National Institute of Health and Care Excellence (NICE) and Royal College of Surgeons' guidelines. Policies were relevant and provided evidence based guidance, standards, best practice and legislation. These were used to develop how services, care and treatment were delivered.
- Patients had their needs assessed, their care goals identified, care planned and delivered in line with evidence-based, guidance, standards and best practice.
- There were processes and procedures in place for staff to manage patient's pain and ensure that patients' nutrition and hydration needs were met.
- Staff confirmed they had received their annual appraisals. The appraisal rates were just above the hospital target at 86% for the service. There was a surgical induction programme for all new staff and a competency framework for all staff in all surgical areas.
- We saw effective multidisciplinary team working that delivered coordinated care to patients. Staff had access to patient related information when required.
- Patients told us that doctors discussed consent prior to any procedures and the records demonstrated clear evidence of informed consent. Staff were clear about their roles and responsibilities around the Mental Capacity Act 2005 (MCA) and had an awareness of the Deprivation of Liberty Safeguards (DoLS).

However, we also found that:

- There were mixed patient outcomes and not always an action plan to ensure improvements.
- Consultants completed informed consent. However, the July 2016 informed consent audit for surgery on fracture neck of femur (NOF) showed an achievement rate of 58%, which the hospital considered to be "too low". We saw the identified recommendation, however, the action did not have a due date and we could not be assured these actions had been met.

Evidence-based care and treatment

- Policies were relevant and provided evidence-based guidance, based on current national standards, best practice recommendations and legislation and could be accessed by all staff via the hospital's intranet system. These were used to develop how services, care and treatment were delivered. This included guidance such as National Institute for Health and Clinical Excellence (NICE) and Royal College of Surgeons (RCS). For example, the hospital had systems in place to provide care in line with best practice guidelines (NICE CG50 Acutely ill patients: Recognition of and response to acute illness in adults in hospital).
- All NICE guidance were reviewed by the clinical business units (CBUs) and circulated to clinical audit leads and business unit directors to ensure compliance and relevance to clinical specialities.
- Staff provided care to patients based on national guidance and staff showed awareness of recent changes in guidance and we saw evidence of discussions based on these guidelines in the team meeting minutes. This meant that staff had all the necessary information to provide up to date care for their patients.
- The specialist head and neck nurses did not have an area within the maxillofacial service to provide support to cancer patients. This was a requirement identified

from the National Cancer Peer review (May 2015) and NICE 2004 (6) guidance for improving outcomes in head and neck care needs. However, this shortfall had been included in the business plan for the redevelopment of the maxillofacial services, which had been presented but not approved, as further work was needed. No timescale had been attributed to the re-presentation of this business plan.

- Venous thromboembolism (VTE) assessments recorded were clear and evidence based, ensuring best practice in assessment and prevention. VTE is a condition where a blood clot forms in a vein.
- Care pathways were used, which included risk assessments such as risk of falls and mobility. These pathways ensured that there were systems and procedures to manage any deviation in the patient's progress.
- Care bundles were used for patients when appropriate. Care bundles are a set of evidence based interventions that when used together will significantly improve patient outcomes. Examples included sepsis and acute kidney injury care bundles.
- Emergency surgery was managed in accordance with National Confidential Enquiry into Patient Outcome and Death (NCEPOD) recommendations and national guidelines, including RCS standards for emergency surgery.
- The pre-operative assessment clinic assessed and tested patients in accordance with NICE guidance for someone due to have a planned (elective) surgical operation. Examples included MRSA testing.
- The service used the World Health Organisation (WHO) 'Five steps to safer surgery' checklist, designed to prevent avoidable harm was audited and findings shared with the appropriate teams. The WHO safer surgery checklist audit from April 2016 to June 2016 looked at a sample of over 1,000 patients. The overall compliance for the checklist was 99%. The pre-list compliance was 99% and the post-brief compliance was 98%. The audit identified the areas of non-compliance, which included; surgeon arriving late for theatres due to ward rounds and failed equipment required replacement so theatre over-ran. Staff confirmed audit feedback was given at monthly meetings and we saw results graphs displayed in theatre. Staff received letters to highlight any non-compliance when completing the checklist.
- Staff used integrated care pathways for surgical procedures such as, hip or knee replacement. Staff in the ward and theatres used enhanced care and recovery pathways, in line with national guidance. Patients' needs were assessed using clinical pathways which were evidence based and used recognised risk assessments.

Pain relief

- Staff confirmed they assessed, managed and recorded the patient's pain levels effectively. Pain management commenced in the pre-assessment clinic where actions to deal with pain management were discussed.
- The effectiveness of pain relief was by using the pain scale within the NEWS charts. Most patients' records showed that pain had been assessed using the pain scale within the NEWS charts, appropriate medicines given as prescribed and effect of analgesia individually evaluated. Any concerns with pain control were referred to the anaesthetist or consultant who re-assessed the patient and amended the medicine prescriptions as required.
- Patient controlled analgesia (pain relief) equipment used for some patients post-operatively was available and staff felt they had sufficient quantities to meet the needs of the patients at any one time.
- Staff confirmed they could also contact the pain team when required who were available to provide support and advice.
- Staff and medical handovers discussed patient's pain when appropriate.
- When required, patients could access pain relief in accordance with the hospital policy.
- During our inspection, we observed staff asking patients about their pain. Five patients said they had been offered pain relief and felt their pain was being managed appropriately.

Nutrition and hydration.

- Staff assessed patients who may nauseous or vomiting and prescribed treatment as required.
- The hospital used the Malnutrition Universal Screening Tool (MUST) as a way of screening patients who may be underweight or at risk of malnutrition. Training had been rolled out across Deene and Barnwell wards to

ensure staff could use the MUST assessment tool appropriately. We looked at 17 records and found no issues or concerns regarding the completion of the MUST records.

- There were processes in place to identify and support patients that needed assistance with eating and drinking. Where applicable patient's nutrition and hydration intake had been recorded. Staff used fluid balance charts to monitor patients' fluid intake. We saw that patients had jugs of water on their bedside tables within reach to promote hydration.
- Nursing staff within the day case unit described the pre-operative fasting guidelines used for adults. These were aligned with the recommendations of the Royal College of Anaesthetists (RCOA) which states that patients can have an intake of water up to two hours before induction of anaesthesia and a minimum pre-operative fasting time of six hours for food solids, milk and milk-containing drinks. This meant that depending on where patients were on the theatre lists, some patients could have been fasting for long periods. Staff advised us they would seek advice from the anaesthetist in such cases and patients offered fluid and light diet if appropriate.
- Staff confirmed they referred patients to a dietitian as required. We saw referrals within the records read with no issues or concerns highlighted with the timeliness of access. Senior staff also confirmed patients who may be obese had access to a dietitian to support their needs.
- Patients were assessed for nausea and/or vomiting post-surgery. Where applicable, patients were given suitable analgesic and antiemetic (a drug effective against vomiting and nausea). We saw these medicines identified in the patient's records.
- Patients had intravenous fluids prescribed and recorded as appropriate.
- Patients we spoke with were positive about the food they had received.

Patient outcomes

- The hospital participated in all national audits they were eligible to enter in order to monitor patient's outcomes, such as the elective surgery Patient Reported Outcome Measures (PROMS) programme and the national hip fracture audit.
- The hospital's annual PROMS from April 2015 to March 2016 looked at primary knee replacement, hip replacement and groin hernia. All indicators were in line with the England averages with the exception of one area regarding groin hernia, which showed fewer patients' health improving and more patients' health worsening. An action plan was in place to show the service was managing the deterioration in the figures.
- We saw the non-operative management of acute achilles tendon rupture audit report for June 2016. This was based on the national evidence of non-operative management of acute achilles tendon rupture (Holm et al 2015). The report found lack of consistency in the management of acute achilles tendon ruptures with no local guidelines to follow. The action plan identified the creation of new local guidelines and pathway with a completion date of July 2016. However, the action plan did not have any identified outcome or how this was monitored within the service.
- From March 2015 to February 2016, patients at the hospital had a similar expected risk of readmission for non-elective admissions and a similar expected risk for elective admissions with the exception of ophthalmology. The ratio of observed to expected emergency readmissions is multiplied by 100. Values below 100 are interpreted as a positive finding. The elective specialty ophthalmology had the largest risk of readmission at 120. However, the theatre productivity operational board for October 2016 identified that ophthalmology had been processed mapped which covered all referral to treatment times. Process mapping refers to activities involved in defining what a business entity does, who is responsible, to what standard a business process should be completed, and how the success of a business process can be determined. The matron at the annual general meeting (AGM) the beginning of October 2016 had reviewed the mapping. Additional key actions for November 2016 were identified which included: exploring off site facilities, equipment and resources to support the activity required within the speciality.
- In the 2015 National Emergency Laparotomy Audit (NELA), the site achieved a rating over 80% for three measures, 50 to 79% for six measures, and below 49% for two measures. Outcomes were variable. In the 2014 NELA, 14 of 28 services were found to be available. Pre-operation input was not available, post-operation input was not available, and peri-operative input was available on request.
- In the 2015 hip fracture audit, the risk-adjusted 30-day mortality rate was 6%, which was within expectations.

The proportion of patients having surgery on the day of or day after admission was 78%, which did not meet the national standard of 85%. The perioperative surgical assessment rate was 82%, which did not meet the national standard of 100%. The proportion of patients not developing pressure ulcers was just below at 98%. The length of stay was 22 days, which made the hospital in the worst 25% against other hospitals.

- The hospital had a fracture neck of femur (#NOF) steering group who met quarterly to monitor, review, and discuss data, audits and trends. We saw an action plan which included the #NOF champion holding weekly sessions to review all admitted #NOF patients, attending multi-disciplinary team meetings and supporting junior doctors on decision making over and above consultant/registrar ward rounds. However, there was no date on the action plan or any indication as to how the service was improving performance to meet patients' needs.
- In the 2015 bowel cancer audit, 64 % of patients undergoing a major resection had a post-operative length of stay greater than five days. This was worse than the national aggregate of four days. The risk-adjusted 90-day post-operative mortality rate was 4%. This was within the expected range against the national average of between 2% and 6%. The risk-adjusted 90 day unplanned readmission rate was 19%, which fell within the expected range of between 60% and 40%. The risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major resection was 44%, which was within the national average.
- We saw a bowel surgery audit carried out within the service in June 2016 relating to pre-operative assessment of high-risk patients with a high Physiological and Operative Severity Score (POSSUM) or American Society of Anaesthesiologists (ASA) score. The audit was based on 60 patients. Information gathered was based by using medical and nursing notes and blood results. The outcomes were compared to non-intensive care unit (ICU) open versus laparoscopic (a surgical procedure that allows a surgeon to access the inside of the abdomen (tummy) and pelvis without having to make large incisions in the skin), elective versus emergency surgery and non-elective and emergency services. The results of the audit showed that:
  - morbidity and mortality scores were significantly reduced in elective laparoscopic operations
  - length of stay was lower in elective laparoscopic operations
  - patients who had elective operations but did not go to ICU stayed in the hospital longer than those who did
  - open elective surgery had a longer length of stay, higher morbidity and mortality scores versus elective laparoscopic cases
  - six of the 60 patients underwent two operations due to complications; one initially was an emergency; three elective laparoscopic non-intensive therapy unit (ITU) procedures; 2 elective open non ITU procedures
- In the 2015 Oesophago-Gastric Cancer National Audit (OGCNCA), the age and sex adjusted proportion of patients diagnosed after an emergency admission was 21%. This placed the hospital within the highest 25% of all hospitals for this measure. The 90 day post-operative mortality rate was not reported. The proportion of patients treated with curative intent (curative intent refers to health care practices that treat patients with the intent of curing them for example by chemotherapy) in the Strategic Clinical Network was 43%, which was; significantly higher than the national aggregate which meant the hospital was in the highest 25% of all hospital for this measure.
- We saw the peri-ocular tumour (which affects the eyes) audit for March 2016. The audit was presented in April 2016 to the joint audit meeting for Northampton and Kettering regional meeting. The audit was based on 97 patients with an average age of 70. Areas audited included:
  - time from referral received to biopsy (<42 days). The audit had a target of 90% but the service achieved 65%. We saw the action required with a due date of November 2016.
  - time from first clinic to surgery (157 days). The hospital partially met this target at 174 days. The actions included notifying clinicians within the department, increasing theatre slots and extra time dedicated to periocular tumour excision and reconstruction.
  - The service met both the complication rate of <9% at 5% and recurrent rate (0.5-10% at 2%
- The surgical service had a theatre delivery plan which included:

  - The development of a safe and effective means of capturing proposed surgical procedures to enable the accuracy of patient records, referral to treatment time tracking and coding
  - To implement a pre-operative assessment service that met best practice and supported the delivery of 85% theatre list utilisation; an increased elective working week from 42 week to 48 weeks and a list rate of 4.47 per speciality by 2020.
- The theatre productivity programme steering group oversaw the theatre delivery plan. The theatre delivery plan had been broken down into areas, which included; reduction in late starts, reduction in cancellations, improved list utilisation, the planning to achieve "Magic Numbers". Magic numbers is a system for determining space needs in health care settings. The theatre productivity programme from July 2016 to September 2016 showed that 42 tasks were on target, six were overdue, three were at risk and 22 had been completed. The delivery plan was RAG rated (red, amber, green). Examples of areas, which required further input, were the implementation of theatre dashboards, the gap analysis of specialties not planning lists four weeks ahead and the cancellation on the day standard operating procedure.
- During our visit to theatre, we observed hospital surgical dashboards on display and the theatre productivity board action plans which included the consolidation of reviews regarding pre-operative assessments and a collation of all "to come in" TCI letters to create a document library of communication to patients as well as an audit of TCI letters to provide a clear understanding of variance across all specialities. These actions had a deadline of November 2016.The hospital did not record their theatre utilisation but provided us with a projection as set out in the theatre delivery plan with a target of 85%. This was also highlighted in the anaesthesia CBU business and governance meeting of May 2016. The October 2016 theatre productivity operational board report had recorded plans to improve the list utilisation within theatres. Examples included the development of an electronic waiting list proforma, which would ensure that staff had all the relevant information available when scheduling patients and a weekly review of these actions to ensure delivery. We saw the service had introduced training to staff regarding the use of the scheduling tool. The trust informed us they were undergoing a review of its data systems. This meant that we could not be assured that the hospital could assess the performance of its operating theatres for the benefit of patients on their waiting lists.

Competent staff

- Staff had the appropriate qualifications, skills, knowledge and experience to deliver effective care and treatment.
- The service provided local induction, learning, development and appraisals for staff. The clinical business unit performance report for June 2016 showed 86% compliance for appraisals. This was just above the hospital target of 85%. Staff spoken with confirmed they had received their annual appraisal and that senior staff had an open door policy where they could discuss any concerns or issues at any time.
- Senior staff confirmed they had a mentoring system whereby staff could be support in their role to improve their performance.
- There was an induction programme for all new staff. This included mandatory training and competency based ward skills. All staff that we spoke with confirmed they had attended an induction.
- There was a surgical induction programme for all new staff, which had been created and implemented by the surgical team. This involved a rotation in surgical areas and attending study days provided by education and development facilitators.
- Nursing staff reported working supernumerary when commencing a new role. This was to ensure competence and offered new staff the opportunity to learn new skills and methods of working.
- Newly qualified nursing staff were supported through the preceptorship programme, which offered role specific training and support.
- Staff accessed study days relevant to their area of work, both internally and externally.
- Junior doctors had scheduled training sessions to maintain their specific training and development plans. They had both educational and clinical supervisors. They also attended monthly audit days where training sessions were provided on certain subjects and updates on audit results and action plans were given.
- We saw evidence that all registered nurses and professional staff that worked in the wards and theatres had valid registrations. This confirmed that nurses and other practitioners such as physiotherapists were

trained and eligible to practise within the UK. There was a process in place to check registrations were renewed. There were training programmes available to support nursing staff with their revalidation. The record showed that the validation of registration for doctors and nurses was 100% complete.

- Four staff within the surgical services confirmed they were undertaking the acute illness management (AIM) training. The aim of the training is to ensure staff members have the necessary knowledge to enable them to recognise, assess and manage acutely unwell adult patients.

Multidisciplinary working

- Our observation of practice, review of records and discussion with staff confirmed effective multidisciplinary team working practices that delivered coordinated care to patients.
- There was an escalation policy for patients who required immediate review. The records showed the hospital's antimicrobial pharmacist assessed compliance against the 72-hour review. Surgical wards undertook daily ward rounds seven days a week, which included physiotherapist and/or occupational therapists as, required. Staff confirmed consultants, when required, saw all new patients during the weekends and was available on-call to provide advice and information.
- We observed a good working relationship between ward staff, doctors and physiotherapists.
- Members of the intensive care unit and resuscitation team provided the outreach service during daytime hours. Developments were underway to implement a new and revised model to facilitate an established Outreach service that would cover 12 hours a day, seven days a week.
- Staff said that they could access medical staff when needed, to support patients' medical needs.
- There was dedicated pharmacy support on all the wards we visited, which helped to speed up patient discharges with "to take out" medicines.
- Surgical and nursing staff reported good working arrangements and relationships with another local NHS hospital.
- The admissions team worked closely with the operating theatre team to prepare operating lists to ensure appropriate arrangements were made. For example, if specialised equipment needed ordering for a specific operation or if there were patients or procedures on the operating list who required prioritisation.
- There was daily communication between the pre-operative assessment staff and ward and theatre staff, so patient care could be coordinated and delivered effectively. Staff described the multidisciplinary team as being supportive of each other. Staff told us they worked hard as a team to ensure patient care was effective and that their contribution to patient care was valued. Patient records also showed that there was routine input from nursing, medical staff and allied health professionals, such as physiotherapists.
- We observed effective team working among heads of departments, administrative, clinical, nursing, pharmacy, therapists and ancillary staff during our inspection.
- We saw staff working together to assess and plan ongoing care and treatment in a timely way when patients were due to move between teams or services, including referral, discharge and transitions.
- Discharge letters were sent to the patient's general practitioner (GP) with details of the treatment provided, follow up arrangements and a list of all medicines provided on the day of discharge.

Seven-day services

- Consultants were on call seven days a week for patients in their care. Staff we spoke with confirmed that consultants reviewed all new patients at the weekend. Overall responsibility for the patient remained with the named consultant who was responsible for the care and treatment.
- The pharmacy was available on weekdays as well as Saturday and Sunday mornings. Outside of these hours, there was an on-call pharmacist to dispense urgent medicines.
- There was access to all key diagnostic services 24 hours a day, seven days a week, which supported clinical decision-making.
- The service did not provide a full seven-day service therapy service, for example; dietetics and speech and language therapy provided a Monday to Friday service. There were no plans in place to move to a seven-day service. However, physiotherapists provided a seven-day service for higher risk patients.

- Pre assessment clinics were scheduled on Saturday mornings. This meant that patients who found it difficult to attend the clinic on a weekday had access to pre assessment services.
- Patients had access to diagnostic services such as x-rays, ultrasound, computerised tomography (CT) and magnetic resonance imaging (MRI) seven days a week.

Access to information

- Computers were available in the ward and theatre areas. All staff had secure, personal log-in details, access to e-mail and all hospital systems. A member of staff was able to log on to the intranet system and show us how policies and procedures were accessed. It was clear they were familiar with this process.
- There were arrangements to ensure staff had all the necessary information to deliver effective care. Staff, including agency and locum staff, had access to patient-related information and records when required. This included care and risk assessments, care plans, case notes, and test results to enable them to care for patients appropriately. This meant when a patient was admitted for surgery clinicians had all the necessary information such as test results and recent treatment available.
- Staff had access to the weekly 'Hot Topics' information which provided guidance on areas highlighted as concerns. Areas covered included the completion of VTE assessments, the availability of diabetic information on patients' records and the importance of keeping wards clutter free.
- Nursing staff told us that when patients were collected from the recovery suite they received a comprehensive handover. This was reflected in the records read. When a patient was transferred between wards staff confirmed they conducted a comprehensive handover. This ensured that staff had the relevant information such as medical and social history and on-going care needs and plans of treatment.
- Computers were available in the ward and theatre areas. All staff had secure, personal log-in details, with access to e-mail and all hospital systems. A member of staff was able to log on to the intranet system and show us how policies and procedures were accessed. It was clear they were familiar with this process.
- The hospital had a single equality strategy for 2016/2021. All policies, procedures and functions were assessed to ensure that any detrimental effects on protected and vulnerable groups were identified and eliminated.
- GPs received copies of discharge letters to ensure continuity of care within the community. The summary had the consultant surgeons contact details this meant that the GP had a point of reference if further information was needed.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff understood the consent and informed decision-making and how patients were supported to make decision as required by legislation and guidance, including the Mental Capacity Act 2005.
- The hospital had a consent policy that staff were familiar with.
- Staff understood consent, decision making requirements and guidance. The hospital had four nationally recognised consent forms in use. For example, there was a consent form for patients who were able to consent, another for patients who were not able to give consent for their operation or procedure and another for procedures under a local anaesthetic.
- Staff understood when to use the forms and whether the consent being provided was implied, verbal or written. Implied consent is consent which is not expressly granted by a person, but rather by their actions and the facts and circumstances of a particular situation. Verbal consent means that patients are read a verbal version of a consent form such as an information sheet and give their verbal consent rather than a written consent.
- The mandatory e-learning provided to staff included safeguarding, information about the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff understood their responsibilities in relation to gaining consent from patients, including those who lacked mental capacity to consent to their care and treatment. Staff said they would seek advice from a senior member of nursing staff should a formal assessment of mental capacity require completing.

- The clinical business unit performance report for June 2016 showed that the anaesthetics team were 93% compliant and the surgical team at 88% regarding their MCA and DoLS training. This was above the hospital target of 85%.
- We saw the informed consent for surgery on fracture neck of femur (#NOF) fracture records' audit report for July 2016. This was based on 50 patients identified as #NOF who had undergone a surgical intervention. The audit showed an overall achievement rate of 58% which was below hospital expectations. The results showed:
  - Variability in the number of risk factors recorded on the consent forms.
  - Unclear whether the undocumented risk factors had been conveyed to patients.
  - Risks such as pain, stiffness or even scarring were not identified as being discussed and documented.
  - No evidence of deep vein thrombosis or pulmonary emboli, neurovascular damage identified as being discussed with the patient
- The identified recommendations on the audit report were:
  - Ensure a copy of the major risk factors in surgical interventions of #NOF was displayed in the doctors' office as a reminder of mandatory documentation in consent forms
  - Amendments to the junior doctor's induction handbook for trauma and orthopaedics to include a page on the major risk factors.
- The clinical audit summary form and action plan for July 2016 also confirmed the directorate governance meetings, departmental , consultant and educational meetings also oversaw the consent audit. However, the action did not have a due date for completion and therefore we could not be assured these actions had been met which meant that patients undergoing consent for #NOF may not have all the identified risk discussed with them.
- We saw the consent form audit for August 2016 completed on Geddington and Ashton ward, the surgical day case unit and DASU. This was based on 30 patient records of which eight had incomplete consent forms. We saw the actions to be taken which included; consent to be captured at pre-assessment and outpatients when the form is completed and also for the trauma nurse practitioners to obtain consent from patients on admission. Staff within the pre-assessment unit confirmed they obtained patient's consent during their initial visit. The records seen confirmed no concerns or issues with the recording of consent. The directorate governance meetings, departmental, consultant and educational meetings also oversaw the consent audit.
- We looked at 17 records and found consent forms had been completed appropriately. Staff confirmed that if they had concerns regarding a patient's ability to understand any decision or information provided they would refer to their senior manager or the consultant in charge of the patient. Staff confirmed the patient's capacity to consent was discussed at their pre-assessment and they were made fully aware of the patient's individual needs.

Are surgery services caring?

Good

We rated the service for caring as good because:

- Patients were generally supported, treated with dignity and respect and were involved in planning their treatment and care. Feedback from patients and those who were close to them was positive about the way staff treated and cared for them.
- Patients were given time to understand their care, condition and treatment options and were communicated with and received information in a way that they could understand.
- Patients were encouraged to be as independent and mobile as possible following their surgery.
- Staff recognised when patients and those close to them required additional support to help them understand and be involved in their care and treatment. Patients were allocated a named nurse, which meant they knew who was caring for them and who to approach if they needed assistance.

However, we found that:

- The PLACE audit 2016 score for ensuring patients were treated with privacy and dignity ranged between 50% and 80%. For example, the audit showed Ashton ward at 50% and Geddington ward at 80%.
- The hospital submitted data to the Friends and Family Test (FFT). The data provided showed the average FFT

response rate was 14% which was worse than the England average of 29% from August 2015 to July 2016. However, between 93% and 100% of patients said they would recommend the service provided by the hospital.

- Nursing handovers took place at the end of each patient's bed or in their side rooms, which made it difficult to respect privacy and confidentiality.

Compassionate care

- Staff respected generally patient's privacy and dignity. For example, we observed that they knocked on doors before entering. One patient told us they thought staff were "wonderful and kind" and another said they felt "safe" and "valued the frequent checks" by staff.
- The hospital used the "Hello my name is" scheme. The aim of the introduction was to help preserve patients' dignity, promote respect and the best practice in the way they were approached. However, it was unclear if this campaign was well embedded within the service. For example, staff wore their photo identities clipped to their hip pockets. We did not observe staff wearing a name badge so they could be easily identified. Also, staff did not introduce themselves to patients for example; when entering a side room and conducting a handover.
- The PLACE audit 2016 score for ensuring patients were treated with privacy and dignity ranged between 50% and 80%. For example, the 2016 audit showed Ashton ward at 50% and Geddington ward at 80%.
- Patients spoke warmly about the caring approach and thoroughness of making safety checks on arrival to the operating department by operating theatre staff.
- Nursing handovers took place at the end of each patient's bed or in their side rooms. During an observed handover, we found that this made it difficult to respect the patient's privacy and confidentiality due to the nearness of patients on the wards. Senior staff confirmed they were aware of the issues but ensured they respected the patients and their confidentiality.
- We observed positive interactions between nurses, allied professionals and patients. One patient told us how they appreciated the time staff took to help them settle. We observed staff taking time to interact with patients and those close to them in a respectful and considerate manner.
- The hospital submitted data to the Friends and Family Test (FFT). This is a method used to gauge patient's perceptions of the care they received and how likely patients would be to recommend the service to their friends and family. This is a widely used tool across the NHS. The data provided showed the average FFT response rate was 14% which was worse than the England average of 29% from August 2015 to July 2016. For example; Geddington ward and the treatment centre had an average response rate of 11% and 4% (400 and 227 patients respectively). Both services showed patients recommending the service (93% and 100%).

Understanding and involvement of patients and those close to them

- Patients told us they had been given opportunities to discuss their surgery and the risks and benefits involved with their consultant, and felt actively involved in decision-making.
- Information was provided pre operatively that described what patients needed to do before and after surgery to ensure a desired outcome. Examples included stopping smoking before anaesthesia and wound management following surgery.
- Patients were involved in making choices around their care within their pathway. For example, a patient told us that staff talked to them about the treatment options available and supported them in their decision. Another patient told us that they had felt very anxious about their procedure and, as they were due to go to theatre, they were not sure if they wanted to proceed. Staff took time to have a further discussion with them going over the options for treatment ensuring they fully understood what was involved.
- Consultants visited the wards daily and were available to answer any questions they might have and informed patients of what to expect.
- Patients told us that they felt comfortable asking questions and that staff took time to explain and answer their queries.
- We observed staff communicating with an interpreter whose patients' first language was not English.
- Staff confirmed they recognised when patients and those close to them required additional support to help them understand and be involved in their care and treatment.
- Patients were allocated a named nurse on admission who managed the admission process and supported the patient during their pre and post-operative period.

- Patients assessed for treatment as a day case, signed a document to say they understood the advice they were provided. This included that they must not eat and drink for a specified time pre operatively and should not drive post operatively.

Emotional support

- Staff ensured pre-admission assessments included consideration of patients' emotional well-being.
- Patients felt staff had time to listen and provided reassurance if they had any concerns. We observed staff providing emotional support to a patient on Geddington ward who was distressed and required re-assurance.
- Patients had access to clinical nurse specialist, for example, breast care nurses and stoma care nurses. This meant that patients received specialist support when coming to terms with any adaptions in their everyday lives.
- Patients had an allocated nurse who was able to support their understanding of care and treatment and ensure that they were able to voice any concerns or anxieties.
- Patients said they were encouraged and supported to manage their own health, care, wellbeing and independence.

Are surgery services responsive?

Requires improvement

We rated the service for responsive as requires improvement because:

- The hospital has not provided data for referral to treatment time (RTT) for admitted performance for surgical services since November 2015 due to having concerns around the accuracy and quality of its RTT data and reported position.
- There were currently 218 patients who had to be re-assessed due to having exceeded the three month pre-assessment period. This meant that these patients would have to be re-assessed prior to coming in for their surgery.
- Estimated discharge planning arrangements was commenced during pre-assessment. The wards visited had a notice board with the estimated date of discharge (EDD) on display for each patient. However, we observed the EDD had been exceeded by several days/ weeks for certain patients with no relevant update. This meant that staff may not have the most up to date data to manage the discharge planning of patients.
- Reported complaints took an average of 69 days to investigate and close. This was not in line with the hospital's complaint policy.
- The service recorded the "did not attend" (DNA) performance rate. For example from October 2015 to September 2016, oral surgery was 12% (1,015 patients DNA against 7,766 who attended) and trauma and orthopaedic surgery 10% (3,109 patients DNA against 27,459 who attended). However, the report did not indicate what percentage of DNA was acceptable and we did not see an action plan or processes in place to manage the number of patients who DNA's.

However, we also found :

- There were 5,573 patients on the elective waiting list with the highest being ophthalmology at 1,269. The hospital had noted that ophthalmology remained the speciality seeing the greatest growth in waiting list volume with 25% more patients than at the start of the year (2016). However, this service had processed mapped and reviewed by the matron at the annual general meeting.
- The hospital had a RTT recovery programme for validating patients on the waiting list. Private providers had been contracted to support the treatment of some of the hospital patients. The cancer 62 day standard showed the hospital had met 92% of urgent GP referrals.
- The average length of stay for surgical elective patients was comparable with the England average. The length of stay for patients with a benign enlargement of the prostate had been reduced due to the introduction of a new light laser treatment.
- The service had an enhanced recovery programme which is an evidence-based approach that helps patients to recover more quickly after having major surgery.
- There was a 'care passport' scheme to support patients with dementia and/or a learning disability. The 'butterfly' scheme was used to discreetly identify patients living with dementia. Staff had access to admiral nurses to provide support when required.

- There were translation services available to support patients which ensured that patients had the relevant information about their care.

Service planning and delivery to meet the needs of local people

- Patients had all the necessary information to ensure the service was planning and meeting their individual needs.
- The waiting area within the maxillofacial service was very congested. The department provided emergency treatment for all patient groups including regular attendances from prisoners and patients with severe facial disfiguration at various stages of their cancer treatment. There was no waiting room to provide privacy for these patients. However, the service had prepared a business case that had not yet been approved by the board at the time of the inspection that would redesign the service in a new more spacious location. This area had been highlighted as a concern within the local surgical risk register.
- In autumn 2015, the hospital had introduced a new laser operation to support patients who required treatment for benign enlargement of the prostate by using a light laser to reduce the size of the prostate. This process reduced the surgical time and the length of stay was no more than one day. The hospital continued to provide this service through a day case procedure.
- The hospital had developed close links with surrounding NHS providers and other independent sector hospitals to meet the needs of local people.
- The booking system was flexible to patient needs, and where possible patients could select times and dates to suit their family and work commitments.
- Consultants had planned and dedicated theatre lists, which enabled patients to be booked onto these lists in advance. Operating theatre lists for elective surgery were planned in conjunction with the operating theatre manager and bookings team. This was to ensure aspects such as, type of operation and equipment required were taken into account before booking patients onto the list. This also ensured that the service met patients' needs and available operating time was used effectively. The operating theatre manager explained that when they were approving operating theatre schedules, checks were also made to ensure the availability of other services such as imaging.
- The service had an enhanced recovery programme, which was an evidence-based approach that helped patients to recover more quickly after having major surgery. The aim of the programme was to ensure that patients:
  - Were as healthy as possible before receiving treatment
  - Received the best possible care during their operation
  - Received the best possible care whilst recovering.
  - Encouraged early mobilisation to avoid complications such as VTE, chest infections and pressure tissue damage
- The recovery steering group and hospital management committee met weekly to review the progress and learning between work streams, make decisions and raise awareness whilst ensuring lessons were shared across the service.
- There was information available to staff on how to contact members of the clergy to meet patient's individual spiritual needs. Patients had access to a chapel and multi faith room on site.
- We saw that during mealtimes, most patients sat out of bed in order to eat and staff gave assistance to patients when needed.
- Consultants were on call seven days a week for patients in their care. Staff we spoke with confirmed that consultants, as required, reviewed patients at the weekend.
- The hospital had put forward a business case (in May 2016) to enhance the service it offered to spinal patients by working collaboratively with other local hospitals. The proposed partnership arrangement would include a combined spinal on-call rota which would support the hospital's patients having access to an on-call spinal consultant 24 hours a day, seven days a week. As of November 2016, the business case was currently under negotiation with a local hospital with a view of ascertaining how they can reduce the financial cost of the scheme.
- The environment within the maxillofacial service area was cramped and not conducive to patients who were partially sighted, hard of hearing or disabled. They had limited to no access to the x-ray room due to the entrance being too small for a wheelchair. This contravened the Equality Act 2010. A business case for replacement environment had been presented to the board, but not yet ratified.

Surgery

Access and flow

- Patients did not have always have timely access to initial assessments, diagnosis or urgent treatment.
- Staff within the pre-assessment clinic informed us there were currently 218 patients who had to be re-assessed due to having exceeded the three month pre-assessment period. During our inspection, a patient due for surgery that day, had to be re-assessed due to having superseded their three-month pre-assessment period. However, the trust informed us they "currently did not assess patients required for surgery until they are towards the top of the waiting list and therefore no patient has had to be re-assessed." This meant that we could not be assured the service had an indication of how many patients would have to be re-assessed prior to coming in for their surgery. This may involve the undertaking of another face to face pre-assessment, repeated blood tests and/or other investigations. This meant the service was not supporting an effective and efficient pathway for this group of patients. This had not been identified on the risk register as a concern.
- The service recorded the "did not attend" (DNA) performance rate which was highlighted in the recovery programme (October 2016). For example from October 2015 to September 2016, oral surgery was 12% (1,015 patients DNA against 7,766 who attended) and trauma and orthopaedic surgery 10% (3,109 patients DNA against 27,459 who attended). However, the report did not indicate what percentage of DNA was acceptable and we did not see an action plan or processes in place to manage the number of patients who DNA's.
- From April 2015 to March 2016, the average length of stay for surgical elective patients at the hospital was comparable with the England average at three days. For surgical non-elective patients, the average length of stay was 5.5 days, compared to 5.1 for the England average. However, non-elective patients in trauma and orthopaedics' average length of stay were 10 days compared to nine days for the England average.
- The hospital had not provided data for referral to treatment time (RTT) for admitted performance for surgical services since November 2015 due to concerns around the accuracy and quality of its' RTT data and reported position. The hospital was working on a plan of data improvement including education, training, changes to systems and processes and validation of patient pathways.
- The hospital had made additional arrangements to reduce their RTT by contacting private providers to request their support in the treatment of some of their patients for example; general surgery, and urology. A business case had been put forward to increase the number of colorectal consultants to meet the increase in demand as well as the increase in locum consultants in areas such as ophthalmology. However, there was no timescale of when this business case would be approved and implemented.
- The hospital had a RTT recovery programme with a trajectory of validating 202,000 pathways by the end of November 2016. The data for October 2016 showed the hospital remained ahead of its performance improvement trajectory with a performance of 68% and was on plan to achieve the agreed 77% target level by the end of November 2016. A further 1,038,270 pathways were safely closed which equated to 95%. There were five low harms identified as of November 2016, one in ophthalmology, two in ear, nose and throat, one in trauma and orthopaedic and one in general surgery. In order to manage the recovery programme the hospital had increased the number of validators to 81, with 21 new validators joining the hospital at the beginning of October 2016. Weekend working had been implemented to maximise the management of "business as usual" (BAU) against backlogs. As of October 2016, 100,704 patients had been validated; this was higher than the projected figure of 88,475. This meant the hospital's performance was running above the expected levels of 11,000 per week.
- Consultants had been contacted to gain agreement and specific dates to undertake additional theatre slots. For example, we saw the following additional lists had been included from October 2016 to November 2016; 62 in ophthalmology, 43 in trauma and orthopaedics and 24 in oral surgery.
- The elective waiting list volume remained stable from March 2016 to October 2016. The records showed that the trajectory was to be agreed to support the active reduction of this list to 3,240 patients. Currently there were 5,573 patients with the highest being ophthalmology at 1,269. Ophthalmology remained the speciality with the greatest growth in waiting list volume with 25% more patients than at the start of the year (2016). Actions to manage the volume of ophthalmology patients had been created by the theatre productivity operation board. This involved process mapping the

service and exploring off site facilities, equipment and resources to support the activity required within the speciality. They had an action date of November 2016 to review these plans.

- For the period (quarter two 2014/15) to (quarter one 2016/17), the hospital cancelled 537 operations. This was similar to the England average. Of the 537 cancellations, one was not treated within 28 days. As a percentage of elective admissions, cancelled operations fell during 2015/16, before peaking in quarter four. The hospital's percentage of cancelled operations has remained below the England average since quarter one 2015/16.
- The cancer 62 day standard showed the hospital had met 92% of urgent GP referrals (79 treatments and seven breaches) as of June 2016. This was in line with the national standard. The current patient pathways over 104 day wait for treatment was nine (four either had dates or were being treated). A weekly patient list meeting was held with the CBU and support services such as diagnostics. The meeting discussed patients at risk of breaching or who had already passed their target date.
- Estimated discharge planning arrangements were commenced during pre-assessment including planning estimated length of stay required and assessing whether patients required additional support at home when they were discharged. The wards visited had a notice board with the estimated date of discharge (EDD) for each patient on display. However, we observed the EDD had been exceeded by several days/weeks for certain patients. For example we saw 25% of the patients on Deene B and C wards. Senior staff confirmed that although they were unable to alter the date due to the guidelines from Dr Foster which outlines the sustainable improvements in the organisations performance all patients had an adjusted discharge which they worked towards. However, as this was not on display it meant that staff may not have the most up to date data to manage the discharge planning of patients.
- Patient records showed that staff completed a discharge checklist that covered areas such as, medicines and communication to the patient and other healthcare professionals.
- There was a bed management system in place which was aimed at ensuring patients' needs were met when there were increased demands on beds. However, during our inspection some medical patients were cared for on the surgical wards.

Meeting people's individual needs

- Written information on medical conditions and procedures took into account the patients individual needs.
- The surgical services planned and coordinated patients' individual needs from the surgical assessment unit through to the anaesthetic room and again in recovery when needed. Information from pre-assessment was clearly recorded and relevant information about individual needs was clearly documented. For example, the needs of a patient living with dementia were communicated to staff, which meant they had the necessary information to support the patient's individual needs.
- Staff demonstrated an awareness of the learning disability and dementia 'care passport' scheme passport whose use is to support anyone of any age with a long term condition, who wants to ensure that their care needs are managed appropriately. Staff documented patients' care needs in the care passport, including patient preferences and other useful information, which enabled staff to support them. They confirmed for example; that some patients with learning difficulties had prior access to the theatre area so they could become used to the environment.
- The 'butterfly' scheme was used to discreetly identify patients living with dementia. The use of the symbol enabled staff to identify patients who had a dementia diagnosis and ensure additional care and support were available.
- Staff had access to admiral nurses to provide support when required. Admiral nurses are specialist dementia nurses who give expert practical, clinical and emotional support to families living with dementia to help them cope.
- Staff in pre-assessment clinic referred patients directly to a dietitian where appropriate and, where required, leaflets were available advising patients on healthy weight loss. Within the leaflet, information was given on supportive organisations.
- Patients were discharged at an appropriate time and when all necessary care arrangements were in place.

Patients discharge plans took account of their individual needs, circumstances, and ongoing care arrangements. For example, one patient said that the discharge arrangements had been discussed with them and a discharge time had been given when they would have the appropriate support at home.

- Patients who required additional support to be involved in their care and treatment had access to language interpreters, sign language interpreters, specialist advisors and/or advocates as required. Staff knew how to access an interpreting service
- Patients had access to hot drinks and snacks as required. Staff told us that a range of meals were provided to meet the individual dietary needs of all patients. When the catering department was closed, patients who came back from theatre in the late afternoon had access to food, for example sandwiches. The catering department ensured the ward had suitable supplies to meet patients' needs.
- An interpretation service was available to patients who did not speak English and staff were aware of how to access this. Staff were able to access patient information sheets about surgical procedures in different languages.
- Deene B had introduced a patient diary that involved patients in their own recovery. The diary provided advice and set out expectations which included the importance of exercise, and what to do after discharge such as eating nourishing foods and drink.
- There were appropriate arrangements to support and meet the emotional and spiritual needs of patients including an open visiting policy and access to chaplaincy.
- The maxillofacial service area was cramped and offered poor patient experience. The area did not provide facilities for the partially sighted or hard of hearing patients. There was limited disabled access to the service with no disabled access available to the oral x-ray room due to this being blocked by a radiator and waiting room chairs. Although this breached the Equality Act 2010, which states that, the provider should "protect you from various forms of discrimination relating to disability, and also discrimination and harassment." Staff said they, as far as was possible, made reasonable adjustments to accommodate disabled people. For example, they said they restructured clinical rooms to ensure there was access to wheelchairs to enable patients to be seen. We noted this was highlighted on the risk register as a significant risk. The service had submitted a business case to a recent board meeting with proposals to relocate the service into a suitable clinical area: however, the board had not yet approved this business case and there was no defined timescales for the plans to be implemented. This concern was highlighted in the surgery and anaesthetic local register.

Learning from complaints and concerns

- The hospital received 125 complaints from August 2015 to July 2016 about surgical care services. The service took an average of 69 days to investigate and close complaints; this was not in line with the complaints policy in place (from July 2014 to July 2016), which stated complaints should be responded to within 25 working days.
- In July 2016, the hospital implemented a revised complaints' policy which stated that timescales for response letters to be sent were 25 working days for simple complaints, 30 working days for complex complaints or within the timescale agreed with the complainant depending on the nature and complexity of the complaint. From information provided by the hospital for the period April 2016 to September 2016, it took an average of 33 days to investigate and close and that 81% of complaints had been responded to in line with requirements of the revised policy. This represented an improvement in the way the service managed complaints in accordance with the new timescales detailed in the revised policy.
- Staff we spoke with managed verbal complaints and were aware of the need to escalate complaints that they were not able to resolve.
- Staff directed patients to the patient advice and liaison service if they were unable to deal with their concerns directly.
- Complaints were recorded and responded to including verbal complaints. There was a form available for staff to record verbal complaints to ensure these were managed appropriately. Most complaints were classed as incidents and reported on the incident reporting system. However, some verbal complaints were resolved locally and not reported onto the electronic reporting system. This meant that the hospital did not have an oversight of all complaints and may have missed an opportunity to learn from them.

- Formal complaints were logged onto the hospital's database where they were monitored. Recommendations and themes from complaints were cascaded to staff to ensure learning was shared across the service. Staff were empowered to respond proactively to resolve issues locally where possible, or to escalate any concerns for support and advice.
- Literature and posters displayed within the wards advised patients and their relatives how they could raise a concern or complaint, either formally or informally.
- There was information provided for patients, which included how to make a complaint if there was dissatisfaction with any aspect of their care. All patients we spoke with could describe how to make a complaint should they wish to do so and felt comfortable raising concerns with staff.
- All patients spoken with said they did not have any concerns but would speak with the staff if they wished to raise a complaint. Staff understood the process for receiving and handling complaints.

Are surgery services well-led?

Good

We rated the service for well-led as good because:

- Staff reported that leadership within departments was very strong, with visible, supportive, and approachable managers. All felt that there was a positive working culture and a good sense of teamwork, which was open, honest, and transparent.
- Staff within the surgical service were aware of the surgery and the anaesthetic business plan strategy for 2016/17 which included improving utilisation and increasing the number of patients on each list
- Generally, there was a clear governance structure in place within the surgical clinical business unit to review areas such as; infection control, incidents, health and safety, complaints, estates and policies.
- The hospital had strategic systems in place to assess and control its risks. There was a risk register for the anaesthesia and surgical services. Key risks highlighted were: inadequate staffing levels, the impact of the ventilation works in the main theatres.

However, we also found:

- Routine audits and monitoring of key processes took place across the ward and theatre areas to monitor performance against objectives. However, not all audits had actions or outcomes to improve performance.
- Staff knew the hospital had introduced the new CARE values but some had little awareness of what they were.

Leadership of service

- A medical director, business unit directors, trust director, general manager and head of nursing led the surgical and anaesthesia service. All the clinical leads reported to the business unit directors.
- Staff had an awareness of the chief executive officer (CEO) and the director of nursing (DON) and saw them around the hospital. They told us that the executives would visit the area on occasions. Staff told us they saw the matron and medical director for their area regularly.
- Staff confirmed their line managers had an open door policy whom they could contact directly with any concerns or issues.
- Staff reported that leadership within departments was very strong, with visible, supportive, and approachable managers. All felt that there was a positive working culture and a good sense of teamwork, which was open, honest, and transparent.
- Staff reported that their direct line managers were supportive and kept them informed of day to day running of the departments.
- The nursing team, diagnostic team, physiotherapy team and administration team communicated well together and supported each other.
- Staff within the surgical services said they felt supported by their managers who looked after their welfare. They felt able to raise concerns and that their concerns would be acknowledged.
- Each ward had a lead nurse who provided day-to-day leadership to members of staff on the ward.
- Ward sisters said the hospital had a good leadership development programme which they could access.
- Staff spoke positively about the leadership of both the ward and theatre manager. Staff said the managers had made positive improvements in the planning and organisation of the ward and theatre areas.

- The clinical business unit performance report for June 2016 showed a vacancy rate of 16% in anaesthetics and 13% in surgery. This was higher than the hospital target of 7%. A recruitment and retention plan was in place to manage the shortfall in staffing.
- As at August 2016, the hospital reported a turnover rate of 7% in surgery. The highest turnover rate was reported on Geddington Ward (20%); in absolute numbers the highest turnover was on the Barnwell Ward (5%). DASU reported the second highest turnover rate (4.68 WTE; fourth-highest proportionally at 14%).
- As of August 2016, the hospital reported a sickness rate of 6 % in surgery, theatres and Deene B. Barnwell B and C wards reported the highest absolute sickness rates (6%, 5% and 3% respectively). In the case of Deene B and Barnwell wards these were also the highest two rates proportionally (8% and 6% respectively).

Vision and strategy for this service

- The hospital had recently introduced new CARE values which were:
  - Compassionate – to take the time to be empathetic and open: treating each other and our patients as individuals that matter.
  - Accountable – to take responsibility and ownership both individually and collectively for our decisions and actions
  - Respectful – to value the experience and contribution of others: respecting others' thoughts, feelings, beliefs and behaviours.
  - Engaging - to ask for and listening to the opinions of others and facilitating an open environment for dialogue.
- Although staff knew the hospital had introduced the new CARE values, some had little awareness of what they were. Staff directed us instead to their "I Will" campaign which they said they used as their core value.
- The "I Will" campaign was an amalgamation of five practice development campaigns and sets an expectation was that individual staff would sign a pledge promising patients that they would, keep them safe, keep them comfortable, keep their environment tidy, treat them with compassion and abide by the core values and behaviours of the organisation. We saw posters on display outlining the campaign and staff stated they used this to ensure the provided patients with the best care available.
- We saw the surgery business plan strategy for 2016/17 which included for example:
  - To consistently provide good outcomes and experiences to patients by providing a great learning environment for continuous service improvement and staff development for both elective and emergency services
  - Provide excellent, compassionate care in a suitable environment for both elective and emergency patients
  - To enable elective patients to have choice due to short waiting times and good outcomes
  - Emergency patients will be seen and treated quickly in a dedicated area by a dedicated team
  - Good training and development opportunities for staff to enable recruitment and retention
- We saw the anaesthetic business plan strategy and for 2016/17which included for example:
  - Maintaining 24 hour access to emergency, general surgical and maternity theatre
  - Effective running of elective surgical lists for 48 weeks
  - Improving utilisation and increasing the number of cases on each list
- Senior staff said the surgical and anaesthetic business plans were included as part of their annual appraisals. This was confirmed with staff spoken with.

Governance, risk management and quality measurement

- The clinical business unit (CBU) conducted an annual assessment form regarding health and safety across the service. We saw the May 2016 and June 2016 assessment for the surgery day case unit and main theatres. There were no issues or concerns identified. Areas covered included for example; fire management, security which included safe operating procedures, training records and risk assessments.
- The July 2016 minutes for both the anaesthesia and surgery CBU business and governance meetings demonstrated that key governance areas were discussed including incidents, complaints, estates and policies.
- The cancer management group met monthly with the clinical operating officer and medical director to discuss the progress of patients who may breach the waiting list. Updates were provided by the CBU which included a review of any root cause analysis for patients who had breached their respective tumour sites.

- The hospital had strategic systems in place to assess and control its risks. For example, they used key performance indicators and the hospital performance dashboards, which allowed the executive board to monitor when performance fell below acceptable levels.
- Generally, the service had systems in place to identify and monitor risks. The surgical division held its own risk register and clinical leads we spoke with were able to identify the top risks. Examples included; inadequate staffing levels, the impact of the ventilation works in the main theatres thus reducing the service's ability to meet their RTT and cancer targets. The risk registers seen had been reviewed and had updated actions.
- Nursing and medical staff were also aware of risks locally, and were able to inform us of those which they felt most affected patient safety. The majority of staff stated that recruitment and the financial strain of locum and agency staff caused the highest risks within the organisation. The leads for the service also identified staffing as being the top risk for the service.
- Routine audits and monitoring of key processes took place across the ward and theatre areas to monitor performance against objectives. Information relating to performance against key quality, safety and performance objectives was monitored and shared with staff through performance dashboards that were displayed on noticeboards. However, not all audits had actions to improve performance.
- Incidents and outcomes were reviewed and monitored through clinical governance meetings. Examples included surgical site infection rates, average length of patient stay, readmission rates and complaint themes.
- The service held monthly clinical governance meetings where quality issues were discussed. For example, incidents and audit results. Information was then cascaded to staff through directorate and team meetings and safety bite bulletins. The service also held elective care performance meetings monthly. Quality and performance indicators were discussed, for example, RTT times, medical outliers, actual and planned admissions, and service risks.
- The senior trust management had not taken reasonable practicable action for some risks to ensure the safe management of :
  - the handling of foods within the wards to ensure that it adhered to the Food Safety Act 1990 and the Food Hygiene (England) Regulations 2006 (Temperature Control Schedule 4 EU Regulation No.852/2004).
  - systems and processes in place to manage the cleaning of curtains and fabric chairs within the service.
  - Staff complying with the Standards and Recommendations for Safe Perioperative Practice 2011 by the Association of Perioperative Practice or the hospital's operating theatre policy and the theatre standard operating procedure regarding the wearing of cover gowns and footwear when leaving and entering the theatre area.
  - the maintenance and management of cleaning schedules within the wards.
- Clinical leads we spoke with told us that there was now focus on elective patients and forward planning in capacity. However, we saw that bed capacity was a challenge with non-surgical patients admitted to surgical wards.
- Staff understood their roles and what they were accountable for.
- Senior staff in the service took an active part in the six weekly county-wide mortality reviews which were multidisciplinary and well attended by a range of clinicians and staff

Culture within the service

- Leadership within the surgical services reflected the vision and values of the hospital and promoted good quality care.
- There was a sense of pride amongst staff towards working in the hospital and they felt respected and valued.
- Staff described a supportive and encouraging working environment and one in which openness and honesty was encouraged.
- There was evidence of collaborative working throughout the service and a shared responsibility to deliver good patient centred care.
- Each clinical area displayed thank you cards from patients and relatives.
- Junior doctors stated that their colleagues were "very approachable and happy to answer questions and teach".
- The hospital used the "Hello my name is" scheme. However, it was unclear if this campaign was well embedded within the service. For example, we did not observe staff wearing a name badge so they could be easily identified. Also staff did not introduce themselves to patients when conducting a handover.

Surgery

Public engagement

- The hospital and staff recognised the importance of the views of patients and the public. Using surveys and questionnaires to gather information to enable service improvement.
- Information on patient experience was reported alongside other performance data. This information was used to make informed decisions about the service.
- There was hospital stakeholder group that provided feedback on hospital business plans and patient care improvement plans. The group had representation from patients, carers, staff and commissioners
- The hospital had launched a "Joint School" education session for approximately 400 patients who required hip or knee replacements in July 2016. The aim was to give patients a clear indication of what to expect from their operation and what was expected form them by the hospital. The aim of the joint school was to explain why joint needed replacing, what anaesthetic they could choose to have and what to expect afterwards in terms of their wound care and rehabilitation. Feedback from patients included; "you learn about the exercises you can do in advance of your operation and how you will use them afterwards to help you recover" and staff "painted a very clear picture of what to expect during your operation and what happens afterwards".

Staff engagement

- All staff we spoke with were focused on and committed to providing a high standard of safe care and were proud of the services that they provided.
- Staff in all surgical areas focussed on improving the quality of care for patients by ensuring they had all the information available to provide safe care.
- Staff felt that their efforts to improve the quality of care for patients were recognised by both the patient and the hospital team who acknowledged the good practice the team had contributed regarding the quality of care to patients.
- Senior managers we spoke with said they felt well supported and there was effective communication with the executive team.

Innovation, improvement and sustainability

- The team safety "huddle' meeting, had been introduced within the hospital to improve communication across departments. This appeared to have been positively received by staff from different departments and disciplines.
- The hospital had a scheme where good practice was rewarded each month. We saw doctors received acknowledgement (June 2016) for the work carried out, which included the contribution from doctors in training to the delivery of effective, compassionate, high quality care. Feedback examples from their colleagues included "very kind and caring registrar, always a pleasure to work with" and "the doctor is an excellent supervisor who will happily sit down with you to discuss any concerns you may have".
- The hospital had introduced the "Joint School" to support patients undertaking hip and knee replacements. These were conducted weekly with a view of ensuring patients understood what to expect from their operation. This was currently restricted to 400 patients with a view of expanding the service in the future.

Critical care

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

Information about the service

Kettering General Hospital NHS Foundation Trust offers critical care services at Kettering general hospital intensive care unit (ICU) to level two and level three critically ill patients, who require either organ support or closer monitoring in the immediate post-operative period. Critical care includes areas where patients receive more intensive monitoring and treatment for life threatening conditions.

There are a total of 12 critical care beds for the care and treatment of people aged 16 years and above. The unit has six side rooms, for the safe management of patients who require isolation for infection control purposes. The ICU also has two side rooms that are commissioned for hemodialysis patients.

Patient care was consultant led and consultant cover was available 24 hours a day, seven days a week, ensuring out of hours and weekend cover was provided. During our inspection there was not a full outreach team provision.

The ICU formed part of the anaesthetic clinical business unit.

As part of our inspection, we spoke with 22 staff including nursing staff, junior and senior doctors, administrative staff, and allied healthcare professionals working within ICU as well as other doctors and nurses admitting patients to or receiving patients from ICU. We spoke with four patients and three visiting relatives.

We checked the clinical environment, observed ward rounds, nursing and medical staff handovers and reviewed all or part of eight patients' health care records.

The Care Quality Commission carried out an inspection at Kettering General Hospital NHS Foundation Trust in October 2014. At that time, overall the critical care service was found to require improvement.

Critical care

Summary of findings

Overall, we rated the service as good because:

- There were systems in place to protect patients from harm and a good incident reporting culture.
- The department complied with the Department of Health's Health Building note HBN 04-02, which sets standards for critical care units.
- Effective infection control practices were in place throughout the unit and visitors were encouraged to take part in the prevention of infection.
- Safe numbers of staff cared for patients using evidence-based interventions.
- Staff at all levels had a good understanding of the need for consent and systems were in place to ensure compliance with the Deprivation of Liberty Safeguards.
- Patient's pain, nutrition and hydration were appropriately managed.
- Intensive Care National Audit and Research Centre data showed the intensive care unit to be in line with the England average for all areas except delayed discharges.
- Staff were compassionate and put patients at the centre of the work. They obtained consent prior to procedures and maintained patient privacy and dignity.
- Complaints were dealt with in a constructive and timely way, ensuring that patients or relatives were kept up to date with any actions resulting from their complaint.
- Staff had access to communication aids and translators when needed, giving patient the opportunity to make decisions about their care, and day to day tasks. There were very few complaints about the services and staff dealt with complaints appropriately.
- Dementia training and staff guidance was suitable and staff showed a good understanding of how to provide quality care for those living with dementia.
- There was good local leadership on the unit and staff reflected this in their conversation with us.

However, we also found that:

- There was a lack of sufficient pharmacy support within the department, leading to potentially avoidable medicine incidents.
- The critical care outreach team was not fully established to provide the necessary support and education to the rest of the hospital.
- There was no delirium screening process in place.

Critical care

Are critical care services safe?

Good

We rated the service to be good for safe because:

- There were systems in place to protect patients from harm and a good incident reporting culture. Learning from incident investigations was disseminated to staff in a timely fashion and they were able to tell us about improvements in practice that had occurred as a result.
- The environment and equipment was clean and supported safe care. It was fit for purpose critical care
- Staff complied with infection prevention and control guidelines and encouraged visitors to maintain good hand hygiene.
- Staff had access to a wide range of equipment and all equipment was adequately maintained.
- Staffing on the unit was in line with national guidelines, although bank nurses and agency staff were sometimes used to achieve this.
- Medicines were generally stored safely and securely, although we observed some ambient room temperatures were not being recorded where required.
- Patient records were comprehensive, with all appropriate risk assessments completed.

However, we also found that:

- However, staff had not had level three safeguarding children's training. Whilst the trust strategy was for all staff to receive level 2 training, this was not in line with the Royal College of Paediatrics and Child Health (RCPCH) intercollegiate document 2014.

Incidents

- Staff understood their responsibilities to raise concerns, to record safety incidents and near misses and to report them.
- Staff were able to discuss incident reporting and types of incidents that should be reported. They felt that they were actively encouraged to report these both internally and externally.
- There were no never events or serious incidents reported between August 2015 and July 2016. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. However, serious harm or death is not required to have happened as a result of a specific incident occurrence for that incident to be categorised as a never event.
- No serious incidents had occurred within the ICU from August 2015 to July 2016.
- There were 216 incidents reported from August 2015 to July 2016. The majority of the incidents were categorised as low or no harm (97&). The most common themes related to delays in discharge from ICU to other wards due to lack of beds within the hospital and out of hours transfers. Actions were being implemented to improve patient flow, including improved communication between ICU staff and the bed management team.
- There were 43 incidents relating to tissue viability (including pressure ulcers), appropriate actions were taken when these were identified, with involvement from the tissue viability team where necessary.
- Incidents were discussed at clinical business unit (CBU) meetings; we saw evidence of this in minutes and necessary actions noted.
- During the last inspection morbidity and mortality meetings were not occurring, but were planned to commence. During this inspection, we saw evidence of morbidity and mortality meetings occurring quarterly and these were minuted and shared amongst the service.
- From November 2014, NHS providers were required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and reasonable support to the person.
- Managers of the service had a thorough understanding of duty of candour and could provide examples where this process had been followed previously. We saw evidence of examples of this within incident reports. Nursing and medical staff also could describe the process of being open and honest with patients and those close to them if something went wrong. Training had been provided on this subject and prompts were visible around the ward.

Critical care

Safety thermometer

- The NHS Safety Thermometer is a monthly point prevalent audit of avoidable harms including new pressure ulcers, catheter urinary tract infections and falls. The information for measuring, monitoring and analysing harm to patients and harm free care was collected monthly. Information relating to these areas was displayed throughout the ICU for staff, patients and visitors to see.
- Between August 2015 and August 2016, three pressure ulcers had been reported above grade two. There was one fall reported in the same time period.
- Between August 2015 and August 2016, there had been no catheter urinary tract infections or other hospital acquired infections such as Clostridium Difficile.

Cleanliness, infection control and hygiene

- At the time of our inspection, high standards of cleanliness were maintained cross the department, with reliable systems in place to prevent healthcare-associated infections. The environment and equipment in the unit were visibly clean and all areas were tidy and well organised.
- Within the ICU, 92% of staff had attended infection control training which met the hospital target.
- There was a specific environmental cleaning schedule in place. Housekeeping staff had a thorough understanding of what was required within the ICU and how to record what cleaning had been carried out. We spoke with one housekeeping staff member who was working for the first time on ICU. They had been orientated and explained what tasks needed to be carried out in accordance with the cleaning schedule.
- There was a cleaning schedule for cleaning all the equipment. We saw daily cleaning schedules for damp dusting. Each patient bed space was cleaned daily. Vacant bed spaces were also cleaned daily to ensure they were ready to receive a new admission. We saw 'I' am clean' sticker on equipment that had been cleaned after use.
- We observed that staff followed the hospital's policy regarding infection prevention and control. This included staff being 'arms bare below the elbow', hand washing and the correct wearing of disposable aprons and gloves.
- Hand hygiene gels were available throughout ICU. There was access to hand-wash sinks in the main area and side rooms on the unit. There was a hand hygiene area for all staff and visitors to use prior to entering the unit; this was appropriately located so it could be easily seen when entering the unit. This allowed all those entering the unit to wash hands and use alcohol gel appropriately to avoid the risk of infection. Staff told us they educated visitors on the importance of hand hygiene on the ICU.
- Personal protective equipment (PPE), such as gloves and aprons were used appropriately and were available in sufficient quantities. Two side rooms had a gowning room to allow effective isolation of patients who either had an infection or were prone to becoming unwell if an infection was acquired.
- Waste management was handled appropriately with separate colour coded arrangements for general waste, clinical waste, sharps bins and waste bins were not overfilled.
- The ward audited infection control practice in relation to hand hygiene, wearing of personal protective equipment, aseptic technique and safe disposal of sharps. There was 100% compliance shown in these audits from January 2016 to July 2016.
- The ICU performed within expectations for unit-acquired infections in blood throughout the year 2015 to 2016.

Environment and equipment

- The design, maintenance and use of facilities and premises kept patients, staff and visitors free from avoidable harm.
- The environment was spacious and well lit and corridors were free from obstruction to allow prompt access, ensuring people were kept safe. The unit complied with the national standards Health Building Notes 04-02 in terms of space and equipment required for intensive care facilities.
- The security of the unit was appropriate, the entry to the ICU was controlled by an intercom and visitors were required to identify themselves upon arrival.
- Staff had access to adequate supplies of equipment. The ICU was equipped to provide care for 10 ventilated patients.
- There were two resuscitation trolleys available in the department, along with a difficult airway trolley. This equipment was checked daily, and documented as complete and ready for use. Staff told us that weekly checks, where trolleys were untagged and each item of

equipment reviewed, were carried out in line with hospital policy. However, there was no documentation to show this occurred and managers could not provide this to us.

- A transfer grab bag was available within the department; this was used for in hospital transfers to other wards or for diagnostics. This bag was not sealed and had no record of equipment checks. We found two items of equipment, which were out of date within this bag. This was rectified immediately by ward staff.
- The transfer trolley, to allow patients to be transport by ambulance whilst using life support equipment, had received regular checks and staff told us it was always rechecked prior and post use. This trolley was suitable for use and had all required equipment available for a long distance transfer.
- There were several storerooms within the ICU. Two along the main entrance corridor which contained large quantities of disposable equipment, this was where the ward would restock its smaller stores from. A further two stores for moving and handling equipment and spare items such as ventilators and fluid pumps were also located within the unit. There were also linen and sluice rooms for clean and dirty utilities. All of these rooms were well maintained, stock was stored in an organised manner and items that expired soonest were stored at the front of shelves.
- Systems were in place to allow timely review of electrical items; a schedule was in place to identify when items required the next safety check. Electrical appliances and equipment had been electrical equipment tested to ensure they were safe to use and each had a stickers with appropriate dates. If an item of equipment was found to be faulty this would be reported and replacements for all equipment were available on the ward.
- We reviewed staff competencies for equipment within the ICU. All permanent staff were signed off as competent for equipment, including ventilators. Agency staff had to provide documentation of equipment competencies during their first shift on the ICU.
- Arrangements for managing clinical waste were suitable and staff were aware of how clinical and domestic waste should be segregated. Clinical waste bins were stored securely.
- Managers told us that during the construction of the unit the floors were not correctly sealed. This meant that on occasion the edges of the floor would come loose, posing an infection control risk and also a trip hazard. This was present on the CBU risk register and steps were being taken to mitigate and rectify the problem.

Medicines

- Medicines, including controlled drugs, were managed appropriately to keep patients safe. Storerooms were well-organised and only allowed authorised people to have access through key codes and manual keys.
- Medicines were stored securely with secure access limited to nursing staff. Controlled drugs which require special storage and recording were stored following good guidance procedures including daily checks by two nurses on quantities and records. Medicines requiring cool storage were stored appropriately in locked medicine refrigerators. Daily temperature records for the medicine storage room and for the medicine refrigerator documented that medicines were stored within safe temperature ranges.
- Fridge and ambient room temperatures were recorded in the medicine and storeroom daily. We found that a chemical relating to haemodialysis was being stored in a room that did not have a thermometer, according to manufacturer's instructions this should be carried out to ensure it was not stored above 25 degrees celsius. We raised this with managers of the ward who immediately sourced a thermometer to address this concern.
- Safe systems were in place for the disposal of controlled drugs and staff knew their responsibilities in relation to this. Staff could explain and demonstrate how to manage controlled drugs and how this was required to be checked and documented in line with hospital policy and national guidance.
- We reviewed medicine charts of six patients and found that they accurately reflected the prescribed and administered medications for that patient. Medicine charts and patient records also clearly documented any patient allergies.
- Learning from medicine incidents was shared. We were told by nursing staff that the 'Pharmacy Matter' newsletter (September 2016) and a Medication Safety Group newsletter (August 2016) was available on the intranet and was shared with staff.
- The ICU did not have dedicated pharmacy input at the time of our inspection. This had been recognised by the management team as a risk to the ward and recruitment was ongoing to try to improve pharmacy input. By the

end of October 2016, the ICU would have a band 7 pharmacist, three times a week. However, this was still not compliant with guidelines for the provision of intensive care services (GPICS) standards that state each critical care unit must have a dedicated pharmacist for a minimum of five days a week.

- There had been 40 incidents relating to medicines between August 2015 and August 2016. Pharmacy staff and managers felt that two of these were directly relatable to the lack of pharmacy input in the ward. There was no critical care clinical pharmacist (Band 8a) available on the ward. We were told that this has had an impact by an increase in prescribing drug errors which could have been identified by the pharmacist. Although none of the errors resulted in patient harm, it was a risk to patient safety.

Records

- Patient's individual care records written and managed in a way that keeps them safe.
- Medical notes were in good order and information was easy to access.
- We reviewed eight sets of nursing and medical records which were fully completed, legible with entries timed, dated and signed for.
- Risk assessments had been carried out on all patients which included malnutrition screening, falls risks, patient manual handling assessment, wound care and communication charts. Records demonstrated personalised care and multidisciplinary input into the care and treatment provided.
- Whilst risk assessments were present and completed, they were all individual papers rather than a joint booklet, this meant there was a higher risk of losing an item of the record due to it moving when the folder was lifted out of a drawer or from the patient's bedside. Managers told us that there was a plan in place for a whole records review to update them and make them more user friendly.
- There was documented evidence of the decision and time to admit to ICU which is in line with the National Institute of Health and Care Excellence CG50 guidance.
- The nursing and medical notes were stored by the patient bedside to allow staff to quickly access them and not have to leave the patient bedside; these were stored in a folder to maintain patient confidentiality.
- Daily observation charts were used to record vital signs along with cardiac and respiratory indicators. Fluid intake and output records were complete, reviewed and recorded during the daily handover between shifts from nurse to nurse.
- Records were designed in a way that allowed essential information, for example allergies and medical history, to be recorded and easily viewed.
- There was evidence in the medical records of discussions with the patient and their relatives regarding progress and treatment planned.

Safeguarding

- Appropriate arrangements were in place to ensure patients were kept safe. The hospital had safeguarding policies and procedures available to staff on the intranet, including out of hours contact details for hospital staff. There were posters displayed with contact details of the hospital's safeguarding team.
- The nursing and medical staff were able to explain safeguarding arrangements, and when they were required to report issues to protect the safety of vulnerable patients.
- Information and relevant contact numbers for safeguarding were seen on staff noticeboards and in public areas.
- All staff within the ICU were required to complete up to and including level two safeguarding adult and children training. 89% of medical staff and 94% of nursing staff had completed this training which was in line with the hospital target of 85%. However, staff had not had level three safeguarding children's training. Whilst the trust strategy was for all staff to receive level 2 training, this was not in line with the Royal College of Paediatrics and Child Health (RCPCH) intercollegiate document 2014.
- Most staff we spoke with demonstrated an understanding of female genital mutilation, and what to do this if was suspected.

Mandatory training

- All staff mandatory training within the ICU met, or exceeded the hospital target. 100% of staff had completed basic life support training, 92% had completed fire safety training, 100% had completed manual handling training and 91% had completed equality and diversity training.

- There were additional ICU specific modules of mandatory training, all of which also met the hospital target. These included blood transfusion sampling, administration of blood components and collection of blood components.

Assessing and responding to patient risk

- Risks to patients were assessed and their safety monitored and maintained.
- Patient assessments were carried out to manage risks in line with national guidance. Risk assessments were undertaken in areas such as venous thromboembolism (VTE), falls, malnutrition and pressure sores. These were assessed and documented in the patient's records on admission and 24 hours later in line with best practice.
- On the ICU, patients were closely monitored so staff could respond to any deterioration. Patients were cared for by levels of nursing staff recommended in the core standards for critical care GPICS. Patients who were classified as needing intensive care (level three) were cared for by one nurse for each patient. Patients who needed high dependency type care (level two) were cared for by one nurse for two patients. We saw the appropriate staffing levels were maintained throughout the inspection period.
- There was not a full outreach provision during our inspection. The outreach provision that was in place did monitor national early warning scores throughout patients within the hospital and responded where available to those patients who were deteriorating and requiring ICU input. Plans were in progress to increase this provision and provide a full service.
- The national early warning score (NEWS) was used to monitor acutely ill patients in accordance with NICE clinical guidance CG50. NEWS charts were used to identify if a patient was deteriorating. In accordance with the hospital's deteriorating patient policy, staff used the NEWS charts to record routine physiological observations, such as blood pressure, temperature and heart rate, and monitors a patient's clinical condition. There were clear escalation processes in place to advise on what steps should be taken if there was an increase in NEWS scores. We checked NEWS documentation in all records we reviewed in the ICU. We found NEWS to be consistently completed and when they deteriorated this was appropriately escalated.
- There was a hospital policy for management of sepsis and a sepsis bundle care pathway could be implemented if sepsis was suspected. ICU had access to appropriate antibiotics when required to facilitate immediate antibiotic treatment for those patients with suspected sepsis.
- Poor compliance with venous thromboembolism (VTE) assessments was picked up during a recent audit; we saw that appropriate steps were being taken to improve compliance with these assessments. Records were reviewed during inspection had found VTE assessments to be recorded as necessary
- We spoke with doctors who did not work in ICU who were able to accurately describe the correct referral process when needing to admit a patient to critical care in accordance with the hospital's policy.
- Staff could explain patient transfer processes, and what actions needed to be in place to keep patients safe whilst not on the ward. There was an accessible policy that described the transfer process clearly.
- Admission to ICU should be within four hours of the decision to admit, although the hospital was not always meeting this indicator due to ICU capacity. On occasions, patients were nursed in recovery or within the emergency department whilst waiting for a bed on ICU.
- We observed three patients being admitted to ICU from other areas within the hospital, these were managed safely and effectively. There was good interaction prior to the patient being admitted to the ward and handover from ward staff to ICU staff.

Nursing staffing

- During our last inspection, nurse staffing was raised as a significant concern within the ICU. However there had been significant improvements in nurse staffing during this inspection.
- There were 65.5 whole time equivalent (WTE) nursing staff working within the ICU. There was one vacancy that had just been recruited to, and the service was waiting for finalisation of employment checks. In addition to this, there were four WTE healthcare assistants to provide support.
- The hospital used agency staff and the hospital's own bank staff to ensure staffing levels remained safe during staff sickness or other absence. We observed there was a folder that documented all agency and bank staff competencies and contained a copy of their induction. Managers told us that if staff did not have the correct ITU competencies they would not work on the ward.

- The ICU had a private social media page specifically for covering vacant shifts, especially at short notice. Managers felt this generally had a positive effect on staffing levels.
- We reviewed nursing staff rotas over the previous three months and saw that staffing generally met the necessary levels (11 trained nursing staff per shift). Managers told us that if staffing levels affected the ability to care for the acuity of patients on the ward then capacity would be discussed with the bed management team to ensure patient safety.
- Nursing staff levels in ICU met the Guidance for the Provision of Intensive Care Services 2015 (GPICS). Staffing related to levels of patient care was in line with core standards at all times during the inspection; that is, level three patients (intensive care) cared for on a one to one basis, whereas level two patients (high dependency) had one nurse for two patients.
- An acuity tool had been created and introduced into the ICU so that they could evidence that their staffing levels met the patient need on the ward at all times. Managers felt this worked well and enabled them to ask for further support when required and provided effective information at bed meetings.
- Staff levels for each shift were displayed on the entrance to ICU. We saw that this was updated daily and was an accurate reflection of staff on the ward.
- We observed the nurses handover, each nurse had a handover at the bedside for the patient they were looking after and the senior nurse in charge had a one to one meeting with the senior nurse from the previous shift this was recorded on a standardised handover sheet. The nursing staff had a safety huddle later in the shift to give each nurse an update on the status of each patient. These were both comprehensive, effective and relevant information was shared between staff. We observed that all handovers, including bedside, were carried out in a way that maintained confidentiality of patients.
- We were told and we observed that the nurse in charge of ICU was always supernumerary (does not have a patient allocated to them) leaving them free to co-ordinate the shift. This was reflected in staffing rotas and had improved since the last inspection.
- There was a dedicated practice development nurse working in ICU that was responsible for coordinating the education, training of ICU staff as well as supporting the induction of new staff, this was in line with the GPICS 2015.
- There were dedicated physiotherapists that worked on ICU, they were directly involved in assessing and managing patient care. They could provide respiratory management and rehabilitation care as required.
- Nurse staffing remained on the CBU risk register due to previous problems with ICU nurse staffing.

Medical staffing

- Care in ICU was consultant led and delivered. There were eight consultants who worked in the department; all but one of these had fellowship from the Faculty of Intensive Care Medicine (FFICM). There was continuous consultant cover from staff with no other simultaneous commitment.
- In addition to consultants, there were a number of junior doctors who provided care to the patients under the supervision of the consultant. Minimum numbers for this staff group were, for day shift, one Registrar equivalent, one foundation year one or two and one acute care common stem doctor. We looked at rotas and saw there were often more staff than this. Minimum night cover was one registrar who must have advance airway skills.
- During the inspection, the consultant to patient ratio met the GPICS 2015 standards. We reviewed medical staff rotas over the previous four months, which showed these levels were being consistently met.
- Staff told us consultants were immediately available 24 hours a day throughout the week and there were no problems contacting them for advice or patient review. Consultants were able to attend the department within 30 minutes of contact/escalation.
- At shift change, the medical staff team, including all grades of doctors, used a safety handover process to ensure appropriate information was shared, and any problems were highlighted and discussed to maintain patient safety.
- If locum staff worked within the department they were provided with an induction and had their competencies checked before commencing their shift.

Major incident awareness and training

- Potential risks to the service were anticipated and planned for in advance.
- There was a major incident policy in place relating to all services within the hospital including ICU. Staff were aware of the policy and how to access this. Managers of the service understood actions that would be taken should a major incident occur.
- A comprehensive fire risk book was available within the nursing station of the ward and evidenced regular fire drills and alarm checks. There was a designated fire marshal on the ward for each shift. 92% of staff had attended fire safety training within the previous 12 months.

Are critical care services effective?

Good

We rated the service good for effective because:

- Consultants and nurses delivered care and treatment based on a range of best practice guidance.
- Patients were cared for by appropriately qualified nursing staff who had received an induction to the unit and achieved specific competencies before being able to care for patients independently. Medical staff received regular training as well as support from consultants.
- There was good access to multidisciplinary services, including physiotherapy and dietetics.
- Staff managed pain relief effectively and patients' nutrition and hydration needs were closely monitored.
- Staff at all levels had an understanding of the need for consent and systems were in place to ensure compliance with the Deprivation of Liberty Safeguards.
- The unit had few readmissions within 48 hours of discharge and rarely transferred patients for non-clinical reasons.

However, we also found that:

- There was unsatisfactory pharmacy input into the ICU. At the time of our inspection, there was no dedicated pharmacist and support provided by pharmacy did not meet national guidelines.
- There were not seven-day services for outreach or dietetic services.
- Multidisciplinary meetings did not occur within the service. This was not in line with national guidance. Most staff felt this was an area for improvement.
- There was a lack of guidance and processes relating to delirium.

Evidence-based care and treatment

- Patients' care and treatment was assessed and delivered in line with national and best-practice guidelines. For example, the National Early Warning Score (NEWS) with a graded response strategy to patients' deterioration complied with the recommendations within NICE Guidance 50 Acutely ill patients in hospital and the Guidance for the Provision of Intensive Care Services 2015 (GPICS).
- Patients were ventilated using recognised specialist equipment and techniques. This included mechanical invasive ventilation to assist or replace the patient's spontaneous breathing using endotracheal tubes (through the mouth or nose into the trachea) or tracheostomies (through the windpipe in the trachea). The unit also used non-invasive ventilation to help patients with their breathing using masks or similar devices. All ventilated patients were reviewed and checks made and recorded hourly.
- The ICU met best practice guidance by promoting and participating in a programme of organ donation, led nationally by NHS Blood and Transplant. In the NHS, the number of patients suitable for organ donation is limited for a number of reasons. The vast majority of suitable donors would be cared for in a critical care unit. There was a link nurse for organ donation working alongside the ICU. They directly supported the organ donation programme and worked alongside the clinical lead. We saw visible information for staff to advise them on how to contact the organ donation team and what information would be required.
- There was a hospital policy for management of sepsis and a sepsis bundle care pathway could be implemented if sepsis was suspected. ICU had access to appropriate antibiotics when required to facilitate immediate antibiotic treatment for those patients with suspected sepsis.
- Care bundles were in place for ventilated patients, the ICU showed 100% compliance with these since January 2016.

- The hospital did not have specific guidance on delirium in accordance with the National Institute for Health and Care Excellence NICE CG83 guidance. We did not see evidence that patients were screened on admission. We were advised that this screening process was being considered for implementation within the ICU.
- Venous thromboembolism (VTE) assessments were recorded on the drug charts, ensuring best practice in assessment and prevention and offered treatment in accordance with NICE guidelines.
- The ICU submitted data to the Intensive Care National Audit and Research Centre (ICNARC) an organisation reporting on performance and outcomes for intensive care patients nationally. There was a small dedicated team to collate this information.
- The hospital took part in the national cardiac arrest audit. The National Cardiac Arrest Audit (NCAA) is the national, clinical, comparative audit for in-hospital cardiac arrest. The purpose of NCAA is to promote local performance management through the provision of timely, validated comparative data to participating hospitals. NCAA is a joint initiative between the Resuscitation Council (UK) and ICNARC (Intensive Care National Audit & Research Centre). NCAA monitors and reports on the incidence of and outcome from, in-hospital cardiac arrests and aims to identify and foster improvements, where necessary, in the prevention, care delivery and outcome from cardiac arrest. The resuscitation services teams oversaw this data and established where improvements in care were necessary.
- All patients were screened by a physiotherapist within 24 hours of admission to ICU. A physiotherapy rehabilitation pathway was in place for patients who were intubated or were to stay in ICU for more than 24 hours.

Pain relief

- Pain relief was well managed throughout the ICU. Patient records we reviewed showed that pain had been risk assessed using the scale found within the NEWS chart and medication was given as prescribed. Pain management for individual patients was discussed at handovers as required.
- We saw evidence in records of staff observing signs of pain in patients with a reduced consciousness level or reduced communication. If there were any signs of pain in these patients, this was acted upon.
- Staff had access to the hospital pain control team when required and stated they were accessible.

Nutrition and hydration

- The Malnutrition Universal Screening Tool (MUST) was used to assess patient's risk of malnutrition. We saw 100% compliance with completion of MUST score completion.
- Staff said they monitored patient's nutritional state and, where required, would make a referral to the dietician (usually if the patients MUST score was above two).
- We spoke with two dieticians who provided support to the ward, they advised us that their attendance was usually prompted by a referral rather than regular visits to each patient. Notes from dieticians were clearly visible in patient records and documented what actions had been taken following patient assessments.
- Any feeding through tubes or intravenous lines was evaluated, prescribed and recorded.
- In all patient records we reviewed, we observed that fluid balance charts were completed appropriately and used to monitor patients' hydration status.

Patient outcomes

- Around 95% of adult general critical care units in England, Wales and Northern Ireland participate in Intensive Care National Audit and Research Centre (ICNARC) the national clinical audit for adult critical care; the Case Mix Programme (CMP). Following rigorous data validation, all participating units received regular, quarterly comparative reports for local performance management and quality improvement. The ICU fully participated and completed a full set of data for this audit.
- The ICNARC annual report from 2015/16 showed that the unit was performing as expected (compared to other similar services) in all indicators apart from one (delayed discharge).
- The unplanned readmission rate within 48 hours was 0.8%, which was better than national average of 1.2%.
- There was a dedicated member of staff whose role included inputting ICNARC data for ICU. This staff member had a good understanding of the data and who to validate areas of data where appropriate.
- Within the ICU, the risk adjusted hospital mortality ratio was 1.03. This was within the expected range.

- We observed that where audit performance did not meet hospital or national targets, action plans were put in place to improve outcomes. Audits were discussed during departmental meetings.

Competent staff

- Staff had the skills, knowledge and experience to deliver effective care and treatment to patients.
- There was a comprehensive induction for new staff. This included both a hospital wide induction and local induction. On joining the ICU, staff were given a new nursing staff orientation pack. This pack contained comprehensive information about how the ICU worked, staff members that worked within the ICU, and training and development. New staff worked for a supernumerary period to allow them to become familiar with the department.
- Each new member of staff had a critical care network competency booklet to work through to ensure they gained the correct skills knowledge and competency to work in critical care.
- We saw that over 50% of nursing staff had gained the post registration award in critical care nursing which was in line with the Guidance for the Provision of intensive Care Services 2015 (GPICS).
- Staff told us they had opportunities for personal development and to enhance their skills. If they wished to attend a clinical course this was supported by the management team.
- Junior doctors all reported good supervision, they each had a specific personal development plan which they felt enhanced their training opportunities. Training time for this staff group was protected.
- Medical and nursing staff told us that they had sufficient support relating to revalidation. Revalidation is a process by which doctors and nurses can demonstrate they practice safely.
- 85% of staff within the ICU had received an appraisal. Staff we spoke with found their appraisals to be meaningful and allowed them to discuss any further training or developmental needs.

Multidisciplinary working

- Multidisciplinary working (MDT) was not always effective within the ICU.
- There was no dedicated critical care pharmacist to provide advice and support to clinical staff in the unit at the time of our inspection. The central pharmacy team would be contacted if the ward had a concern or query.
- Physiotherapy staff provided a presence on the ward five days a week between 8am and 5pm. Outside of these hours there was an on call facility available.
- There was no dedicated dietetic service within the ICU; there were two dieticians who provided support to ICU when referrals were made. The ICU was managed within their workload from the remainder of the hospital, however ICU patients were prioritised. There was a nutrition team consisting of a dietician, a nurse and a gastroenterologist available for four hours a week, this team could provide support to the ICU when required.
- Speech and language services were accessible on referral.
- MDT meetings did not occur within the ICU. This was not in line with the GPICS 2015 recommendations. Most staff we spoke with felt this was an area the unit could improve, as nursing and medical staff worked separately from the allied healthcare professionals providing physio and dietetic services.
- The GPICS 2015 suggest there should be microbiology input into the daily ward rounds: this occurred within the ICU.
- Staff described the multidisciplinary team as being supportive of each other. Healthcare professionals told us they felt supported and that their contribution to overall patient care was valued. Physiotherapy staff described effective working relationships with sisters on the ward and communicated well with them.
- Staff that had received patients from ICU onto the wards told us they had a good handover and appropriate information to continue caring for the patients.
- The critical care outreach service was not fully established during our inspection. The original critical care outreach service was no longer in place, but there was a provisional service covered by three members of staff. This meant that on average there were two to three days of cover each week. The hours that would be covered by the outreach team were communicated by email to the rest of the hospital.
- We saw a comprehensive business plan relating to the implementation of a new outreach team (acute illness response team), phase one has a planned

implementation of November 2016 and will result in a seven day service for 12 hours per day. Phase two has a plan of providing a 24 hour, seven day service, with an estimate time of implementation of March 2017.
- The resuscitation team were providing significant support to outreach services during our inspection, the working relationship between resuscitation services and critical care appeared productive and beneficial to the service moving forward.

Seven-day services

- There was a consultant available on call out of hours seven days a week. This was in line with the GPICS 2015.
- All patients were admitted into the unit were assessed by a consultant within 14 hours of admission, which met the national standards.
- Critical care medical staff felt that the consultants were supportive and were available for advice, including out of hours.
- Physiotherapy teams provided cover five days a week, between 8am and 5pm. Outside of these hours and at weekends there was an on call service which staff told us was easily accessible.
- Dietetic services were available to the ward three days a week; this was on a referral basis. There was no out of hours or weekend cover from the dietetic team.
- There was no in-ward pharmacy input during our inspection. This was in the process of being re-established following staff leaving the hospital. Phase one of re-establishment was to provide interim cover three days a week, following this, the aim was to provide a full pharmacy service by a senior pharmacist with critical care specialty.

Access to information

- Staff had access to relevant information to assist them to provide effective care to patients admitted to the ward. There were ward clerks who coordinated the provision and requests for medical records.
- We observed the doctors' handover between shifts where patient's progress was reviewed. The nurses had a separate handover at the patient's bedside, and the senior nurse in charge had a one to one meeting that was recorded on a standardised handover sheet. This included information about any incidents that had occurred such as medication errors, delayed discharges, how they had been responded to and a detailed evaluation of each patient's clinical status.
- Staff said they had good access to patient related information and records whenever required.
- We saw a patient transferred to the unit and staff had access to all the information. Staff said they were given a handover of the patient's medical condition and ongoing care information was shared appropriately in a timely way.
- We reviewed four sets of notes of patients that had been discharged from ICU to the wards and found a comprehensive discharge summary for transfer to the ward and a rehabilitation prescription that was designed to ensure continuation of care.
- We observed on-going care information was shared appropriately at handovers.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- There was a hospital policy to ensure that staff were meeting their responsibilities under the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).
- Staff could describe the process for making an application for requesting a DoLS for patients and when these needed to be reviewed.
- Staff understood consent, decision making requirements and guidance.
- Patients gave their consent when they were mentally and physically able. Staff acted in accordance with Mental Capacity Act 2005 when treating an unconscious patient, or in an emergency. We observed consent and comprehensive best interest assessments being carried out by medical staff and well documented in patient records.
- Staff received training regarding the Mental Capacity Act 2005 as part of their mandatory training at the hospital. 93% of staff had completed this training which was in line with the hospital target.

Are critical care services caring?

Good

We rated the service as good for caring because:

- The ICU provided a caring, kind, and compassionate service, which involved patients and their relatives in their care. All the feedback from patients and their relatives was positive.

- Observations of care showed staff maintained patients' privacy and dignity and patients and their families were involved in their care.
- Staff provided emotional support to patients and staff directed patients to access the hospital multi-faith chaplaincy services, when required.
- Patients' and relative feedback was sought on the care they received to ensure they were happy with the care provided.

Compassionate care

- Patients were treated with dignity, respect and compassion throughout their stay on ICU.
- Staff responded compassionately to pain, discomfort, and emotional distress in a timely and appropriate way. We observed caring interactions with patients whilst they were being repositioned or assisted with feeding.
- We observed numerous acts of kind and compassionate care including staff taking extra time with patients to support them making their own meal choices by ensuring they had their glasses if required and talking slowly through menu choices. Staff often remembered patients favourite meals and told them when these items were on the menu. We observed staff repositioning patients who were unconscious and ventilated, staff talked to the patients despite this and still explained what they were doing and were gentle and considerate during movements.
- Dignity and confidentiality were well respected in the ward. If a patient was being assessed or repositioned then curtains would be closed to protect their privacy.
- Due to the nature of critical care, we often cannot talk to as many patients as we might in other settings. However, patients we were able to speak with told us they were extremely happy with their care and staff were very responsive to their needs.
- All staff introduced themselves appropriately and knocked on the door of side rooms before entering, including domestic and housekeeping staff.
- The ICU carried out internal patient and relative surveys as friends and family tests are not always well responded to following a patient's discharge from the ICU due to its nature. The most recent internal surveys showed that 100% of patients felt they were treated with dignity and respect. Comments within the surveys included, 'Everyone has been very helpful, friendly, chatty and sympathetic when required.'
- Thank you cards from relatives and patients were displayed within the ward.

Understanding and involvement of patients and those close to them

- Patients and relatives said they felt involved in their care. They had been given the opportunity to speak with the consultant looking after them.
- We observed relatives being met at the ICU entrance when their relative had first been admitted; staff explained the ICU processes and what they could expect when visiting their relative.
- Relatives we spoke with said they had been given time with the nurses and doctors to ask questions.
- Within the most recent internal patient survey, 100% of patients felt that explanations regarding their condition and the care they received were given in terms they could understand. Also, 100% of relatives felt their relative was receiving best possible care.

Emotional support

- Patients and those close to them were able to receive support to help them cope emotionally with their care and treatment from the staff.
- We observed staff assisting relatives following the unexpected death of a patient, they allowed relatives as much time as necessary on the ward and a member of staff ensured they were available to answer questions and provide emotional support.

Are critical care services responsive?

Good

We rated the service as good for responsiveness because:

- Senior staff had an understanding of the needs of the service and patients and worked well with other specialities to facilitate access to the ICU.
- The majority of patients were admitted within four hours of the decision to admit and data showed there had been no patients transferred for non-clinical reasons.
- A system was in place to allow identification of patients with complex needs, living with dementia or on an end of life care pathway.

- Staff had access to communication aids and translators when needed, giving patient the opportunity to make decision about their care, and day to day tasks.
- Quiet rooms were available for staff to speak to relatives and relatives had access to numerous facilities to assist them whilst their loved one was being cared for on the ICU.
- There were very few complaints about the services and staff dealt with complaints appropriately.

However, we also found that:

- Timeliness of discharges from the unit was worse than the England average; this was mainly due to flow within the rest of the hospital.

Service planning and delivery to meet the needs of local people

- The ICU admitted both elective surgical patients who required close monitoring post operatively and emergency patients. The ICU operational policy contained details on admission to the ward and the routes this may be from, including admissions through the emergency department and admissions from theatres.
- There was a recovery area within theatres, which had equipment to safely monitor and care for critically ill patients.
- GPICS Core Standards highlight the need for specialised critical care follow up clinics once patients were discharged home. Patients following discharge from critical care can develop complex physical and psychological problems that last for a long time. These patients benefited from the support offered by a specialised critical care follow-up clinic. A rehabilitation service was in place to facilitate these follow up reviews and was offered to discharged patients.
- There were excellent facilities for visitors to the ICU. Visitors had access to a waiting room, a quiet room, a cloakroom, separate toilets and kitchen facilities. Within the ICU, there were two separate rooms for relatives to stay overnight when requested, each of these had en-suite facilities and there was a shared kitchen/living room area. Staff told us they were very pleased to be able to offer these facilities to relatives and felt they were extremely useful to enable support of family members.

Meeting people's individual needs

- There was access to a range of information for families and friends displayed in the visitor's room on topics such as admission and discharge and follow up clinics. There was also information about access to the patient advice liaison service (PALS) should relatives have a concern about the service.
- The ward had a board that was updated each day with patient details. Included on this board were magnetic stickers, which allowed staff to discreetly display which patients were living with dementia, were end of life or had an infection. All staff we spoke with were aware what each magnet meant and what this might mean for the patient.
- Two folders relating to dementia and learning disabilities were accessible to staff. These contained information on caring for patients living with dementia or a learning disability, lead nurse contacts and further advice. Staff often cared for people living with dementia and they understood what requirements they might have. There were plans in place to turn one room into a dementia friendly area, making it less clinical and more familiar to normal home surroundings.
- We heard examples of where patients' carers had been accommodated on the ward overnight where this helped a patient's anxiety and behavioural traits associated with their condition.
- There were telephone and face-to-face translation services available. The necessary contact details for this were available to staff in numerous areas of the ward. There were also posters around the ward to allow patients and relatives to identify their language to staff and allow timely access to the correct interpreters.
- The hospital's translation policy allowed staff or relatives who were fluent in another language to interpret for patients, but only when this did not involve consent or decision-making.
- Leaflets and other documentation were available in other languages upon request.
- There were information leaflets available for both patients and relative such as sedation and ventilation, discharge from critical care and a general guide to intensive care.
- Information leaflets were available in large print and different languages.
- The ICU was accessible for wheelchair users and a disabled toilet was available.
- A hearing loop was available within the ICU for patients or visitors with hearing difficulties.

Critical care

- An intensive care guide for patients and relatives was available within the department. This guide contained information relation to staffing on the ICU, what level of care would be provided, guides for visitors and what to expect on discharge from the ICU. The guide also contained a list of useful contacts should patients or visitors require further specific support.
- A staff guide for withdrawal of active treatment in end of life care patients was present on the ICU. This guide detailed communicating with relatives and involving them in decision making during the process.
- There was a link nurse for organ donation based on ICU, to directly promote and support staff and relatives with the organ donation programme.
- The chaplaincy service provided a 24-hour service and offered support to patients and relatives, multi-faith services were available where requested.
- Visiting times were between 2pm and 8pm each day. However, staff told us they were often flexible to enable the needs of relatives to see their loved ones in difficult circumstances.

Access and flow

- Between April 2015 and March 2016, there had been 624 admissions to ICU. Admission to the ICU required consultant oversight. Of these admissions, 0.8% had a non-clinical transfer out of the unit: compared with other units this unit was within the expected range.
- ICU occupancy had been above the England average since January 2015.
- The percentage of bed days occupied by patients with discharge delayed more than eight hours was 12.2%, compared to the national average of 5.3%. The trust provided additional information from April to June 16 which showed that the percentage of bed days occupied by patients with discharge delayed more than eight hours was 7.7%, as compared to the national average of 4.8%.
- Staff told us delayed discharges occurred due to lack of bed availability in the rest of the hospital. Sometimes patients have to go to a specialist ward but there were no available beds in that ward. Staff reported the situation had improved over time and they prioritised admissions of high-risk critically ill patients into the unit.
- For ICU at Kettering General Hospital, 5.9% of admissions were non-delayed, out-of-hours discharges to the ward. The trust provided additional information for April to June 2016 which showed 1% of admissions were non-delayed, out-of-hours discharges to the ward.
- There had been no cancelled elective surgeries within the last six months because of lack of critical care beds.
- There was a recovery area within theatres, which had equipment to safely monitor and care for critically ill patients; however, this was intended for short term and not for prolonged patient support. It was mostly used for supporting patients whilst a bed was made available for them in the main ICU. We saw that patients were cared for in recovery whilst waiting for a bed on ICU; however, the ICU did not record the amount of time patients spent in this area so we could not see whether patients remained in recovery for prolonged periods.
- There were no incident reports relating to patients remaining in recovery inappropriately or for prolonged periods. Recovery was not a suitable environment for patients waiting to be transferred to a ward as they did not have access to toilet facilities and relatives could not always visit.
- We saw that three patients had their admission to the ICU delayed due to capacity. These patients were cared for either in the emergency department or within theatre recovery.
- The ICNARC annual report from 2015/16 showed that the unit had a higher than national average for delayed discharges of 12.2% compared to the national average of 5.3%. The trust provided additional information which showed that the ICNARC quarterly report from April to June 2016 showed that the unit had a higher than national average for delayed discharges of 7.7% compared to the national average of 4.8%.

Learning from complaints and concerns

- Between August 2015 and July 2016, there were three complaints relating to ICU. The hospital took an average of 27 days to investigate and close complaints. The hospital policy was for complaints to be investigated within 25 days. The complaints related to complications following treatment, lost property, and bereavement issues.

- Managers of the service met with complainants and discussed their concerns. We saw actions put in to place following complaint investigations and this shared with families to provide them with assurance that steps were taken to prevent future occurrences.
- There were leaflets and posters available throughout the ward to advise patients, visitors and family on how to make complaints. Managers told us that staff were encouraged to try to resolve complaints on the ward as they occurred. These complaints were still passed onto the PALS service to ensure they were recorded.

Are critical care services well-led?

Good

We rated the service as good for well-led because:

- The leadership team had a clear vision and strategy and staff were able to verbalise future plans.
- There was an effective governance structure, both within critical care and within the anaesthetic directorate.
- We saw good local leadership within the unit and staff reflected this in their conversations with us.
- Staff said the culture on the unit was very open and any member of staff could approach the leadership team with any issues or new ideas.
- The management team had oversight of the risks within the services and mitigating plans were in place.

Leadership of service

- Critical care services were included in the anaesthetics and surgery business unit. The ICU was led by a lead nurse and a clinical lead consultant for critical care services, which met national guidelines for the provision of intensive care services (GPICS 2015). These leaders were visible, accessible and experienced in critical care.
- We were told that the nurse in charge of ICU was always supernumerary (did not have a patient allocated to them), leaving them free to co-ordinate the shift, we observed this during all days of our inspection. This met the national core standards for critical care units.
- Junior doctors said consultants were supportive and approachable. They were given the time to develop and learn whilst on the ICU.
- There had been some changes in leadership individuals over the previous six months. Staff told us that all new leaders were very welcomed, and felt that they bought new ideas and determination to improving the ICU.
- Lines of accountability and responsibility in the unit were clear and staff understood their roles and how to escalate problems. There were three nursing teams with a Band 7 critical care nurse led each nursing team. Nurses told us that the matron was visible and aware of all incidents. Senior staff fed back results of incidents to staff through the morning brief safety huddles and safety bulletins.
- Leaders told us that they tried to empower senior nursing staff within the ward to enable them to take on responsibilities and enable progression planning. Senior nursing staff we spoke with felt this was a positive step for the ward and allowed personal development.
- Most staff felt that the hospital leadership team were visible throughout the hospital, mainly the director of nursing. They felt that the team were patient focussed and friendly.

Vision and strategy for this service

- A vision and strategy was in place for the anaesthetic clinical business unit (CBU), which ICU is part of. The documented vision was to 'deliver & provide an effective, efficient & high quality care across the Emergency & Elective pathways incorporating Critical Care, Theatres, Pain Management and Pre-assessment'.
- Specific strategic objectives were documented within the CBU development plan for each service that came under the anesthetic umbrella.
- Managers were aware of the CBU development plan and the vision for the ICU going forward.
- Some staff we spoke with could describe the hospital's values (compassionate, accountable, respectful and engaging), they told us these were fairly new values and did not believe they were embedded throughout the hospital yet.
- There were plans to extend the hemodialysis provision within ICU to go from three days a week to six days a week. We saw this being discussed at CBU meetings with plans being developed with local commissioning teams.
- Managers also spoke of the potential to develop a high dependency unit area within the ward to allow for stepdown space.

Critical care

Governance, risk management and quality measurement

- A local risk register was in place that covered the surgical and anaesthetic clinical business unit (CBU).
- Within the risk register, the top three risks to the ICU were:
  - Inadequate staffing to provide an outreach service consistently.
  - Delayed stepdown or discharge of patients from the ICU.
  - ICU flooring not appropriately sealed, increasing risk of slips/trips/falls.
- All managerial staff we spoke with were aware of these risks and what actions were in place to mitigate them. However, they did feel it required updating as it was not fully current. We saw the risk register was discussed during CBU meetings.
- There were monthly mortality and morbidity meetings with a focus on quality improvement and improving patient outcomes post critical care.
- The ICU was fully compliant with the gathering of data for ICNARC and dedicated staff for this purpose.
- Ward dashboards were completed monthly to establish quality of care within the ICU. Data relating to records, documentation, incidents, and deteriorating patients were some of the areas collected. This data was displayed on the ward for staff and visitors to observe.

Culture within the service

- All staff we spoke with expressed how supportive the ward culture was and that there was great teamwork amongst all staff.
- All staff told us they felt valued and there was a strong emphasis on quality patient care within the ICU.
- We observed staff, including domestic staff, being provided with emotional support by senior staff following a cardiac arrest on the ward.
- Staff told us that support was always available if they had been involved in an emotional situation or it was the first time they had been involved in a bereavement.

Public engagement

- There was no general public involvement with how the service was run, but patients and their relatives were asked to comment on their care.
- Data from the relative's survey and Friends and Family Test was used to monitor and influence the standards of the services provided.
- The public had been engaged in fundraising for new technology for the department.

Staff engagement

- Staff throughout the hospital were asked to take part in staff surveys to help influence changes and developments.
- The ICU obtained staff feedback via departmental meetings. Staff told us that meetings allowed them to discuss ideas or any areas for improvement openly. Staff felt that managers at these meetings listened to their views.
- All staff we spoke with told us that they felt confident in raising concerns with senior managers.

Innovation, improvement and sustainability

- At this inspection, there had been the following improvements noted since our inspection in October 2014:
  - Nurse staffing levels had improved greatly to ensure patients were provided with safe care. Additional funding was provided to allow successful recruitment of nurses into the ICU.
  - There was a vision and strategy in place for anaesthetic services and managers had a good knowledge of these.
  - New nursing leadership within the ICU meant that concerns were being addressed in a timely way and quality oversight of the ICU was improving.
- The ICU was running an 'Intensive Voices Appeal' to fundraise for the purchase and use of new assistive communication technology. This assistive communicative technology allowed patients to communicate using their eyes as a virtual computer mouse to type messages. The feedback from the use of this technology in the ward had been exceptionally positive.
- Staff told us that if they had any new ideas for the ICU these could be raised and trialled where they benefited patient care.

Maternity and gynaecology

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

Information about the service

The maternity and gynaecological service at Kettering General Hospital NHS Foundation Trust has 63 inpatient beds across the one site. 15 are located within the delivery suite, 12 within the gynaecology inpatient ward (Maple), and 36 within the antenatal and post-natal ward (Rowan). The hospital's maternity services are available across hospital and community settings. There were two dedicated theatres with dedicated theatre teams.

From April 2015 to March 2016, 3,460 women delivered their babies at the hospital.

Maternity and gynaecology are in the women's and children services clinical business unit (CBU).

The maternity service at Kettering General Hospital (KGH) offers a consultant-led delivery suite for low and high-risk births, a water birth suite, community based antenatal clinics, and an antenatal postnatal ward area. The hospital has an early pregnancy assessment unit (EPAU) for women who experience problems before 20 weeks pregnancy and a fetal health unit, where women can be assessed by a midwife and/or doctor during their pregnancy without having to be admitted to hospital. The maternity services also include specialist antenatal clinics for women with medical conditions such as diabetes who require obstetric review and plans of care during their pregnancy.

The gynaecology service at KGH offers inpatient care, outpatient care and assessment facilities. The gynaecology ward has twelve beds, which consist of three four-bedded bays. There are currently no side rooms. Outpatient care includes colposcopy, hysteroscopy, treatment for miscarriage and pre-operative assessment. A team of gynaecologists receives support from specialist gynaecology nurses, general nurses and healthcare assistants.

373 medical abortions and 218 surgical abortions were carried out at the hospital between April 2015 and March 2016.

We visited all wards and departments relevant to the maternity and gynaecology service. For the maternity service, we spoke with seven patients, 22 midwives, managers and support workers. For the gynaecology services, we spoke with six patients and five nurses. We also spoke with eight medical staff who worked across the maternity and gynaecology service. We checked the clinical environment, observed ward rounds and assessed 19 patients' healthcare records. We reviewed the hospital's performance data received before and after the inspection.

Maternity and gynaecology

Summary of findings

We rated the maternity and gynaecology service as requires improvement overall. We rated the service as requires improvement for safe, responsive and well-led. We rated the service as good for effective and caring. We found that:

- The service did not always have sufficient staff, of an appropriate skill mix, to enable the effective delivery of care and treatment. There were times the consultant obstetrician was not present on the labour ward as they would be covering obstetrics and gynaecology and undertaking elective caesarean section lists.
- The locally devised maternity dashboard data did not meet Royal College of Obstetricians and Gynaecologist Guidelines (RCOG) good practice No.7 Maternity dashboard, clinical performance and governance scorecard. Risk information regarding maternity was not all available on all risk documents seen, and as a result, we were not assured the service had oversite of all information to monitor the service.
- Rowan ward did not have sufficient security to minimise the risk of visitors accessing the ward without being challenged. The hospital did not have an abduction policy; it had a flowchart for staff to follow in an event of an abduction.
- Compliance with mandatory training did not meet the hospital target.
- Patient outcomes were variable: in the 2015 National Neonatal Audit Programme (NNAP), the hospital was below the NNAP standard for three of the five indicators. The caesarean section rate for 2015/16 was 30%, which was higher than the national average of 26.5%.
- The hospital had serious concerns around the accuracy and quality of its referral to treatment (RTT) data and reported position. The hospital had not met the set targets for RTT waiting times non-admitted, admitted and incomplete. The service was monitoring their RTT performance as part of their improvement plan. Figures from October 2016, showed gynaecology was were performing below the national standard of patients being seen within 18 weeks. 76% of patients were being seen within 18 weeks, although below the national standard of 92%, the hospital was on track to achieve their trajectory target of 77% by the end of November 2016.
- The maternity and gynaecology clinics ran concurrently. Gynaecology and obstetrics patients and women attending for these appointments shared the same waiting room. This meant that patients who may be having difficulty in conceiving or had experienced a miscarriage were sharing the same area with pregnant women and this was not sensitive to their needs.
- Lack of medical staffing resources to deliver the gynaecology clinic meant the service was breaching the referral to treatment times. Gynaecology was performing below the national standard of patients being seen within 18 weeks.
- The service had not met the trust's timescales for responding to complaints in the period August 2015 to July 2016, but following the introduction of a revised complaints' policy in July 2016, with longer timescales for a response, improvements had been made in responding to complaints with an average response timescale of 27 days (in the period April to September 2016). This was now in accordance with the trust's policy.
- Whilst there was evidence to demonstrate information about midwifery issues were taken to the trust's board, we were not confident the board had full oversight and understanding of all issues affecting the service.
- There was not always effective systems in place to monitor, audit and use learning from quality and safety information to drive improvements throughout the service. There was evidence not all risks were identified and placed on the risk register.
- Whilst a new strategy for the service had been developed and implemented, it was not yet fully understood by all staff in the service. We were not assured progress against delivering the strategy was regularly monitored and reviewed.

However, we also found that:

Maternity and gynaecology

- There was good leadership at a local level, wards and units were well managed. Local leaders demonstrated they understood the challenges to good quality care and had identified the actions needed to address them.
- Women and those close to them were positive about the care and treatment they had received.
- The service provided a vulnerable midwifery team. A dedicated bereavement midwife led on bereavement services for women who had experienced pregnancy loss.
- Individual care records were written in a way that kept people safe from avoidable harm.
- The service used the World Health Organization (WHO) surgical safety checklists in maternity and gynaecological surgery. The overall compliance for the checklist was 100% between April 2016 and June 2016.
- The hospital had received the United Nations Children's Fund (UNICEF) Baby Friendly Initiative full accreditation for its maternity department.

Are maternity and gynaecology services safe?

Requires improvement

We rated the service as requires improvement for safe because:

- The service did not always have sufficient staff, to enable the effective delivery of care and treatment. There had been six incidents reported in June and July 2016 related to staffing not meeting planned staff levels in maternity (with no adverse outcomes for patients identified). Staffing levels met patients' needs on the days of the inspection and vacant posts were in the process of being filled following recruitment.
- The consultant obstetrician covering the delivery suite carried out the elective caesarean section list as well as covering gynaecology. There were times the consultant obstetrician would not be present on the labour ward as they would be covering obstetrics and gynaecology and undertaking elective caesarean section lists, so we were not assured they would always be available or accessible.
- The service had a local version of the national maternity dashboard, which did not meet RCOG good practice No.7 Maternity dashboard, clinical performance and governance scorecard. Without collecting all this information, the hospital was unable to identify all patient safety issues in advance and ensure timely and appropriate action was taken to ensure high quality, safe maternity care. The service was aware of this and were working to address instigate a dashboard that was compliant.
- Risk information for maternity was being collated by a number of people. The information was not all available on one risk document and as a result, we were not assured the service had oversite of all information to monitor the service. We were not assured the security system was adequate on the postnatal ward to minimise the risk of visitors accessing the ward without being challenged. This had not been identified as a risk on the risk register.
- Records on the gynaecology wards were not always stored securely. Patient records were stored in an open trolley behind the nurses' station on the ward.

- Compliance with hospital statutory safeguarding training, safeguarding level three training, skills and drills training and mandatory training in September 2016 did not meet the hospital's target compliance.

However, we also found that:

- Staff were aware of their roles and responsibilities in the management and escalation of incidents.
- Lessons learned were shared effectively.
- We saw that all areas of the maternity and gynaecology service we visited were visibly clean and well maintained.
- Medicines including controlled drugs were safely and securely stored.
- Individual care records were written in a way that kept people safe from avoidable harm.
- The overall compliance for the "Five Steps to Safer Surgery" checklist was 100%.

Incidents

- Staff were aware of their roles and responsibilities in the management and escalation of incidents. Staff told us that they were able to raise concerns and were confident that their concerns were listened to.
- Escalation of risk was identified through a computer-based incident reporting system. We saw the service used a trigger list, which included triggers recommended by the Royal College of Obstetricians and Gynaecologists (RCOG), such as postpartum haemorrhage (excessive blood loss) of more than 1000 millilitres and third or fourth degree trauma. Specific incidents such as unexpected admission to neonatal intensive care unit (NICU), maternal unplanned admission to intensive care unit (ITU), and venous thromboembolism (VTE) were identified, and the trigger list did prompt the reporting of medical complications. We saw evidence the recommendations were used to guide incident reporting in maternity.
- The maternity service reported three serious incidents (SIs) to the strategic executive information system (STEIS) between August 2015 and July 2016. These incidents met the reporting criteria set by NHS England. One incident was identified as affecting a baby only. One incident was identified as affecting a mother only and there was one medication incident in accordance with the serious incident framework 2015. We reviewed three root cause analysis investigation reports and saw evidence of learning from these event and actions taken to mitigate future risk. Learning was shared with staff in a variety of methods including team huddles, which were held at the start of each shift and staff noticeboards.
- We saw that 848 maternity (midwifery and obstetrics) incidents and 125 gynaecology incidents were reported between August 2015 and July 2016. For maternity, five incidents were classified as causing major harm, four moderate harm, ten minor harm and 739 no harm. For gynaecology, three incidents were classified as causing major harm, six moderate harm, seven minor harm and 109 no harm. We did not see any specific themes. We observed that all incidents were reviewed daily and where necessary investigations, including root cause analyses, were carried out. Senior staff held regular meetings to identify where trends had occurred and put in place systems to prevent similar occurrences. They also monitored whether the required actions had been addressed.
- There had been no never events reported for this service from August 2015 and July 2016. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- All incidents were reviewed by the matrons and lead midwives. Incidents were discussed at the women's' and children's clinical business unit (CBU) governance meeting, which was attended by the senior management team. Discussions at the meetings were minuted and provided a summary of each incident. Incidents regarded as serious were reported to the hospital wide governance for consideration and review if any further action was required for example review of status or instigate an investigation.
- The service met the RCOG: Improving Patient Safety they held a monthly meeting to review perinatal and maternal mortality and morbidity. It was attended by the multidisciplinary team members. We saw the minutes and lessons learnt were shared widely across the service.
- Lessons learned were fed back to staff verbally via a 'communication cell' during the daily handover. A monthly clinical risk newsletter was emailed to all staff and a 'Hot Topic' board provided information in ward

areas. We saw a recent copy of the newsletter. It covered current news, such as reducing still birth care bundles, vacancies, mandatory training, equipment updates, environment updates, cardiotocography (CTG), lessons learnt feedback, safeguarding, feedback from incidents, complaints and compliments, annual leave and friends and family test feedback. For example we saw that a change in procedure for issuing to take home medication following an investigation of an incident that had occurred on the delivery suite.

- We spoke with staff about learning lessons from incidents in the maternity and gynaecology service told us they received direct feedback regarding incidents they had been involved with. Staff also told us they received feedback about incidents that had occurred within the service.
- The service planned to include a patient story in mandatory clinical study days to provide learning through patient experience. At the time of inspection, a start date for this had not been identified.
- From November 2014, NHS providers were required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and reasonable support to the person.
- Women and those close to them, were involved in reviews, staff ensured that requirements under the duty of candour were met. We saw a duty of candour letter sent to parents, which offered them an apology and assured them they would be kept informed with the action plan. We saw within route cause analysis (RCA) of incidents that duty of candour was considered. The hospital had a duty of candour policy (being open), which staff could access via the hospital intranet. Staff we spoke with were aware of the importance of being open and honest with patients and relatives when something went wrong. Staff we spoke with were able to describe examples where the duty of candour had been applied. The manager of the area or the staff member directly involved in an incident was required comply with the requirements of duty of candour. If a patient had requested feedback on an incident this was completed by the staff member completing the local investigation. We saw evidence of duty of candour principles being carried out.
- The service held monthly meetings to review perinatal and maternal mortality and morbidity as recommended by RCOG Safer Childbirth and Improving Patient Safety 2007. Multidisciplinary team members (MDT) attended the meeting. We attended a meeting and saw minutes from previous meeting. Evidence of reviews of serious incidents, discussions and lessons learnt were shared across the service and where appropriate across the hospital.
- We saw the service reported all births between 22+0 and 23+6 weeks gestational age who did not survive the neonatal period to MBRRACE-UK as per recommendation 8 of the MBBRACE report published June 2015.

Safety thermometer

- The service did not complete the national maternity safety thermometer. The trust told us the commissioners had agreed what information that could be collected using the trust's electronic systems and to undertake quality improvement work and use evidence based tools to measure improvement based on that information the service was able to collect.
- The maternity safety thermometer is a national system that collates safety and quality information. The thermometer allows maternity teams to take a 'temperature check' on harm and records the proportion of mothers who have
- experienced harm free care, and also records the number of harm(s) associated with maternity care. The maternity safety thermometer measures harm from perineal and/or abdominal trauma, post-partum haemorrhage, infection, separation from baby and psychological safety. It also records babies with an apgar score of less than seven at five minutes and/or those who are admitted to a neonatal unit. The apgar score is an evaluation of the condition of a new-born infant based on a rating of 0, 1, or 2 minutes for each of the five characteristics namely; colour, heart rate, response to stimulation of the sole of the foot, muscle tone, and respiration with 10 minutes being an optimum score.
- Not all the information on the national maternity safety thermometer was shown on the service's local

dashboard, such as the apgar score, infections and separation from baby and psychological safety. We were not assured all staff were therefore aware of this information.

- The maternity service collected limited information as part of its safety monitoring. The service had developed a local version of the national maternity dashboard, which measured outcomes. The indicators used included the percentage of caesarean sections and other assisted deliveries (where forceps or a suction cup called ventouse was used to assist delivery of the baby's head). They also included clinical outcomes (the results of patient's care). Staff were aware of the outcomes measures and performance. The maternity dashboard results were displayed publically and staff were aware of the outcome measures and performance. We saw evidence that action was taken to improve safety performance when indicated.
- The dashboard data compared safety-related targets on a monthly basis but it did not meet RCOG good practice No.7 Maternity dashboard, clinical performance and governance scorecard Jan 2008. The locally designed dashboard did not contain detailed information on some clinical activities such as water birth, and home birth rates. It did not contain any information on work force issues such as delivery ratio, midwifery supervisors to midwives ratios or number of hours of prospective consultant presence in accordance with the Safer Childbirth recommendations. Clinical outcome indicators such as eclampsia (the onset of seizures (convulsions)) were also missing from the local dashboard. Without collecting this information, the hospital was unable to identify all patient safety issues in advance and ensure timely and appropriate action was taken to ensure high quality, safe maternity care. We saw evidence the management team were aware of this risk and an action plan had been developed. However, the action plan stated target completion date was July 2016. At the time of the inspection, the updated dashboard was not in place. The management team explained that IT support and a business package was required to support the action plan but this was currently not in place. The issues with the dashboard were not on the service's risk register.
- While there was evidence that risk information was being collated, this was being collated by a number of different people. For example, dashboard information was collated by the lead midwife, VTE data through the safety thermometer, still birth rate by the bereavement midwife and staffing via workforce papers. The information was not all available on one risk document, and as a result, we were not assured the service had oversight of all information to monitor the service.
- The NHS Safety Thermometer is an improvement tool for measuring, monitoring and analysing patient harm and 'harm free' care. This enabled measurement of the proportion of patients that were kept 'harm free' from pressure ulcers, falls, and urine infections (in patients with a catheter) and venous thromboembolism (the formation of blood clots).
- The gynaecology service collected an appropriate range of safety information and it was being monitored by the service. The service collected information about safety risks to patients. This information included the total number of hospital acquired pressure ulcers and infections, the number of medication administration errors, friends and family test response rates and the percentage of respondents who would recommend the service, maternity documentation standards and maternity staffing levels. The NHS safety thermometer results were displayed publically and staff were aware of the outcome measures and performance. We saw evidence that action was taken to improve safety performance when indicated. For example, we saw changes in practice to reduce risks of hospital acquired pressure ulcers.

Cleanliness, infection control and hygiene

- We saw that all areas of the maternity and gynaecology service we visited were visibly clean and mostly well maintained.
- The maternity service reported no cases of hospital acquired methicillin-resistant Staphylococcus aureus (MRSA) or Clostridium difficile infections between April 2016 and June 2016.
- There were generally reliable systems in place to prevent and protect people from a healthcare-associated infection. We saw cleaning schedules on all wards. This was an improvement since the last inspection in September 2014, where we found poor infection control standards and missing 'I am clean' stickers on equipment being used in patient areas.
- On the current inspection, we saw paintwork on the doorways and walls were chipped on the delivery suite meaning that cleaning could not be effective to ensure

that infection was controlled; this was also raised at the previous inspection. However, we did see work had commenced to address this; painters were working on the delivery suite at the time of inspection.

- The fabric of the building on the gynaecology wards was also in a poor state of repair. We saw peeling wall areas and missing floor tiles, which made cleaning and infection control management difficult. Cleaning staff we spoke with told us it was hard to clean some of the areas because of the damage but they were aware took extra time to clean these areas. Plans were in place to address this issue in the coming months.
- A safety and quality schedule was used within the service to ensure that equipment was checked and wards were clean and tidy. Cleaning audits were carried out and information provided by the hospital showed all areas were above the hospital target of 95%
- Equipment was labelled with tags to indicate when it had been cleaned. Sluice areas were clean and had appropriate disposal facilities, including the disposal of placentae.
- We observed compliance with the hospital infection prevention and control policy. We saw staff washing their hands before and after every episode of direct contact or care, which met NICE QS61 statement 3. Staff used protective clothing such as aprons and gloves and adhered to the arms bare below the elbow policy.
- Hand sanitising gel dispensers were available in corridors and wards. We saw posters in corridors advising patients and visitors to use hand gel dispensers.
- We saw that patients scheduled for surgery were screened for MRSA, with appropriate action taken if results were positive.
- We saw evidence in patient notes that pregnant women were offered the influenza vaccination.

Environment and equipment

- Whilst the delivery suite had appropriate security arrangements in place, we were not assured the antenatal and post-natal ward (Rowan ward) had sufficient security arrangements to prevent intruders from entering the ward and minimising the risk of visitors accessing the ward without being challenged.
- A video intercom entry system was used to identify visitors and staff requesting entry into the delivery suite and Rowan ward. We observed staff asking visitors who they were visiting before entering the wards.Access and from to the wards was gained via a set of double doors and once the doors had been released open through the buzzer entry system, the doors took 20 seconds to close which meant it was easy for someone to tailgate into the department some-time after the original requesting visitor had entered or left. This meant that there was a risk that someone could access the ward without being challenged.On the delivery suite, entry to the ward was managed by ward clerks who provided 24-hour cover. This reduced the risk of unauthorised access to the delivery suite. However, the ward clerk provision was not 24-hour on the postnatal/antenatal (Rowan) ward. There was a potential risk of visitors accessing the ward without being challenged. This had not been identified as a risk on the risk register. Staff said, and we saw members of staff who allowed visitors access to the unit, that they spoke to the visitor to check who they were visiting.
- During our last inspection, we found the trust was aware that the shower and toilet facilities in some of the maternity wards were not fit-for-purpose, or compliant with disability requirements. On this inspection, staff told us about the maternity improvement works that had commenced since the last inspection. The trust had completed £5 million of improvement and refurbishment works to the maternity wing. These included the completion in February 2016 of a maternity theatres project, which included two new theatres and a recovery area. During August 2015 to the end of January 2016, gynaecology procedures were temporarily relocated to main theatres or the Treatment Centre whilst the new theatres were being built. At the time of the inspection, these had opened and one of the new theatres was being used for obstetrics and the other for gynaecology procedures. The improvement works included an upgrade of bathrooms and showers by providing ensuite bathrooms in the labour suite and on antenatal and postnatal ward (Rowan). We saw on the current inspection shower and toilet facilities on Rowan ward had been replaced and were now fit for purpose. This was on the clinical business unit risk.
- New equipment had been put in place across the maternity unit including new flooring, new workstations and a new bedside call system throughout. A second water birthing pool had also been installed since the

last inspection. Staff spoke positively about the environmental changes and told us it had made a difference in their ability to care for women and to staff morale.

- We found equipment was clean and fit for purpose. Portable appliance testing or external company servicing of all equipment that we looked at was found to be in date, meaning that it was safe for use.
- The service had all equipment recommended by the safer childbirth document. Emergency clinical equipment such as resuscitation, oxygen, resuscitaires (used to support new born babies who may need extra warmth or resuscitation after delivery) for new-born babies on the maternity unit and suction equipment was stored appropriately so that it was available for use at short notice. It was checked each day to ensure it was in working order. We saw recordings to confirm this.
- A cardiotocography (CTG) machine was used for women whose babies needed monitoring in labour. CTG machines are used to monitor the baby's heart rate and the frequency of contractions when a woman is in labour. This involves two straps being applied across the woman's abdomen that are attached to the machine and does restrict movement. The service did have a number of telemetry CTG machines, which were operated by Wi-Fi that enabled women to be mobile. CTG machines were checked daily.
- Fetal blood analysers, fetal heart rate monitoring for high risk pregnancies were available and accessible and were checked daily. We saw documented evidence that the post-partum haemorrhage trolley weekly checks were being carried out in a timely way. The anaesthetic machine in theatres was checked daily as well as before every surgical case.
- We spoke with staff from all wards within the maternity and gynaecology services. They told us they had adequate supplies of medical equipment.
- Maternity staff knew the birth pool cleaning and evacuation procedures. A booklet on the delivery suite contained photographs demonstrating evacuation of the pool. There was a net available in each pool room, in order to support the evacuation of women from the pool.
- We found that the antenatal clinic was also used as a gynaecological clinic. We observed both maternity and gynaecology clinics running concurrently. Gynaecology and obstetrics patients and women attending for these appointments shared the same waiting room and clinic times, which meant that patients who may be having difficulty in conceiving or had experienced miscarriage were sharing the same area with pregnant women and this was not sensitive to their needs. This had not been identified as a concern by the hospital or been placed on the service risk register.
- The service had sufficient facilities for hand washing and bins for general and clinical waste.
- We saw emergency equipment was carried by community midwives such as oxygen, with suitable equipment for neonates and adult such as masks. They also carried emergency drugs such medicines for the management of post-partum haemorrhage and catheterisation equipment. All equipment was checked on a weekly basis Equipment was transported securely and was compliant with local protocols and legislation.

Medicines

- We observed medicines, including controlled drugs, were handled and securely stored. Controlled drugs are medicines that require additional security. Records demonstrated that twice-daily stock checks of controlled drugs were maintained and that these were correct. Any allergies were clearly documented in the prescribing document used.
- Staff in the ward areas carried out daily temperature checks of the medicine fridges; these were recorded and were within acceptable ranges. This ensured that medicines were stored at an appropriate temperature to maintain their stability. Staff were aware of the temperature thresholds and what to do if temperature thresholds were breached.
- Nurses and midwives were aware of the correct processes and procedures for the administration and recording of medications.
- Medicine incidents were recorded onto an electronic recording system. Learning from incidents was cascaded to staff during staff meetings.
- There was access to emergency medicines, such as those used for allergic reactions and for treating low blood sugars to prevent further complications. Emergency medicines were stored securely on emergency trolleys. This meant they were available in an emergency.

- We saw the nurse or midwife administering medicines was identified by wearing a red tabard. This indicated that they were not to be disturbed during the medicine round to allow them to concentrate on the administration of medicines.
- Midwives may supply and administer pain relieving medicines under a system known as midwives' exemptions. Their midwifery training provided necessary training and competency to administer this medication. We were told and we saw sealed medicine packs were dispensed by the pharmacy for community midwives to supply and administer. This was best practice and ensured the medicines had been checked for safe administration.
- During our last inspection, we found staff had raised concerns about a lack of a "clean area" for intravenous drug preparation, and that a drugs fridge was in an open area and not secure. Plans had been submitted for approval to create an appropriate environment. This issue had been addressed since the last inspection.

Records

- Individual care records were written in a way that kept patients safe. We reviewed 19 patients' healthcare records and found that they were accurate, complete, legible, contemporaneous and up to date. We saw records had been completed with relevant current and previous clinical information. Information needed to deliver effective care and treatment such as risk assessments such as diabetes, pre-eclampsia, high body mass index and venous thromboembolism (When a blood clot breaks loose and travels in the blood) and test results were accessible. We saw these available on the wards we visited. We saw information was passed on efficiently during transition from one ward to another.
- Women carried their own pregnancy records, which were brought into the hospital and these were supported by hospital-held information to ensure staff had a full history including a complete record of the minimum set of antenatal test results. The notes stayed with the patient in the delivery room, unless there were reasons such as the notes contained sensitive information. These notes were kept in the nursing/ midwifery office.
- Detailed recordings were made regarding the assessments of babies shortly after birth and further notes had been made during the length of the hospital stay.
- On discharge, women were given written information and relevant contact details in case they needed extra support.
- As part of monitoring staff practices supervisors of midwives carried out regular audits on the content and standard of recordings made by midwives. Where poor practice was identified, processes were put in place to rectify it. For example, we saw a copy of an audit carried out in July 2016 to demonstrate that identification and appropriate management of mental ill health was of a quality standard since the previous audit in September 2015. The audit was developed from reviewing the NICE audit guidance sheet for Antenatal and Postnatal Mental Health clinical guideline 45. The audit highlighted the transition period between hand written notes and Maternity Medway had been a success and that mental health questioning was firmly embedded within maternity services. There had been increased emphasis on the importance of mental health in maternity services. Following the audit some recommendations were made:
  - To continue to direct midwives to the Perinatal Mental Health policy in regards of when to refer women to shared obstetric care and to familiarise themselves with the most recent NICE guidelines (last published December 2014)
  - Continue to communicate with staff through level 3 safeguarding training, feedback from audit and offer help and support if needed. Staff we spoke with were aware of the audit and the recommendation made. The team planned to repeat the audit annually.
- Records on the gynaecology wards were not always stored securely. We saw that patient records were stored in an open trolley behind the nurses' station on the ward. The nurses' station was often unmanned. This meant that patient records were not stored securely; patient's information was not always protected.
- During our last inspection, we found a new 'Medway' computer system was being installed to improve information and record management practices and improve diagnostics and screening access, and the sharing of relevant information. We saw on this inspection that the computer system was effectively running across the service. Staff spoke positively about the impact the new system had on their practice.

- Community midwives carried laptop computers, which contained patient records. These were protected by separate log-in sessions. Midwives reported lost or stolen devices to security so they could be disabled. This meant that patient's information was protected.
- On the maternity unit, we saw red books were used for each new born. Red books are used nationally to track a baby's growth, vaccinations and development. Records we reviewed were accurate, complete, legible, contemporaneous and up to date.

Safeguarding

- Arrangements were in place to safeguard adults and babies from abuse, harm and neglect and reflected up to date safeguarding legislation and local policy. Safeguarding training and refresher training was part of the mandatory annual workshop. We were told by senior staff that all midwives, medical staff and maternity care assistants had access to level three safeguarding children training; this is in line with national recommendations (Working together to safeguard children, 2015; Intercollegiate Document, Safeguarding children and young people: roles and competences for health care staff, March 2014). Updates were provided annually on the mandatory maternity study day. We saw evidence that training covered all aspects of safeguarding children and included professional responsibilities, categories of abuse, safeguarding processes and child protection. The study day also included guidance and responsibilities regarding domestic violence, child sexual exploitation, parental drug and alcohol misuse, perinatal mental health and female genital mutilation (FGM). Staff were also encouraged to access e-learning courses.
- The training data confirmed that as of 16 November 2016 safeguarding adult level two training compliance for midwives in maternity would be 97% and gynaecology staff was 96%, which was above the hospital's target of 85%. People were booked to attend further training sessions.
- We saw 100% of midwives in maternity had up to date safeguarding children level two training and 94% had received safeguarding children level three training.
- Compliance with safeguarding children level two training was at 96% for nurses on Maple ward. However, for safeguarding level three training, compliance was 50%, as out of the two nurses allocated to cover the termination service (who were deemed as requiring level three training), only one was trained."
- Not all medical staff had received training. 76% of medical staff had up to date training in adult safeguarding level 2, 89% had up to date safeguarding children level two training and 82% had received safeguarding children level three training which was below the hospital's target of 85%. However, staff we spoke with demonstrated an understanding of the hospital's safeguarding procedures and its reporting process.
- We were showed evidence the service would be at 92% compliance by December 2016 as staff were booked to complete their training in December.
- Safeguarding supervision is a Department of Health requirement (Working Together to Safeguard Children, 2010). A safeguarding case supervision policy was in date and community midwives undertook safeguarding supervision in line with hospital policy.
- A flag showed on the maternity records system for any woman who had a safeguarding concern to help alert staff. Staff uploaded any safeguarding plans required to the information system.
- The local safeguarding team were informed of any woman, unknown to the service who presented herself for treatment. The local safeguarding team then made enquiries with the social services department in the woman's home locality.
- Whilst the hospital did not have a separate baby abduction policy, baby abduction was discussed within the hospital's internal crisis plan. However, this plan did not include the measures that should be taken to ensure security and to prevent a baby's abduction whilst on hospital premises, as defined under the Child Abduction Act 1984. There was a flowchart on what action to take in the managing major incidents policy. While not all staff were able to direct us to the abduction flow chart on the intranet, all staff we spoke with were able to tell us how they would respond to an abduction or attempted abduction. They described a lockdown procedure with main doors to the maternity block being closed following the alarm and a member of staff on guard.
- Staff knew how to make referrals to other agencies in cases of domestic abuse disclosure. Staff we spoke with were confident in talking about the types of concerns

that would prompt them to make a safeguarding referral as well as the referral process. We reviewed a sample of records and found these contained relevant information such as reason for concern and previous information known.

- A baby identity tagging system was in use to ensure the safety of babies in the maternity unit. Every baby had an identity tag applied to each ankle shortly after birth and included the baby's name, date of birth and mother's name. The identity tags were checked on admission to the postnatal ward following transfer from delivery suite and on a daily basis, as part of the routine postnatal check. Staff told us if they found a baby with only one tag, they would apply a second. If both tags were missing staff would report it via the electronic incident reporting system and all babies in the unit would be checked to confirm their identity. We checked five babies during our inspection and all had two identity tags secured to their ankles.
- Posters regarding domestic violence and how to seek help were displayed in patient and public toilets throughout the unit.

Mandatory training

- Mandatory training provided by the service met with the recommendations of safer childbirth document. It covered a range of topics and included health and safety, manual handling, infection control, hand hygiene, conflict resolution, equality and diversity, information governance and adult basic life support. Maternity specific training included management of obstetric emergencies. Staff had an opportunity to practice emergency drills and emergency scenarios such as postpartum haemorrhage, shoulder dystocia, eclamptic fit and vaginal breech.
- Staff within the maternity and gynaecology service were aware of the need to attend mandatory training.
- 65% of midwifery staff had attended mandatory training at the time of inspection, which was significantly below the hospital target of 85%. We were showed evidence the service would be at 92% compliance by December 2016. 17% of staff were booked to complete the training in November 2016 and a further 11% were booked to complete their training in December 2016.
- The service used learning via simulation training (skills and drills training); however, compliance was low at the time of the inspection. 54% midwifery staff had attended skills and drills training at the time of inspection. A plan was in place to address the low compliance. We were showed evidence the service would be at 93% compliance by December 2016. 13% of staff were booked to complete the training in October 2016, 12% in November 2016 and a further 13% were booked to complete their training in December 2016. Skills drills are the accepted format by which healthcare professionals gain and maintain the skills to manage a range of obstetric emergencies. These include shoulder dystocia (where a baby's shoulders becomes stuck delaying the birth of the baby's body), vaginal breech birth, postpartum haemorrhage, cord prolapse (when the umbilical cord comes out of the uterus before part of the foetus), and maternal and neonatal resuscitation.
- Training data confirmed that as of 31 October 2016, 91% of midwifery staff had attended neonatal and basic life support training.

Assessing and responding to patient risk

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

Maternity and gynaecology

- Women with high risk pregnancies due to pre-eclampsia, diabetes, obstetric cholestasis, intrauterine growth retardation, for example, were regularly monitored and reviewed by an obstetrician for medical advice.
- There was a designated triage area so women with urgent health issues, such as pain, vaginal bleeding, or suspected broken waters, could be assessed and reviewed on the delivery suite .Triage is the process of determining the priority of a pregnant woman's treatment based on the severity of their needs. Women were provided with the telephone number for the unit and could access it directly if they had any concerns.
- There had been no maternity outliers such as puerperal (a bacterial infection) sepsis and other puerperal infections, elective caesarean section, emergency caesarean section, neonatal readmissions and maternal readmissions reported since December 2009.
- The hospital had a guideline for the management of sepsis in the obstetric patient, which met national guidance. The guideline helped staff identify women at risk of sepsis and initiate the required treatment.
- For maternity and gynaecological surgery, the service used the World Health Organization (WHO) 'Five Steps to Safer Surgery', which is a surgical safety checklist. Completion of the checklist was audited, and, between April 2016 and June 2016, showed they had looked at a sample of over 1,000 patients. The overall compliance for the checklist was 100%.
- The surgical safety checklist for maternity aimed at improving patient safety and reducing harm in maternity care across the NHS. It was produced in conjunction with the Royal College of Obstetricians and Gynaecologists (RCOG), and was an adaptation of the WHO surgical safety checklist. The checklist is for women having a caesarean section or other surgical procedure related to childbirth, for example, the removal of the placenta. In addition to the checks provided by the surgical checklist, the maternity checklist required staff to check:
  - the resuscitaire has been checked and was in working order and the neonatal team have been called, if required;
  - ensure that the urinary catheter is draining;
  - check that the baby/babies have been identified with ID bands;
  - check to ensure that cord bloods have been taken, if required.
- For women using the maternity services, the booking visit took place before 12 weeks of pregnancy and included a detailed risk assessment. An initial maternity booking and referral form was completed by community midwives at the booking visit. Information provided by the hospital showed in the inspection period June to October 2016 90% of women had an antenatal risk assessment completed at booking which met the hospital target. On-going risk assessments were carried out at subsequent antenatal visits and women were referred to the obstetric team if risk factors were detected.
- A screening midwife was responsible for antenatal and newborn screening. The regional quality assurance screening team for the West Midlands and NHS England collected data on nine key performance indicators (KPIs) for screening including the number of women tested for human immunodeficiency virus; the number of women referred for hepatitis B virus specialist assessment; the number of completed laboratory request forms for Down's syndrome screening; the number of women tested for sickle cell and thalassaemia (the name for a group of inherited conditions that affect a substance in the blood called haemoglobin); the number of women tested by 10 weeks gestation; the number of laboratory requests with completed family origin questionnaire; the number of avoidable repeats for new born blood spot test; and the number of babies having New-born and Infant Physical Examination (NIPE).
- January 2016 to March 2016 information demonstrated compliance with five of the nine threshold achievable target KPIs, including those for antenatal infectious disease screening, two of the sickle cell and thalassemia screening measures and new-born physical assessments.
- One measure fell below the threshold achievable level: this was for completion of laboratory forms for Downs' syndrome screening. The service achieved 95.7% against the acceptable threshold of 97%. The service identified the reason for this was that there were 33 babies that they were unable to account for, due to the NIPE documents not containing the required information on the maternity information system.
- In three measures, the service met the threshold acceptable level (but fell below the threshold achievable level): these were:

▪ The number of avoidable repeats for new-born blood spot test. The hospital scored 1%, better than the acceptable threshold target of 2% but worse than the threshold target of 0.5%.

▪ The number of women tested for sickle cell disease and Thalassaemia - timeliness of the test. The hospital achieved 51%, above the acceptable level threshold of 50% but below the achievable threshold measure of 75%. The hospital identified the reason for not meeting the KPI of this was that the possible impact of the bank holidays as the hospital did not have the facility to provide testing on bank holidays. 24 forms had information such as gestation missing.

▪ For the number of babies having new born and NIPE examinations, the hospital results were better that the acceptable threshold target of 95% at 99%, but below the achievable threshold target of 99.5%. Nine cases were accounted for this and all were followed up either by the hospital or by the GP.

- The hospital had reviewed and identified the reasons for not meeting the KPIs and had plans to address the issues through mandatory training. Actions were being monitored by the maternity governance group.
- Babies were monitored before birth using cardiotocography (CTG) when necessary. In obstetrics, cardiotocography (CTG) is a technical means of recording the foetal heartbeat and the uterine contractions during pregnancy. The machine used to perform the monitoring is called a cardiotocograph, more commonly known as an electronic foetal monitor (EFM).
- The senior midwives on duty provided a CTG review known as 'fresh eyes'. This was carried out hourly or more frequently if indicated in accordance with The National Institute for Health and Care Excellence (NICE) intrapartum guidelines. It involved a second midwife checking a CTG recording of a baby's heart rate to ensure that is it was within normal parameters. The service audited the review as part of their monthly audit of records.
- Multidisciplinary CTG case reviews were held weekly to facilitate discussion and learning.
- We saw that VTE scores were monitored and recorded in women's' records on the maternity and gynaecology wards. VTE is the term given to blood clots. Treatment to prevent blood clots was prescribed and administered in accordance with the hospital policy. Women were re-assessed within 24 hours of admission for risk of VTE and bleeding which met NICE QS3 statement 1 and 4.
- Women who had a general anaesthetic for a caesarean section remained in the recovery area until they were fit for discharge. Upon return to the ward they were cared for and their health monitored by staff who had been trained for this purpose. Care records included documentation confirming that appropriate monitoring had taken place for each woman.
- We saw clear documentation that identified the safest method of delivery for each woman. The recordings told us that the rationale for the method of delivery had been discussed with each woman and their agreement sought. The women we spoke with told us they had been kept well informed during their pregnancy and labour. Other women explained to us why they required a change to their original birth plan.
- We saw completion of certificate for terminations was in line with the Abortion Act (1967) and Abortion Regulations (1991). Forms were signed by two clinicians, which was in line with the legislation. We saw this was completed in the nine sets of termination of pregnancy notes we reviewed.
- Patients who needed specialist care such as tissue viability were referred by doctors or nursing/midwifery staff and arrangements were made for the provision of other specialist services if necessary.
- NHS England's 'Saving Babies' Lives' care bundle (2014) for stillbirth recommends measuring and recording foetal growth, counselling women regarding foetal movements and smoking cessation, and monitoring babies at risk during labour. The service had carried out a benchmark audit of their services against these recommendations in April 2016.
  - Customised fetal growth charts were in use to help identify babies who were not growing as well as expected. This meant that women could be referred for further scans and plans made for their pregnancy. Scans were offered at 28, 32 and 36 weeks.
  - Counselling women regarding foetal movements, counselling services were available at the hospital. Information and advice leaflet on reduced fetal movement (RFM), based on current evidence, best

practice and clinical guidelines, was provided to all pregnant women by, at the latest, the 24th week of pregnancy and was discussed at every subsequent contact.
    - Recording of smoking status of each pregnant woman and exposure to smoke was recorded at booking appointments. Referral to stop smoking service or other action was offered.
    - Monitoring babies at risk during labour: maternity staff who care for women in labour were required to undertake an annual training and competency assessment on cardiotocograph (CTG) interpretation and use of auscultation. The hospital had a fresh eyes system in place for review of cardiotocograph (CTG) interpretation, with a protocol for escalation if concerns are raised. All staff were trained in the review system and escalation protocol.
- The critical care outreach team supported midwives with the care and management of critically ill women. Any woman who needed additional support and care, such as central venous lines, was transferred to the intensive care unit.
- Information provided by the hospital demonstrated in June 2016 booking appointment for pregnant women were undertaken before 10 weeks of pregnancy in 80% of cases and by 12 weeks 94% had been seen.
- Within the community a group of midwives with the lead midwife, had been developing a MEOWS tool to support earlier identification of sepsis. This work has involved other disciplines within the hospital to ensure effectiveness. We were not given a time scale for the roll out of the new tool.
- There were local agreements with the ambulance service on attendance at emergencies or when transfer was required.
- If a woman arrived at the delivery suite in labour without having booked, the midwife in charge would see the patient and contact would be made with their GP.

Midwifery staffing

- The maternity department did not always have sufficient staff, to enable the effective delivery of care and treatment. On the days of our inspection, we saw all areas were fully staffed. Staff rotas we reviewed for July, August and September 2016 demonstrated there were reduced staffing levels particularly affecting the antenatal and post-natal ward and the clinics. However, there were plans in place to address the risk to care delivery. Staff were moved between wards to meet the demands of the service.
- Historically there had been a difficult in recruiting qualified midwives. A skill mix review had been carried out in August 2016 and band four assistant practitioners role had been introduced in support roles, alongside qualified staff. Although they were not registered practitioners, they had a level of skill through their experience and training. We saw assistant practitioners were working within their level of competence and supported the service.
- Staffing levels and skill mix were planned and reviewed four hourly so that patients received safe care and treatment on the delivery suite, in line with relevant tools and guidance. Midwifery staffing was reviewed on a monthly basis by the head of midwifery with establishment sheets updated and circulated to the maternity lead midwives and discussed. Staffing on the delivery suite was providing one to one care for patients at the time of the inspection.
- The hospital did not use Birthrate Plus, however; the midwifery overview was done based on Birth-rate Plus tool guidance. Birthrate Plus is a midwifery workforce planning tool, which demonstrates required versus actual staffing need to provide services. Birthrate Plus is recommended by the Department of Health; endorsed by the Royal College of Midwives and incorporated within standards issued by the NHS Litigation Authority. It enables the workforce impact of planned change(s) to be clearly mapped, in order to support service improvement and planning for personalised maternity services.
- Staffing numbers were on display outside all inpatient areas in line with NHS England/CQC: Hard Truths guidance 2014.
- The midwife to birth ratio was 1:29. Safer Childbirth' recommends that there should be one midwife employed for every 28 births. Local commissioning groups also requested a 1:28 ratio within the 2015/16 service specification. The national minimum midwife-to-woman ratio is 1:28/29 for a safe level of service to ensure the capacity to achieve one-to-one care in labour. The recommended total care ratios indicate the maximum number of women that a midwife can provide antenatal, intra partum and

postnatal care for within the service. However, midwife recruitment had remained a challenge. Work was being done with the recruitment department to address these issues to maintain consistent staffing to provide 1:1 care.

- The delivery suite utilised the National Patient Safety Agency (NPSA) audit tool and a year's data was evaluated and presented to the August governance meeting and reflected in annual staffing reviews.
- The head of midwifery (HOM) and/or lead for women's and children services met with the director or deputy director of nursing and quality (DoNQ) quarterly to hold reference point meetings regarding all staffing in the women's and children services. A formal paper regarding staffing within women's and children services was completed each August by the HOM and given to the DoNQ. The midwifery staffing overview for this report was done based on Birth-rate plus tool. Recommendations made from the staffing review had resulted, through business planning, an additional midwifery post and two health care assistants. These included a plan to recruit into maternity leave posts who were then given permanent posts as vacancies arose.
- The delivery suite coordinators reviewed staffing levels each four hour period (08:00/12:00/16:00/20:00/00:00/04:00) and an acuity pro-forma was completed. When the acuity was greater than staffing ratios this was highlighted as a red flag in accordance with NICE NG54 (2015) guidance. When a red flag occurred, the midwife in charge, (delivery suite coordinator) completed an electronic incident report. This was reviewed by the lead midwife to ensure the escalation policy for 'women's' and children's' internal crisis plan' had been correctly implemented. When a red flag occurred the delivery suite coordinator completed a hospital risk assessment that highlighting their mitigation and actions. We saw staff reassigned from the antenatal and postnatal ward to cover gaps in the delivery suite.
- There had been six incidents reported in June and July 2016 related to staffing not meeting staff acuity in maternity this had an impact on care, for example, discharges had been delayed. There were also two incidents regarding staffing affecting the fetal health unit in May and June 2016 where staffing levels had impacted on the ability to provide care and appointments were delayed We asked the service what actions were taken in response to these incidents. The skill mix review had been carried out to look at staffing throughout the service. Staff were moved from other areas to support staffing.
- Delivery suite actual staff rate was above the planned level of 37.56 WTE, at 39.87.
- The hospital reported a vacancy rate of 10% whole time equivalent (WTE) (equating to 4 posts) and a turnover rate of 19.61% WTE in maternity services in August 2016. This average was skewed by the proportionally very high rate of vacancies at 47%, and turnover rate of 32% in obstetrics and gynaecology; without these figures, the other three wards averaged a vacancy rate of 7%.
- As at August 2016, the hospital reported a sickness rate of 4.3 % in maternity services: unlike vacancy and turnover, this figure was not skewed by figures for any single ward.
- The service did not use agency staff, they relied on bank staff or specialist midwives or midwifes in managerial posts to provide cover. On occasions, community midwifes, who were hospital employees, would be called to provide cover.
- Midwifery handover took place at the change of each shift. Handover included a review of all women on the wards and allocation of workloads. We observed the end of the morning handover on the delivery suite. The handover was held in the handover room on the delivery suite. The door was closed and a white board was referred to throughout the handover. The staff involved were the band 7 delivery suite supernumerary co-ordinator and the medical staff on duty for the day: the consultant obstetrician covering the delivery suite was present for the start of the handover. The handover was attended by junior medical staff and an anaesthetist. The handover was structured, systematic and covered name of woman, gravida (number of times she had been pregnant), parity (number of births and miscarriages), gestation of pregnancy, expected date of delivery or date of planned caesarean section and reason for presence on the delivery suite (labour, induction of labour, complication of pregnancy e.g. vaginal bleeding). The handover took 20 minutes; there were seven women in the delivery suite each with a named midwife. Following the handover the team decided in which order they would visit each labour room to discuss the plan of care with the woman and her named midwife. The consultant obstetrician attended the gynaecology and obstetrics theatre

huddle. The elective caesarean section list commenced at 10.15am. There was a woman in the delivery suite who was having twins and the consultant checked with the delivery suite co-ordinator whether he could go ahead with the first elective caesarean section before leaving the care of the twin delivery with the midwives & junior medical staff.

- We observed one handover where patient care was discussed and discharges planned. The handover was effective. Staff member leading the handover worked systematically providing a detailed handover of each woman and plan of care being followed. The handover also included discussion regarding women who may later require care on the delivery suite.
- During our last inspection and this inspection, we found there were no consultant midwives for the unit; consultant midwives were recommended by the safer childbirth guidelines 2007. The consultant midwife role is a strategic one with the potential to provide leadership and influence a range of areas including the promotion of normal childbirth, the midwifery contribution to research and evidence-based practice through to audit. Without a consultant midwife there was a risk opportunities for strategic development would be lost.
- All areas were reporting planned and actual staffing levels using safe staffing protocols and the daily shift cover of midwives and healthcare assistants was on display in each area we visited.

Gynaecology staffing

- The gynaecology department did not always have sufficient staff, to enable the effective delivery of care and treatment. On the days of our inspection, we saw all areas were fully staffed.
- The average fill rate in June 2016 for the gynaecology inpatient ward (Maple) for nursing staff for days was 140% and for nights was 118%. The average fill rate for care staff for days was 111% and nights was 147%. The staffing was flexed between the wards to ensure safe level of nursing cover.
- Maple Ward actual staff rate was also above the planned staffing level of 17.62 by 0.38 WTE. However, obstetrics and gynaecology planned staff rate was 8.61 and their actual 4.87.
- The hospital reported a vacancy rate of 10% whole time equivalent (WTE) (equating to 4 posts) and a turnover rate of 19.61% WTE in maternity services in August 2016. This average was skewed by the proportionally very high rate of vacancies at 47%, and turnover rate of 32% in obstetrics and gynaecology; without these figures, the other three wards averaged a vacancy rate of 7%.
- The gynaecology service used agency staff. We saw that agency staff received an effective induction to the ward on their first time the worked within the service.
- All areas were reporting planned and actual staffing levels using safe staffing protocols and the daily shift cover of nurses and healthcare assistants was on display in each area we visited.

Medical staffing

- Medical staffing was not appropriate, as there was not always an effective level of cover to support service needs.
- The maternity unit had provision for 60 hours of consultant presence, including in the daytime on week days, and mornings at weekends. Since there was no separate obstetric team to staff the elective caesarean section lists, this effectively reduced the consultant hours dedicated to cover the labour ward This had not changed since the last inspection. We found that the consultant obstetrician covering the delivery suite carried out the elective caesarean section list as well as cover for gynaecology. This would include undertaking a ward round on the antenatal in-patients. This meant there would be times the consultant obstetrician was not present on the labour ward as they were covering obstetrics and gynaecology and undertaking elective caesarean section list. We did not have any further information on the impact of this it had been raised with the executive board as a concern but it was not on the service's risk register.
- Staff on delivery suite said there was a business case in progress to increase consultant staffing: at the time of inspection there was no defined timescale for this. We fed this back to the trust as an area of concern. On our unannounced inspection staff confirmed that no extra consultant hours had been provided since feedback at last inspection and there had been no practical increase in consultant cover provided.
- We saw occasions in where multi-disciplinary team (MDT) meetings were cancelled due to no consultant available However, we saw no other evidence of impact; Consultants were available within 30 minutes if

required. We saw no evidence of any incidents or complaints made. The service complied with the Association of Anaesthetists of Great Britain and Ireland (AAGBI) obstetric anaesthetic guidance.

- The hospital reported in August 2016 that their actual staffing numbers were 1.26WTE below their planned staffing level. Actual staff for labour wards was 5.9 WTE, which was above the planned staff of 5.4WTE. Actual staff for Maple ward was 9.48WTE, which was slightly above the planned staff of 9.46 WTE.
- The largest deficit was on Rowan ward where the actual staff was 14.56 WTE, which was below the planned staff of 16.34WTE.
- As at August 2016, the hospital reported a medical staff vacancy rate of 6.33% (2.4 posts), a turnover rate of 11.26 % and a sickness rate of 1.2 % in obstetrics and gynaecology services. We did not have sufficient information to break this down to ward level.
- The proportion of consultants working at the hospital was lower than the England average.
- The proportion of junior doctors was reported to be the same as the England average.
- A consultant was on site 8.00am until 6pm, Monday to Friday. Between 6pm to 7pm Monday to Friday, the on call consultant was present on site. On call consultant cover between Monday and Friday was provided from home 7pm to 8am. At weekends, the consultant was on site 9am until midday and on call from home all other times.
- Middle Grade staff provided twenty four hours day seven days a week cover on site, on a shift basis. Ward cover was provided weekdays from 8.30am to 5pm. Weekends were cover by shifts 9am to 9pm; 9pm to 9am Weekdays on call to 5pm to 8.30am
- Junior Staff provided twenty four hours day seven days a week cover on site. Ward cover weekdays 08.30 to 17.00 hours.
- Anaesthetic cover was available 24 hours a day, seven days a week. From 8am to 5pm Monday to Friday two consultant anaesthetists were dedicated to the maternity service. From 6pm to 8am one anaesthetist was available on-site
- We observed one medical handover, which was thorough. Patient care was discussed and discharges planned. The doctor leading the handover worked systematically through the current patients using the white board as a prompt. The handover included discussions regarding women who were on the antenatal ward who may later require care on the delivery suite. For example, inductions of labour, raised blood pressure at term, planned caesarean section, and those in early labour. Following the handover the team decided in which order, they would visit each labour room to discuss the plan of care with the women and their named midwife. The consultant obstetrician then attended the gynaecology and obstetrics theatre huddle.
- Formal multi-disciplinary handovers were carried out four times during each day on the delivery suite attended by medical staff and the labour ward coordinator. We observed the morning handover, which was structured and included discussion on all maternity and gynaecology inpatients and overnight deliveries. Care was assessed and planned at this handover and work allocated to the appropriate doctor. Junior medical staff and an anaesthetist attended the handover. The handover was structured, systematic and covered name of woman, gravida (number of times she had been pregnant), parity (number of births and miscarriages), gestation of pregnancy, expected date of delivery or date of planned caesarean section and reason for presence on the delivery suite (labour, induction of labour, complication of pregnancy e.g. vaginal bleeding).

Major incident awareness and training

- The hospital had contingency plans for maternity services, which covered staffing and closure of the unit. Senior staff we spoke with were aware of these plans Staff were aware of the procedures for managing major incidents and fire safety incidents.
- Potential risks were taken into account when planning services, for example, seasonal fluctuations in demand, the impact of adverse weather, or disruption to staffing
- Between January 2015 and June 2016, the maternity unit was not closed on any occasion.
- There were arrangements in place should maternity services be suspended. These were outlined in the escalation policy.

Are maternity and gynaecology services effective?

Maternity and gynaecology

Good

We rated the service as good for effective because:

- Generally, policies were based on national guidance produced by National Institute for Health and Care Excellence (NICE) and the royal colleges. Staff had access to guidance, policies and procedures via the hospital intranet.
- Care was provided in line with the NICE guidance. Pain of individual women was assessed and managed appropriately.
- The hospital had received the UNICEF Baby Friendly Initiative full accreditation for its maternity department.
- We saw effective communication between consultants and midwives. Communication with community maternity teams was efficient. Access to medical support was available seven days a week throughout the service.

However, we also found that:

- In the 2015 National Neonatal Audit Programme (NNAP), the hospital was below the NNAP standard for three of the five indicators. The hospital met the NNAP audit standard in two areas.
- Whilst policies were based on national guidance, we found that five antenatal clinical guidelines on the delivery suite had overdue review dates. However the polices were in line with national guidance.

Evidence-based care and treatment

- Policies were based on national guidance produced by National Institute for Health and Care Excellence (NICE) and the royal colleges. Staff had access to guidance, policies and procedures via the hospital intranet.
- During our last inspection, we found the maternity service could demonstrate that there was a process for identifying relevant legislation, current and new best practice, and evidence-based guidelines and standards, which were reviewed and approved through the women and children clinical management team obstetric scrutiny committee. However, although doctors approved and signed off guidelines, staff told us that there was a lack of medical input and scrutiny in the development of some guidelines, and limited evidence that NICE guidance was being audited and followed. The compliance rate for NICE guidelines in the women and children's directorate was 67% in June 2014. On the current inspection, we saw evidence that the scrutiny meeting were held monthly however it was noted five antenatal clinical guidelines we reviewed on the delivery suite had overdue review dates.
- Clinical guidelines were available to all staff on the hospital's intranet. The guidelines were also kept in ring binders for the convenience of quick access on the wards and on the delivery suite; however it was noted five antenatal clinical guidelines that we reviewed on the delivery suite and on the intranet had overdue review dates. It was noted however that they were still in line with national guidance.
  - Pre-labour rupture of membranes (index number 012) was due for review in February 2016.
  - Management of hyperemesis gravid arum (index number 018) was due for review in February 2016.
  - Assessment and management of gestational hypertension and pre-eclampsia in the antenatal and postnatal period (index number 020) was due for review in July 2016.
  - Management of pregnant and post-natal women who present for care outside the maternity unit (index number 023) was due for review in April 2015.
  - Substance and alcohol misuse in pregnancy (index number 029) was due for review in February 2015.
- These were raised with the midwife in charge at the time of inspection who assured us they would ensure they would be reviewed at the next scrutiny meeting.
- Antenatal, intrapartum and postnatal care was provided in line with NICE quality standards. Policies we saw within the service reflected these guidelines.
- The care of women using the maternity services was not always in line with Royal College of Obstetricians and Gynaecologist Guidelines (RCOG) including Safer Childbirth: minimum standards for the organisation and delivery of care in labour. These standards set out guidance for the organisation, which included safe staffing levels, staff roles and education, training and professional development, and the facilities and equipment to support the service. We saw evidence the service had monthly meetings to review perinatal and maternal mortality and morbidity an equipment recommended by the safer childbirth document and the mandatory training provided by the service met with the recommendations. However, the midwife to birth ratio was 1:29 where the 'Safer Childbirth' recommends that

there should be one midwife employed for every 28 births. The dashboard data compared safety-related targets on a monthly basis did not meet guidance and the service did not have a consultant midwives were recommended.

- Care was provided in line with the NICE Quality Standard 22. This quality standard covers the antenatal care of all pregnant women up to 42 weeks of pregnancy, in all settings that provide routine antenatal care, including primary, community and hospital-based care.
- Women were cared for in accordance with NICE Quality Standard 190 Intrapartum care. This included having a choice as to where to have their baby, care throughout their labour, monitoring during labour and care of the new born baby.
- Care of women who planned for or needed a caesarean section was managed in accordance with NICE Quality Standard 132.
- NICE Quality Standard 37 guidance was adhered to in respect to postnatal care. This included the care and support that every woman, their baby and, as appropriate, their partner and family should expect to receive during the postnatal period. For example, on the post-natal ward staff supported women with breast feeding and caring for their baby prior to discharge.
- Care was provided in line with the NICE guideline (CG110), Pregnancy and complex social factors: A model for service provision for pregnant women with complex social factors. This guideline covers the care of vulnerable women including teenagers, substance misuse, asylum seekers and those subject to domestic abuse.
- The service provided a birth options clinic. The clinic provided an opportunity for women who have previously had a caesarean section or traumatic birth to explore the birth choices for their current pregnancy.
- The Foetal Medicine Clinic (FMC) provided women with evidence based individualised care. All women had individualised plans of care agreed and documented in their maternity notes. Women always had a named midwife responsible for their care. All women received a letter detailing the care given following each FMC appointment. A copy of this letter was sent to the GP, the named community midwife, and the referring consultant. A record of all discussions and care given was clearly documented in maternity notes the notes were regularly audited and reviewed.
- Blood was tested at the initial assessment to determine Rhesus factor and Anti-D immunoglobulin administered to women who were found to be rhesus negative.
- Choice was offered in line with RCOG Evidence-based Clinical Guideline Number 7: The Care of Women Requesting Induced Abortion. Following consultation in a designated termination of pregnancy clinic, women could choose to have early medical abortion (EMA), late medical abortion or surgical treatment under general anaesthetic.
- RCOG Clinical guideline No. 7 advises that information about the prevention of sexually transmitted infections (STIs) should be made available. All women were tested for chlamydia infection prior to any treatment (chlamydia is a sexually transmitted bacterial infection). Women with positive test results were referred to sexual health services. Women were also referred to sexual health services for further screening for other STIs and treatment.
- Contraceptive options were discussed with women at the initial assessment and a plan was agreed for contraception after the abortion. These included long acting reversible contraception (LARC) which are considered to be most effective as suggested by the National Collaborating Clinic for Women's and Children's Health.
- A discharge letter was given to women providing sufficient information to enable other practitioners to manage complications in line with the Department of Health's Required Standard Operating Procedures 3: Post Procedure.
- All of the hospital's policies and guidelines reflected UNICEF Baby Friendly standards and supported all mothers to initiate and continue breast-feeding.

Pain relief

- Pain of individual women was assessed and managed appropriately. Women on both the maternity and gynaecology wards told us that their pain and administration of pain relieving medicines had been well managed.
- We observed staff discussing pain management with patients and we saw evidence in patient records that actions had been taken to assist with patient comfort.
- Pain relief was managed in line with NICE CG 190: Recommendations for non-regional and regional pain relief during labour. On the maternity ward, we saw a variety of pain relief methods available including TENS

(transcutaneous electrical nerve stimulation) machines and Entonox, a ready to use medical gas mixture of 50% nitrous oxide and 50% oxygen that provides short term pain relief. Epidurals were available 24 hours a day and were in line with the Association of Anaesthetists of Great Britain and Ireland (AAGBI) guidance.
- Two birthing pools were available on the delivery suite for women to use water immersion for pain relief in labour.
- The service complied with RCOG guidance "the care of women requesting induced abortion" and offered pain relief during surgical and medical abortion. Women we spoke with told us they had received antenatal access to evidence based information about the availability and provision of all types of analgesia and anaesthesia.

Nutrition and hydration

- Women told us they received support and advice for breastfeeding their babies. On this inspection. The initiation of breast feeding rate was 75% between January and June 2016, which was the slightly below the national average of 77%.
- The hospital had received the UNICEF Baby Friendly Initiative full accreditation for its maternity department. This is the top award from UNICEF to accredit organisations that have established and implemented very high standards of care for all pregnant women and new mothers. It means the organisation is committed to supporting mothers to initiate breast feeding and encourages them to exclusively breastfeed for the first six months while at the same time also supporting parents who choose to bottle feed.
- All maternity staff including midwives, obstetricians, maternity support workers and healthcare assistants had completed recognised breast feeding training
- Adequate arrangements were in place to ensure women and their babies received nutrition and hydration.
- Women we spoke with told us their fluid and dietary needs had been met and they were provided with fresh jugs of water regularly.

Patient outcomes

- In the period from March 2015 to April 2016, performance information for maternity showed that:
  - The normal delivery rate was 61%, which was better than the RCOG recommendation of 60%.
  - The ventouse delivery rate was 5%, which was comparable to England average of 6%.
  - The forceps delivery rate was 5%, which was comparable to the England average of 4%.
  - There had been 22 still births.
  - There had been 349 admissions to neonatal intensive care unit (NICU) 142 of those were full term babies. There is no national threshold for this clinical maternity indicator. There is no national threshold for this clinical maternity indicator.
  - The caesarean section rate for 2015/16 was 30%, which was higher than the national average of 26.5%. The standardised caesarean section rate for elective sections within the service was 13% against the national average of 11%. Emergency sections were at 17% higher than the national rate of 15%. The hospital had introduced measures to try and reduce the number of caesarean sections performed. The multidisciplinary team reviewed every emergency caesarean section performed at the daily patient safety meeting to identify any instances where a caesarean section could have been avoided. Learning from these reviews was cascaded to staff. Women who requested elective caesarean section due to fear of childbirth were offered therapeutic counselling to address their fears and concerns. A vaginal birth after caesarean section clinic was also established.
- The maternity dashboard provided by the hospital showed that (from October 2015 to June 2016):
  - There were 80 home births between October 2015 and June 2016. The home birth rate was 2.8%, which was slightly above the national average of 2.3%.
- In maternity dashboard for June 2016:
  - The ventouse delivery and forceps rate was 10%, which slightly above the hospital target of between 8% to 9%.
  - The locally agreed standard for third and/or fourth degree tears was an occurrence of less than 9% per month. The number of 3rd degree tears in assisted vaginal deliveries rate was 6%. The number of 3rd degree tears in unassisted vaginal deliveries was 1%.
- In the 2015 National Neonatal Audit Programme (NNAP), the hospital was below the NNAP standard for three of the five indicators. The hospital met the NNAP audit standard in two areas: whether all mothers who delivered babies between 24+0 and 34+6 weeks gestation were given a dose of antenatal steroids and the proportion of babies born at less than 33 weeks

gestation were receiving any of their mother's milk when discharged. The hospital achieved 61%, above the national benchmark performance of 58%. The hospital did not meet the standards in these three areas:

- Whether all babies born at less than 32 weeks gestation had their temperature taken within an hour after birth. The audit standard was 98 to 100% of babies to have their temperature taken within an hour of birth. The hospital achieved 82%.
- Whether there was a documented consultation with parents by a senior member of the neonatal team within 24 hours of admission. The audit standard was 100%. The hospital achieved 94%.
- Whether all babies with a gestational age at birth of less than 32 weeks, or with a birth weight of less than 1501g (whatever their gestational age), were undergoing first Retinopathy of Prematurity(ROP) screening was carried out in accordance with the current national guidance. The audit standard was that 100% of eligible babies should receive ROP screening within the time windows for first screening recommended in the guidelines. The hospital screened 95% of babies on time.
- The results of an audit were presented to the maternity governance meeting and an action plan had been devised to address issues raised. The action plan was monitored through the governance meetings.
- The service actively participated in national audits including the National Screening Committee antenatal and newborn screening audit. We saw a copy of the antenatal and newborn screening annual report for 2015-2016. The report had been produced to assist the service by providing a benchmark for future service planning and quality improvement initiatives. Recommendations had been identified and were being actioned.
- NHS England's 'Saving Babies' Lives' care bundle (2014) for stillbirth recommends measuring and recording foetal growth, counselling women regarding foetal movements and smoking cessation, and monitoring babies at risk during labour. Customised fetal growth charts were in use at the hospital use help identify babies who were not growing as well as expected. This meant that women could be referred for further scans and plans made for their pregnancy. Scans were offered at 28, 32 and 36 weeks.
- Counselling women regarding foetal movements, counselling services were available at the hospital. Information and advice leaflet on reduced fetal movement (RFM), based on current evidence, best practice and clinical guidelines, was provided to all pregnant women by, at the latest, the 24th week of pregnancy and was discussed at every subsequent contact. Recording of smoking status of each pregnant woman and exposure to smoke was recorded at booking appointments. Referral to stop smoking service or other action was offered. Monitoring babies at risk during labour: maternity staff who care for women in labour were required to undertake an annual training and competency assessment on cardiotocograph (CTG) interpretation and use of auscultation. The hospital had a fresh eyes system in place for review of cardiotocograph (CTG) interpretation, with a protocol for escalation if concerns are raised. All staff were trained in the review system and escalation protocol.
- The gynaecology ward was monitoring some outcomes via the nurse sensitive indicators reporting to the ward dashboard and generally met the services' targets in terms of quality and safety.

Competent staff

- Staff had the right qualifications, skills, knowledge and experience to do their job when they starter their employment, to enable them to take on new responsibilities however we were not assured training was available on a continual basis.
- Maternity staff were required to complete annual cardiotocography (CTG) training. The service used the K2 perinatal training programme. All staff were required to complete the acid base and fetal physiology and cardiotocography interpretation chapters as a minimum. Staff were also required to attend a minimum of two CTG meetings per year. CTG meetings were held once a week and included individual case reviews and associated CTG interpretation.
- We saw evidence that regular impromptu emergency scenarios were held to maintain and improve the skills needed in the event of an emergency.
- Midwifery and medical staff were required to attend annual 'skills and drills' training to ensure they had the necessary knowledge and skills to manage obstetric emergencies including sepsis and maternal collapse, major obstetric haemorrhage and neonatal resuscitation. However, compliance was low at the time of the inspection. 54% midwifery staff had attended

skills and drills training at the time of inspection. A plan was in place to address the low compliance. We were showed evidence the service would be at 93% compliance by December 2016.

- The induction programme for new permanent staff and students included mandatory training and competency based ward skills. New staff were inducted to the clinical area.
- Student midwives spoke highly of their mentors and felt well supported. Newly registered nursing staff were supported through the preceptorship programme, which offered role specific training and support.
- The service had monitoring processes in place to ensure that doctors were working within the General Medical Council (GMC) revalidation guidelines and would be able to revalidate in line with the scheduled date. Medical revalidation was introduced in 2012 to ensure that all doctors were up to date and 'fit to practice'. All of the consultants working in obstetrics and gynaecology departments had either been revalidated or were working towards revalidation in line with the timescale notified to them by the GMC.
- Nursing revalidation was supported by the hospital working within the nursing and midwifery council guidelines and nurses would be able to revalidate in line with the scheduled date. Nursing staff told us they were given assistance and support to complete the appropriate reflective accounts, and training to complete this.
- The function of statutory supervision of midwives is to ensure that safe and high quality midwifery care is provided to women. The Nursing and Midwifery Council (NMC) sets the rules and standards for the statutory supervision of midwives. Supervisors of midwives (SoMs) were a source of professional advice on all midwifery matters and were accountable to the local supervising authority midwifery officer for all supervisory activities.
- Staff received supervision. The service recorded training and preceptorship as part of supervision for midwives and gynaecology nurses. Supervision also occurred on an as required basis and was an on-going element of the appraisal process.
- The NMC Midwives Rules and Standards (2012) require a ratio of one Supervisor of midwives for 15 midwives. We saw that the SoM ratio was 1:16 (local supervising authority Report 2015) which meant that there were not enough SoMs to support midwifery practice, identify shortfalls and investigate instances of poor practice. However, midwives reported having access to, support from a SoM 24 hours a day, seven days a week, and knew how to contact the on-call SoM.
- Appraisal rates for staff demonstrated that 100% nursing staff on Maple ward had been appraised and 100% of midwives and doctors working within the maternity department had been appraised.
- The service employed two part time practice development midwives to plan and develop training suitable for the needs of the service. Trends in incident reporting were used to assist in the identification of training required.

Multidisciplinary working

- Staff reported good multi-disciplinary (MDT) working. Staff also reported medical and nursing / midwifery staff worked well together.
- We saw effective communication between consultants and midwives. Communication with community maternity teams was efficient.
- A multidisciplinary handover took place twice a day on the delivery suite and included an overview of all maternity and gynaecology patients.
- The handover also included discussion regarding women who were on the antenatal ward who may later require care on the delivery suite, for example: inductions of labour, raised blood pressure at term, planned caesarean sections and women in early labour.
- Following the handover, the team decided in which order they would visit each labour room to discuss the plan of care with the women and their named midwife.
- Following the handover in each room, the consultant obstetrician went to the gynaecology and obstetrics theatre huddle.
- Senior paediatric colleagues who had advanced skills for immediate advice and urgent attendance were available to attend the delivery suite 24 hours a day if the situation arose.
- In the community, we were told of effective multidisciplinary teamwork between community midwives, health visitors, GPs and social services. We observed a handover call between the midwife covering triage and a community midwife. The midwives discussed the name of women, gravida (number of times they had been pregnant), gestation of pregnancy, expected date of delivery and the reason for their call to the triage. A plan of action was discussed and the

community midwife agreed to, for example, visit the women at home to address their concerns. The teams worked closely together, the community team told us they often provided cover for the hospital during peaks in activity.

- In the maternity records we reviewed, we saw detailed discharge letters to the mothers' GP informing them of the current medical situation for the mother and their baby.
- We observed the discharge arrangements made for patients accessing the termination of pregnancy (TOP) service, and saw detailed discharge letters and a review of contraception in all records reviewed
- The ward informed community midwives and GPs when a woman had suffered a pregnancy loss. They informed the obstetric office so that ongoing appointments could be cancelled.
- We saw patients were referred to specialist consultants internally and externally if their condition required specialist care.
- During our last comprehensive inspection visit, we received a significant complaint regarding poor communication practices. We did not see any evidence of these concerns on the current inspection.
- We saw there was a supportive relationship between midwives and obstetricians with positive effective communication.

Seven-day services

- Access to medical support was available seven days a week throughout the service. Consultant cover was provided seven days per week with on-call arrangements out of hours. We saw from records emergency admissions were seen and had a thorough clinical assessment by a suitable consultant within 14 hours from the time of arrival at hospital, which was in line with the service's target.
- Local diagnostic services were available daily with out of hour's facilities for emergency procedures such as x-ray, computerised tomography (CT), ultrasound sonography and pathology Out of hours, antenatal and postnatal services were available to community-based mothers in emergencies. All women could report to the hospital in an emergency via the maternity reception.
- The early pregnancy service ran on Monday to Saturday mornings. There was no access to scanning on Sundays.
- Community midwives were on call over a 24 hour period to facilitate home births.
- The service met AAGBI Obstetric Anaesthetic Guidance, 2013. An anaesthetist was available for emergency work on the delivery suite 24 hours seven days a week.

Access to information

- Intranet and e-mail systems were available to staff which enabled them to keep pace with changes and developments elsewhere in the service, and access guides, policies and procedures to assist in their specific role.
- Midwives told us, and we observed from looking at records that information from community and antenatal clinic appointments were available to women, this information was also stored electronically.
- The use of a mainly electronic health care records system in the maternity department ensured that all the care the patient had received, along with diagnostic test results, were easily accessible and stored in one place.
- Women's medical and obstetric history was recorded for staff to consider when there were concerns about pregnancy, labour and during the postnatal period. We were told information needed to deliver effective care and treatment such as care and risk assessments such as diabetes, pre-eclampsia, high body mass index and Venous thromboembolism (When a blood clot breaks loose and travels in the blood) , care plans, case notes and test results were accessible. We saw these available on the wards we visited. We saw information was passed on efficiently during transition from one ward to another.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Training on the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) was part of the hospital's mandatory training. We saw the MCA / DoLS training compliance as of October 2016 for Maternity and Gynaecology was 79% for midwives 83% for nurses and 74% for medical staff. The service told us all staff will have completed mandatory training by the end April 2017.
- The hospital had set procedures in place for assessing patient's capacity, whether they came into the hospital as an emergency or as a planned admission. Staff we spoke with talked confidently about mental capacity assessments within the remit of their role.

Maternity and gynaecology

- We saw the procedure of consent was reviewed prior to surgical procedures, which was good practice. Records we looked at included signed consent forms. The five steps of the World Health Organisation checklist 'Five step to safer surgery' had been followed.
- We observed patients giving verbal consent before staff provided care or treatment.
- Women we spoke with in the maternity and gynaecology services, including TOP, told us staff always asked for permission before providing care.
- Staff we spoke with, including community based midwives, demonstrated a clear understanding of Fraser Guidelines and Gillick competencies. (Gillick and Fraser competency is used to help decide whether a child is mature enough to make their own decisions. The Gillick competency and Fraser guidelines helps to balance children's rights and wishes with the hospital's responsibility to keep children safe from harm. Gillick competence is concerned with determining a child's capacity to consent. Fraser guidelines are used specifically to decide if a child can consent to contraceptive or sexual health advice and treatment.)
- Completion of certificates for terminations, in line with the Abortion Act (1967) and Abortion Regulations (1991), was carried out by two clinicians, which was in line with the legislation. We saw this was completed in the five sets of TOP notes we reviewed. The abortion notification forms (HSA4) for termination of pregnancy were captured within a designated HSA4 sent log book. Patient number corresponded with the serial number and the date sent. This was kept with all the TOP documentation in the ward's office. All HSA4 forms were sent by recorded/signed for delivery.

Are maternity and gynaecology services caring?

Good

We rated the service as good for caring because:

- Women and those close to them were positive about the care and treatment they had received. Staff were kind and caring towards patients.
- Patients, partners and relatives felt involved in their care and were happy that they had received sufficient information to make informed decisions about their care.
- The NHS Friends and Family Test (FFT) showed that the maternity service generally performed in line with the England average. In the CQC's Maternity Survey of Women's Experience of Maternity Services 2015, the service performed the same as other hospitals in the three main areas; labour and birth; staff during labour; and care in hospital after birth.

Compassionate care

- Women, partners and patients' relatives we spoke with were positive about the care they had received on the delivery, maternity and gynaecology wards. One woman said, "The staff here are very caring towards us, I have no complaints about my care here".
- Women we spoke with felt that there were enough staff to meet their individual needs.
- We observed caring, compassionate and informative interactions between staff and patients.
- We observed staff protecting women's privacy and dignity on the maternity and gynaecology wards by knocking on doors and waiting to be invited in. We also observed staff waiting outside of curtains and asking permission to enter.
- The service performed the same as other hospitals in the three main areas; labour and birth, staff during labour, and care in hospital after birth in the CQCs Maternity Survey of Women's Experience of Maternity Services 2015.
- Between August 2015 and July 2016, the hospital's maternity Friends and Family Test (FTT) performance (% recommended) was generally better than the England average in all four areas of maternity. In July 2016, the hospital's performance was:
  - Antenatal was better than the England average. The hospital scored 96% compared to a national average of 95%,
  - Birth was better than the England average. The hospital scored 100% for birth compared to a national average of 97%,
  - Postnatal was better than the England average, the hospital scored 95% compared to a national average of 93%, 100% for

  - Postnatal community was better than the England average the hospital scored 100% compared to a national average of 98%.
- The FFT score for the gynaecology service in July 2016 was 97% of patients recommending this service, which was better than the national average of 95%.
- The hospital performed similar to other hospitals for 16 out of 17 questions in the CQC maternity survey 2015 published in 2016. The hospital performed worse than other hospitals for one out of 17 questions in this survey: "Thinking about the care you received in hospital after the birth of your baby, were you given the information or explanations you needed?" The service was in the process of addressing this issue. The team had launched a listen to me campaign. On arrival on the unit, each woman was allocated a midwife and this was their named individual so if they had any concerns in relation to their care they could raise this with their named individual. Leaflets were given to all women to explain this campaign. The name of the senior midwife was also give to each woman so if they felt they had not been listened to by their allocated midwife who would follow up any concerns. Women we spoke with were aware of the listen to me campaign.
- We observed that care was provided in line with NICE QS15:
  - Patients were treated with dignity, kindness, compassion, courtesy, respect, understanding and honesty.
  - Patients experienced effective interactions with staff who demonstrated competency in relevant communication skills.
  - Patients were introduced to all healthcare professionals involved in their care, and are made aware of the roles and responsibilities of the members of the healthcare team.
  - Patients' preferences for sharing information with their partner, family members and/or carers are established, was respected and reviewed throughout their care
- We observed triage support provided, for example, when women contacted the hospital for advice by the delivery suite staff that demonstrated appropriate help and support was provided for mothers in labour before arrival at the acute setting.

Understanding and involvement of patients and those close to them

- We saw staff communicated well with women when attending their gynaecological appointments and on arrival to the delivery suite so that they understood their care, treatment and condition.
- Women and their partners we spoke with on the maternity ward told us they felt involved and reported that communications with staff were good throughout their stay.
- None of the patients we spoke with on the gynaecology ward had any concerns regarding their care.
- A patient we spoke with told us the consultant staff always introduced themselves and explained their care.
- Patients, and where appropriate their relatives, were kept informed and involved with decisions when appropriate by staff.

Emotional support

- Women were able to telephone the maternity triage unit 24 hours a day and speak with a midwife for support. Midwives told us this was regularly used by pregnant woman and mothers who required support and advice such as breastfeeding support and advice throughout the night.
- A dedicated bereavement midwife led on bereavement services for women who had experienced pregnancy loss.
- Midwives provided support for women who had experienced pregnancy loss to collect keep sakes such as photographs. This was in line with the Sands guidelines 'Pregnancy loss and death of a baby' 2016. (Sands is a stillbirth and neonatal death charity aims is to improve the quality of care offered during pregnancy and in the event of a baby dying. They work in partnership with health professionals and others to minimise the risks of stillbirth and to ensure the families of those babies who do die receive the best possible care.)
- Midwives observed women for anxiety and depression levels.
- Appropriate non-directive help and support was demonstrated for women by the staff before and after termination of pregnancy. Psychological support and counselling was available and offered. We saw information on these services was provided.
- Counselling and psychology support for termination of pregnancy was provided at the hospital. Staff also referred women to their GP's if further support was required.

Maternity and gynaecology

- Staff in the hospital chaplaincy team provided pastoral and religious support to patients and their families.

Are maternity and gynaecology services responsive?

Requires improvement

We rated maternity and gynaecology services as requires improvement for responsive because:

- The trust had serious concerns around the accuracy and quality of its referral to treatment (RTT) data and reported position. The hospital had not met the set targets for RTT waiting times non-admitted, admitted and incomplete. The service was monitoring their RTT performance as part of their improvement plan. Figures from October 2016 (unvalidated data), showed gynaecology was performing below the national standard of patients being seen within 18 weeks. 76% of patients were being seen within 18 weeks, although below the national standard of 92%, the hospital was on track to achieve their trajectory target of 77% by the end of November 2016.
- The trust monitored monthly and quarterly the hospital's performance on the 31 day wait for second and subsequent treatment radiotherapy, 62 day wait for first treatment from consultant screening service referral for all cancers. This was broken down into speciality. From information provided by the trust, the hospital's RTT recovery performance for the medical oncology position on 7 November 2016 was 63% (according to data pending validation), which was below the national standard of 92%.
- Gynaecology services were not always responsive to patient's needs for example; there were no side rooms on the gynaecology ward. This meant that women who were having a termination due to abnormalities were cared for on the delivery suite in rooms next to women delivering healthy babies.
- The maternity and gynaecology clinics ran concurrently. Gynaecology and obstetrics patients and women attending for these appointments shared the same waiting room. This meant that patients who may be having difficulty in conceiving or had experienced a miscarriage were sharing the same area with pregnant women and this was not sensitive to their needs.
- Lack of medical staffing resources to deliver the gynaecology clinic meant the service was breaching the referral to treatment times. Gynaecology was performing below the national standard of patients being seen within 18 weeks.
- The service had not met the trust's timescales for responding to complaints in the period August 2015 to July 2016, but following the introduction of a revised complaints' policy in July 2016, with longer timescales for a response, improvements had been made in responding to complaints with an average response timescale of 27 days (in the period April to September 2016). This was now in accordance with the trust's policy

However, we also found that:

- Patients' individual needs and preferences were considered when providing care and treatment.
- Women were supported to make a choice about the place to give birth.
- Specialist midwives provided care and support to women. For example, women who suffered pregnancy loss and women with gestational diabetes.
- There were facilities for people who did not speak or read English and who required hearing loops.

Service planning and delivery to meet the needs of local people

- The maternity service met women's individual needs in accordance with the following NICE guidance:
  - QS22 statement 2: Pregnant women were cared for by a named midwife throughout their pregnancy.
  - NICE CG 62: Antenatal care was readily and easily accessible to all pregnant women and was sensitive to the needs of individual women and the local community.
- There was no midwife led birthing unit (MLU) at the hospital. All babies delivered were on the consultant led delivery suite. Midwifery-led models of care were offered to women with an uncomplicated pregnancy as recommended by NICE CG 62. As part of its business planning strategy, the trust was reviewing whether to have an MLU.
- The August 2016 finance report evidenced maternity income had underperformed by £130k. We were told this was due to fewer deliveries than planned (49 women). Staff told us women who were classed as low

risk were attending midwife-led units provided by other providers locally. This was noted on the clinical business unit risk register, however there were no plans at the time of the inspection to open a midwife led unit.

- The service met NICE CG 62 guidance, in that information was given in a form that was easy to understand and accessible to pregnant women with additional needs, such as physical, sensory or learning disabilities, and to pregnant women who did not speak or read English.
- We saw a variety of patient information leaflets available on the maternity and gynaecology wards for example; information on treatment procedures such as colposcopy (A colposcopy is a procedure to find out whether there are abnormal cells on or in a woman's cervix or vagina.), perineal repair, dilatation and curettage (D&C) and on conditions such as pelvic pain, urogynaecology (surgical and non-surgical treatment of pelvic floor disorders), prolapse vulval (become weak and collapse inwards), perineal lesions (lesions around the anus in a woman who is pregnant) and recurrent miscarriages. The information provided was generally in English although staff told us all information could easily be provided in other languages. Some of the information leaflets such as the leaflets provided following the death of a baby, the birth registration following a still birth, baby memorial book and practical help and advice.
- There was a Maternity Services Liaison Committee (MSLC), although they had changed their name to the Maternity Northants. A meeting was held every quarter, the meeting was for women and partners who had used maternity services to meet and discuss feedback and developments within the service. Meetings were also attended by members of the maternity senior management team.
- During our last inspection, we found the provider was aware that the current shower and toilet facilities in some of the maternity wards were not fit-for-purpose, or compliant with disability requirements. Refurbishment of the Rockingham wing was underway at the time of the current inspection to provide facilities to better meet needs of patients

Access and flow: Gynaecology

- The trust had serious concerns around the accuracy and quality of its referral to treatment (RTT) data and reported position, with the correction of this being a hospital priority. The hospital was working on a plan of data improvement including education, training, changes to systems and process and validation of patient pathways.
- The hospital was not reporting referral to treatment (RTT) performance at the time of inspection due to historical problems with data. The most recent RTT reported was November 2015. The hospital was working to resolve the issues by validating samples of their data and planned to report again from December 2016.
- The hospital was monitoring their RTT performance as part of their improvement plan. Figures from October 2016, showed gynaecology was were performing below the national standard of patients being seen within 18 weeks. 76% of patients were being seen within 18 weeks, although below the national standard of 92%, the hospital was on track to achieve their trajectory target of 77% by the end of November 2016. This target was agreed with the local clinical commissioning groups as part of the overall recovery plan for RTT performance.
- The hospital provided a monthly clinical business unit (CBU) performance report for women and children. For June 2016 the gynaecology department had met the referral to treatment target for
  - 31 day wait for second or subsequent treatment anti-cancer drug treatments. The hospital had achieved 98% against the target of 100%
  - 62 day wait for first treatment from urgent GP referral to treatment, all cancers. The hospital had achieved 85% against the target of 84%
  - Maximum waiting time of 2 weeks from urgent GP referral to first outpatient appointment for all urgent suspect cancer referrals. The hospital had achieved 96.5% against the target of 93%.
- The hospital had not met the set targets for
  - Referral to Treatment waiting times non-admitted (achieve monthly). The hospital had achieved 85.6% against the target of 95%
  - Referral to Treatment waiting times, admitted (achieve monthly) The hospital had achieved 56.1% against the target of 90%
  - Referral to Treatment waiting times, incomplete (achieve monthly) The hospital had achieved 50.0% against the target of 92%
- The trust monitored monthly and quarterly the hospital's performance on the 31 day wait for second and subsequent treatment radiotherapy, 62 day wait for first treatment from consultant screening service referral

for all cancers. This was broken down into speciality. From information provided by the trust, the hospital's RTT recovery performance for the medical oncology position on 7 November 2016 was 63% (according to data pending validation), which was below the national standard of 92%.

- Information provided by the hospital showed in October 2016, the gynaecology department was were performing below the national standard of patients being seen within 18 weeks. 76.1% of patients were being seen within 18 weeks. Although below the national standard of 92%, the hospital was on track to achieve their target of 77% by the end of November 2016.
- Issues in outpatient departments to deliver the gynaecology cancer pathway meant there were a number of women breaching the referral to treatment times. The two week wait for cancer patients had been managed by adding two additional clinics on Mondays and Fridays.
- Colposcopy and hysteroscopy was offered on an outpatient basis. (A colposcopy is a procedure to find out whether there are abnormal cells on or in a woman's cervix or vagina. A hysteroscopy is a procedure carried out to examine the uterus).
- The service carried out 373 medical terminations and 218 surgical terminations between and April 2015 and March 2016 in the termination of pregnancy service (TOP).
- The TOP clinic was provided from the ambulatory gynaecology clinic, and a designated area on the gynaecology ward. All young people would be seen in gynaecology rather than paediatrics.
- The TOP service held two clinics per week. This ensured women were offered the abortion procedure within five working days of the decision to proceed, that the total time from access to procedure did not exceed ten working days and women who present beyond 12 completed weeks or require abortion for urgent medical reasons, receive care promptly to minimise further risk to health.
- Women attending appointments in the TOP service received details of a 24-hour telephone helpline number to use if they had any concerns.

Access and flow: Maternity

- Women could access the maternity services via their GP or by contacting the community midwives directly.
- Post-natal follow up care was arranged as part of the discharge process with community midwives and, where necessary, doctors. We observed this being arranged during our inspection. The red book was issued on transfer to the postnatal ward and facilitated on-going care and monitoring of the baby until five years of age.
- Between October 2014 and March 2016, the bed occupancy levels for maternity were generally higher than the England average, with the hospital having 66% occupancy between January and March 2016 compared to the England average of 61%.
- Community midwives carried out home assessments and home deliveries. There were 80 home births between October 2015 and June 2016.
- There were no designated triage area: women with urgent health issues, such as pain, vaginal bleeding or suspected broken waters, could be assessed and reviewed on the delivery suite. Triage is the process of determining the priority of a pregnant woman's treatment based on the severity of their needs. Women were provided with the telephone number for the unit and could access it directly if they had any concerns. We observed triage support provided, for example, when women contacted the hospital for advice by the delivery suite staff that demonstrated appropriate help and support was provided for mothers in labour before arrival at the acute setting. The midwives discussed the name of women, gravida (number of times they had been pregnant), gestation of pregnancy, expected date of delivery and the reason for their call to the triage. A plan of action was discussed and the community midwife agreed to, for example, visit the women at home to address their concerns.
- A midwifery-led early pregnancy assessment unit (EPAU) offered appointments between 8:30am and 4:30pm each weekday and on Saturday mornings between 9:30 and 1pm. Referrals for investigation and treatment into bleeding in early pregnancy were accepted from midwives, GPs, nurse practitioners and emergency department. There was access to scans and medical opinion was accessible from the on call registrar.
- Bed occupancy levels for maternity were generally higher than the England average between October 2014 and March 2016 with the hospital having 66% occupancy in March 2016 compared to the England average of 61%.

- Between January 2015 and June 2016, the maternity unit was not closed on any occasion.
- Care and treatment was only cancelled or delayed when absolutely necessary. If services were cancelled, reasons for cancellations was explained to people, and people were supported to access care and treatment again as soon as possible.
- NICE guidance recommends that women are seen by 10 weeks of pregnancy so that the early screening of for example; Downs's syndrome, which must be completed by the 13 weeks and six days of pregnancy, could be arranged in a timely manner. The service told us between January 2015 and June 2016, 80% of women were seen by a midwife for their booking appointment before 10 weeks of pregnancy and between 88 to 94% before 12 weeks.
- Staff told us that often clinics did not run on time, and that over booking of clinics had resulted in clinic delays. We saw one incident recorded in June 2016 where four women booked for one appointment slot, which had resulted in a delay. We did not see any formal complaints about clinic delays, however, women we spoke with in the clinic said that clinics regularly over ran but staff had kept them informed of the reasons for delay and ensured they were as comfortable as they could be. The service was not monitoring these waits.

Meeting people's individual needs

- Gynaecology services were not always responsive to patient's needs for example; there were no side rooms on the gynaecology ward. This meant that women who were having a termination due to abnormalities were cared for on the delivery suite in rooms next to women delivering healthy babies. The issue was on the trust risk register.
- The maternity service had arrangements in place to support women who had complex needs, with access to clinical specialists and medical expertise.
- Booking appointments were generally held at clinics within the local community but alternative arrangements could be made to meet women's individual needs, such as home visits.
- We saw evidence of women being offered information so they could make an informed choice about where to give birth depending on clinical need. The maternity service offered home birth or obstetric led care on delivery suite. Two birthing pools were available for women who wished to use water immersion for pain relief in labour. Women who wanted to have midwifery led care were required to access care from another provider, as this service was not available at KGH.
- A maximum of two birthing partners could stay with women during labour on the delivery suite. Partners could stay to support during induction as a response to patient feedback. However, the service did not have facilities for the partners to stay in the postnatal period once the women had moved out of the delivery suite. We were told the service was reviewing the potential of partners being enabled to stay longer following the birth of their baby in response to comments about the importance of this time period for new parents.
- Most adult wards did not offer the facility for carers or relatives to stay with patients overnight however there were facilities for relatives or carers wishing to stay on site. Rooms with allocated parking bays could be booked through the hospital's staff housing provider in exceptional circumstances.
- On the delivery suite, the team had launched a listen to me campaign. On arrival on the unit, each woman was allocated a midwife and this was their named individual so if they had any concerns in relation to their care they could raise this with their named individual. Leaflets were given to all women to explain this campaign. The name of the senior midwife was also give to each woman so if they felt they had not been listened to by their allocated midwife who would follow up any concerns. Women we spoke with were aware of the listen to me campaign.
- Women had access to healthcare professionals with expertise in perinatal, antenatal and postnatal mental health support. The service provided a vulnerable midwifery team. Each geographical area had a midwife who provided care for vulnerable women including women with a learning disability of a physical disability such as sensory loss. They managed a smaller caseload to reflect the work involved with their caseload. A midwife support worker supported them.
- The Kettering maternity team had a consultant led clinic at the local children's centre. Staff told us discussions about extending this into the other sectors in Corby and Wellingborough had taken place but at the time of inspection, no formal plans were in place. The women in these caseloads met level four or complicated level three threshold within social care. This multi-agency threshold framework is a guidance tool that all

agencies, professionals and volunteers can use to consider how best to meet the needs of Individuals, children and young people. People at level three had diverse and complex needs and targeted, multi-agency support services were required and were supported by a clear co-ordinated action plan. People at level four who required intensive help and are in need of specialist support. People accessed specialist services following a statutory assessment. Specialist services included Children's Social Care, the Youth Offending Service, SEN Services and CAMHS. This could be due to safeguarding issues where there was no risk of actual or likely significant harm, but needs were acute and multi-agency plans were not effective; or because there were child protection issues, where there was actual or likely significant harm. The lead safeguarding midwife provided their supervision.

- The service had a named midwife for diabetes who worked overall as part of a multidisciplinary team. Women with pre-existing diabetes and those with a history of gestational diabetes are at higher risk of serious complications and morbidity. The named midwife for diabetes supported the clear pathway for women with diabetes from preconception to the postnatal period will optimise the plan of care to improve outcomes for the woman and her baby.
- There were effective processes for screening for fetal abnormality. Women identified with a high risk of fetal abnormality, such as Downs's syndrome, were invited into the clinic for on-going treatment and referral to specialist centres if appropriate.
- The service provided a birth options clinic. The clinic provided an opportunity for women who have previously had a caesarean section or traumatic birth to explore the birth choices for their current pregnancy.
- There were two midwives who shared the bereavement role for families but also led the work required for MBRRACE. MBRRACE-UK: Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK is the collaboration appointed by the Healthcare Quality Improvement Partnership (HQIP) to continue the national programme of work investigating maternal deaths, stillbirths and infant deaths, including the confidential enquiry into maternal deaths.
- There was a dedicated bereavement room for women who had experienced a stillbirth. Cold cots were available which meant that babies could stay longer with parents. Cold cot are specialised piece of equipment is designed to keep baby cool following still birth to allow parents to spend up to 72 hours with baby. They are designed to fit in to a Moses basket to keep the environment homely at such a traumatic time.
- Keep sake boxes containing items such as photographs, imprints of the baby's hand and feet were made up for parents who suffered pregnancy loss. The mother could take the box away with them or these could be stored on the delivery suite until the mother was ready to take it home.
- We found that the antenatal clinic was also used as a gynaecological clinic, and we observed both maternity and gynaecology clinics running concurrently. This meant gynaecology and obstetrics patients and women attending for these appointments shared the same waiting room and clinic times this meant that patients who may be having difficulty in conceiving or had experienced miscarriage were sharing the same area with pregnant women and this was not sensitive to their needs. This risk had not been identified by the service.
- Staff provided women who had undergone termination of pregnancy (TOP) with an information leaflet about the disposal of pregnancy remains. Women were asked their preferred option for the dignified option of disposal. This ensured that women were given the opportunity of making informed individual choice. We saw completed documentation in TOP notes we viewed. There was guidance on the disposal of pregnancy remains following pregnancy loss or termination, which were in line with guidance provided by the Human Tissue Authority Guidance on the disposal of pregnancy remains following pregnancy loss or termination March 2015 and RCN guidance about managing disposal of pregnancy remains October 2015.
- Post-mortem examinations were offered in all cases of stillbirth and neonatal death in order to improve future pregnancy counselling of parents which was in line with Recommendation 4 of the MBRRACE UK findings (published on 10th June 2015).
- Women needing termination of pregnancy for fetal abnormality were cared for in labour by a bereavement midwife. This offered continuity of carer for the women if she wanted it.
- Visiting times on the gynaecology ward (Maple) was between 2pm to 4pm and 7pm to 8pm and between 8am and 8pm for partners and family and between 3pm and 8pm for other visitors on the antenatal and

post-natal ward (Rowan). Information on visiting time was provided to all visitors. Under certain circumstances, it was possible to visit the wards outside of these hours following discussion with ward staff.

- The service did not have facilities for the partners to stay in the postnatal period once the women had moved out of the delivery suite. We were told the service was reviewing the potential for partners being enabled to stay longer following the birth of their baby in response to comments about the importance of this time period for new parents. We were not given a time scale for this review at the time of inspection.
- Visiting times on the gynaecology ward (Maple) was between 2pm to 4pm and 7pm to 8pm. Visiting times for the antenatal and post-natal ward (Rowan) was between 8am and 8pm for partners and family and between 3pm and 8pm for other visitors on Information on visiting time was provided to all visitors. Two birthing partners could stay with women during labour on the delivery suite. Partners could stay to support during induction as a response to patient feedback. The service did not have facilities for partners to stay in the postnatal period once the women had moved out of the delivery suite. We were told the service was reviewing the potential of partners being enabled to stay longer following the birth of their baby in response to new parents feedback.
- Women, patients and their relatives had access to a chapel and multi faith room on site.
- Hearing loop facilities were available throughout the hospital.
- We saw evidence of women being offered appropriate information so they could make an informed choice about where to give birth depending on clinical need. We saw evidence of discussions held where risk assessments resulted in a change of place to give birth. For example, we saw that where risks identified had made a home birth not advisable, a change to the consultant led unit was chosen.
- The hospital had a varied menu and catered to a wide range of nutritional and cultural needs. We did not receive any complaints about the quality or variety of the food from the women we spoke with. Food such as light snack and fluids were available and offered to women in labour and after a caesarean section.
- Staff told us information leaflets could be requested in different languages. We saw that there was an interpreter service available face to face or by telephone.
- We noted there were no privacy screens around beds on the delivery suite. If a patient was on the bed receiving care, privacy and dignity was not always achieved when a person walked room or opened the door. Staff were not aware of the issue until we raised it.

Learning from complaints and concerns

- Women we spoke with told us they knew how to make a complaint or raise concerns they told us staff had explained the process.
- The service had not met the trust's timescales for responding to complaints in the period August 2015 to July 2016, but following the introduction of a revised complaints' policy in July 2016, with longer timescales for a response, improvements had been made in responding to complaints with an average response timescale of 27 days (in the period April to September 2016). This was now in accordance with the trust's policy. There had been 22 complaints made about maternity services between August 2015 and July 2016. Six of the 22 complaints related to problems with communication, four to the attitude and behaviour of nursing staff, and four to treatment by medical staff.
- Complaints were handled confidentially, with a regular update for the complainant we saw a formal record of complaints were kept. Once investigated the outcome was explained appropriately to the individual We saw there was openness and transparency about how complaints and concerns were dealt with.
- Information about complaints was shared with the relevant team, for example, we saw evidence of learning in team meeting minutes and on staff newsletters to ensure lessons learnt were used to improve the quality of care.
- During our last inspection, we received two significant complaints around an uncaring approach to pain management, and the lack of 24-hour facilities to support fathers as an integral part of the pregnancy process. We did not receive any complaints about care during the current inspection. We received positive

feedback from all the women we spoke with about the provision of pain relief and we saw partners could stay to support during induction as a response to patient feedback.

Are maternity and gynaecology services well-led?

Requires improvement

We rated the service as requires improvement for well led because:

- Whilst there was evidence to demonstrate information about midwifery issues were taken to the trust's board, we were not confident the board had full oversight and understanding of all issues affecting the service.
- There was not always effective systems in place to monitor, audit and use learning from quality and safety information to drive improvements throughout the service.
- There was not an effective, holistic understanding of performance, which integrated the views of patients with safety, quality, and service performance information.
- Risks had not always been dealt with appropriately. There was evidence not all risks were identified and placed on the risk register.
- Whilst a new strategy for the service had been developed and implemented, it was not yet fully understood by all staff in the service. We were not assured progress against delivering the strategy was regularly monitored and reviewed.

However, we also found that:

- There was clear leadership at a local level, with wards and units being well managed.
- Local leaders demonstrated they had some understanding of the challenges to good quality care and had identified the actions needed address them.
- Midwifery and gynaecology nursing staff were flexible and told us they worked hard to support each other. They all had a strong commitment to their jobs.

Leadership of service

- We observed clear leadership at a local level with wards and units being well managed. Local leaders demonstrated they understood the challenges to good quality care and had identified the actions needed to address them.
- There was a clear management and accountability structure in place for midwives and nurses, which included community midwifery. The department had a documented accountability structure. Gynaecology nursing and midwifery leads reported into the head of midwifery, who was also the CBU lead for women's and children services. They provided operational leadership. Medical staff reported to the clinical director. Medical staff reported to the clinical director via the consultant obstetrician who was the medical clinical lead.
- Senior midwifery management had direct access to the board. However, there was limited evidence to demonstrate information about how midwifery issues were taken to the board. We did not see evidence of midwifery issues discussed in board minutes so we were not confident the board had oversight and understanding of all the issues affecting maternity service.
- The service did not meet all the safer childbirth recommendations. To ensure 24-hour managerial cover, the labour ward had a rota of experienced senior midwives who provided labour ward shift coordinators role. They were supernumerary to the staffing numbers required for one- to-one care. The service had a consultant obstetrician who provided clinical leadership and a labour ward manager. However, the service did not have a consultant midwife. At the time of inspection, the service did not have plans to introduce a consultant role. The service did not meet the recommendation there should be one supervisor of midwives to every 15 midwives. The SOM ratio was 1:16, which meant that there were not enough SOMs to support midwifery practice, identify shortfalls, and investigate instances of poor practice. However, with the abolishment of Midwifery Supervision as of 31st March 2017 the LSA had not been supporting any further training of Supervisors of Midwives and therefore the service was unable to train any more supervisors and as such could not address the ratio.

- Staff told us that they had good working relationships with their managers and felt able to raise concerns if they needed to and that on the wards they regularly saw their local managers. Staff told us leaders were visible and approachable.
- Community midwives reported that they had a good relationship with their local team manager. They told us the head of midwifery was approachable and felt able to contact her if they needed to.
- There were specialist roles within midwifery and nursing, including, a safeguarding midwife, bereavement midwife, practice development midwives, early pregnancy assessment unit nurse and oncology nurse.
- There were consultant leads for specific services within obstetrics and gynaecology for example; there were leads for colposcopy, labour ward, urea-gynaecology and oncology
- The delivery suite had a consultant obstetrician as clinical lead, a lead midwife and a rota of experienced senior midwives who acted as labour ward shift coordinators. They were supernumerary to the staffing numbers required for one- to-one care. However, the service did not have a consultant midwife. A consultant midwife was a recommendation by the safer childbirth guidelines 2007.
- We saw from ward meeting minutes that managers thanked staff for their hard work and dedication to providing care for women and their babies and support for their colleagues.
- During our last inspection, we found a lack of medical leadership and scrutiny regarding performance indicators. The trust told us it had set of expected standards and behaviours for its operational leaders. We saw these were included in job descriptions in the key roles and responsibilities section of job descriptions. However, staff we spoke with were not able to describe these and we did not see any evidence that the leadership had changed or that this had been addressed on the current inspection.

Vision and strategy for this service

- The hospital had launched the nursing and midwifery strategy 2016 to 2020 called 'Delivering safe high quality care to our communities' in October 2016. The strategic plan was written following recommendations from the Francis Report (2013), the Government's response 'Putting Patients First" and the findings of the Kirkup report (2013). Most of the staff knew of the new strategy, which had been launched but were unable to tell us in detail about it.
- Documents about the vision of the hospital "to provide the very best care for every patient every day" were clearly displayed throughout the service and most of the staff we spoke with were able to tell us about the hospital's vision, they said they felt part of the service and part of the hospital.
- There was a clear vision and a set of values for the women and children's clinical business unit of which quality and safety were a priority. Staff we spoke with were able to tell us about the vision and strategy. However, we were not assured progress against delivering the strategy was regularly monitored and reviewed. We reviewed minutes of the clinical management team governance meetings for June 2016 July 2016 and August 2016, we did not see evidence that the strategy was a regular agenda item at the clinical management team governance meetings.
- The director of nursing and quality had a responsibility to the board for maternity services. The trust told us it had a nominated non-executive director with responsibility for maternity services however they did not identify who this was and staff we spoke with were unaware of who the non-executive director with responsibility for maternity services was.
- During our last inspection and this inspection, we found there were no consultant midwives for the unit; consultant midwives were recommended by the safer childbirth guidelines 2007. The consultant midwife role is a strategic one with the potential to provide leadership and influence a range of areas including the promotion of normal childbirth, the midwifery contribution to research and evidence-based practice through to audit. Without a consultant midwife there was a risk opportunities for strategic development would be lost.

Governance, risk management and quality measurement

- We were not assured an effective governance framework to support the delivery of the strategy and good quality care was in place. Not all risks identified by staff and inspection team during the inspection had been recognised by the service and placed on the risk register for example the low attendance at mandatory training,

referral to treatment times the security issues on the antenatal post-natal ward, the locally devised maternity dashboard data did not meet Royal College of Obstetricians and Gynaecologist Guidelines (RCOG) good practice No.7 Maternity dashboard, clinical performance and governance scorecard and the delay in the management of complaints.

- There was not an effective, holistic understanding of performance, which integrated the views of patients with safety, quality, and service performance information.
- The maternity and gynaecology risk register at the time of the inspection contained eight risks. One of the risks relating to gynaecology had been closed in September 2016. It identified information governance at risk due to exposed nature of the nurses' station, which included for example; the risk of patient information on display to hospital staff, patients and visitors who had no rights or needs for the information. The risk had been closed as Maple ward had moved. However, we saw similar risks on Rowan ward that had not been recorded on the risk register. We saw patient records were stored in an open trolley behind the nurses' station on the ward. The nurses' station was often unmanned. This meant that patient records were not stored securely and patient's information was not always protected.
- The maternity dashboard data did not meet RCOG good practice No.7 Maternity dashboard, clinical performance and governance scorecard. We saw evidence the management team were aware of this risk and an action plan had been developed. However, the concerns about the limited scope of the dashboard were not on the service's risk register.
- We were not assured the antenatal and post-natal ward (Rowan ward) had sufficient security arrangements to prevent intruders from entering the ward and minimising the risk of visitors accessing the ward without being challenged. A video intercom entry system was used to identify visitors and staff requesting entry into Rowan ward. We observed staff asking visitors who they were visiting before entering the wards. Access and from to the wards was gained via a set of double doors and once the doors had been released open through the buzzer entry system, the doors took 20 seconds to close which meant it was easy for someone to tailgate into the department some-time after the original requesting visitor had entered or left. This meant that there was a risk that someone could access the ward without being challenged. On the delivery suite, entry to the ward was managed by ward clerks who provided 24-hour cover. This reduced the risk of unauthorised access to the delivery suite. However, the ward clerk provision was not 24-hour on the postnatal/ antenatal (Rowan) ward. There was a potential risk of visitors accessing the ward without being challenged. This had not been identified as a risk on the risk register. Staff said, and we saw members of staff who allowed visitors access to the unit, that they spoke to the visitor to check who they were visiting. This had not been identified as a risk by the management team or on the clinical business unit (CBU) risk register.
- We saw the risk register was discussed at the clinical management team governance meeting in May 2016. However, there was no review of the current register as a whole until June 2016. We saw some evidence of progress against risks on the register was noted however, only two out of eight had action targets or completion dates and four were missing a risk status.
- The management team met weekly to review incidents, which were reviewed at the monthly obstetrics and gynaecology governance group, which in turn reported to the monthly hospital quality board.
- The quarterly perinatal mortality and morbidity meeting reviewed adverse events in order to identify the causes so that steps could be taken to prevent recurrence
- Staff told us that they received feedback in various ways. Performance issues were taken up with the individual staff member. A quality and risk newsletter was available electronically and in hardcopy to share lessons learned from incidents and complaints
- Guidelines were reviewed by the quality and governance lead midwife. Guidelines were discussed at the obstetrics and gynaecology governance group meeting. However, we saw that not all guidelines were in date. This meant there was a risk that not all guidance would be in line with current legislation and this risk had not been recognised by the service.

Culture within the service

- Staff we spoke with told us they felt respected and valued. Staff told us there were good working relationships amongst their peers as well as other disciplines and that Kettering hospital was a friendly place to work.
- Midwifery staff were flexible and told us they worked hard to support each other. They all had a strong

commitment to their jobs. Staff described a very supportive team culture. They told us that they 'willingly worked over and above to ensure women have a good service'.

- From our observations and discussion with staff, they demonstrated a strong commitment to meeting the needs and experiences of patients. All staff were welcoming, friendly and helpful. It was evident that staff cared about the services they delivered. Midwives were keen to normalise the birth experience and to ensure that appropriate support was available following the delivery.
- Staff told us that they were encouraged to report incidents and that they felt confident in doing so and the importance of sharing information with patients and families when an incident occurred involving them; we saw evidence of this in the serious incident reports reviewed.
- We saw action was taken by leaders in the service to address behaviours and performance that was inconsistent with the vision and values.
- Community staff felt part of the overall maternity service. They often supported their delivery suite colleagues by providing staff cover when necessary. The felt respected and valued.

Public engagement

- Patients were given the opportunity to provide feedback through a range of surveys as well as making a formal complaint.
- There was a Maternity Services Liaison Committee (MSLC), which had changed its' name to the Maternity Northants. A meeting was held every quarter, the meeting was for women and partners who had used maternity services to meet and discuss feedback and developments within the service. Meetings were also attended by members of the Kettering hospital maternity senior management team.
- The service contributed to the national inpatient survey, national maternity survey as well as the national friends and family test survey. Information from the Friends and Family Test and complaints were used to monitor and shape services provided. We saw: 'You said, we did' posters, displayed on wards which listed actions they had taken in response to feedback and complaints received.
- We were provided with evidence of issues raised through the different surveys as well as action taken to address these concerns.
- There was evidence that action had been taken from other comments gathered locally, for example, visiting hours on the postnatal / antenatal ward had been extended and partners could now stay with women who were being induced.

Staff engagement

- Staff we spoke with said they felt involved and engaged in the planning and delivering of services and in shaping the culture. They had been involved in the environmental changes made the maternity department. They felt the management team were responsive to their comments.
- There was a staff recognition scheme called the smile awards. Patients, relatives, staff and visitors were invited to recognise staff who went the extra mile by nominating them for a smile award under one of 3 categories; clinical, non-clinical and team. Nominations were reviewed each month and one that stood out from each category was recognised.
- We saw information displayed on the wards advising staff of the whistleblowing procedure.
- Staff we spoke with said Kettering hospital was a friendly hospital with a family feel. Staff said they felt support by their peers and their line managers.
- Staff had the opportunity to provide feedback daily at handover meetings, monthly team meetings as well as during their supervision or appraisal. Most staff felt there was value in raising concerns and action had been taken to respond to their concerns.

Innovation, improvement and sustainability

- The hospital received the UNICEF Baby Friendly Initiative accreditation for its maternity department and neonatal unit in August 2015. Baby Friendly Initiative accredits organisations that have established and implemented very high standards of care for all pregnant women and new mothers. It means the organisation has shown it is committed to supporting mothers to initiate breast-feeding and encourages them to exclusively breastfeed for the first six months while at the same time also supporting parents who choose to bottle feed.
- The service told us the delivery suite had launched the "Listen to me" campaign to ensure women felt listened

to during their stay on the delivery suite. Women were allocated a midwife; women could raise any concerns in relation about their care during their stay. The delivery suite also had a listen to me campaigner who could be contacted if anyone felt they needed to speak to someone else. Leaflets had been developed to provide information on the campaign and we saw these were available on the delivery suite. Women we spoke with on the delivery suite were aware of the campaign.

- The service had organised a MDT study day with obstetricians, paediatricians, midwives, paediatric nurses and neonatal intensive care unit (NICU) nurses as wider team to look at lessons learnt as a result of serious incidents. Staff told us this study day had encouraged them to reflect and learn how to manage communications to ensure positive experiences.
- The delivery suite staff were in the process of organising a further exercise for the delivery suite co-ordinators and other key staff, to understand the impact of positive communications.
- A 'Great expectations' group had been set up by the community team and provided support and guidance for women who had had been identified as being at risk of suffering with anxiety and depression in maternity.
- The trust told us they felt the development of the tool was a pioneering and innovative project as they were not aware that such a tool was being used by other organisations.

Services for children and young people

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

Information about the service

The children's and young people's service at Kettering general hospital consisted of a Neonatal Intensive Care Unit (NICU) and a paediatric ward (Skylark ward) as well as an outpatient centre.

The NICU has 18 cots. There were four cots for babies who required intensive care, six cots for babies who required higher dependency care and eight cots for babies who required special care.

The paediatric ward had 26 inpatient beds; all 26 beds were open from Tuesday to Friday evenings, when the elective lists were running. From Friday evenings until Tuesday mornings, only 18 beds were open. There were two beds for children who required closer observation and cubicles, which could be used for isolation. There were 16 beds in cubicles as well as two four bedded bays.

The paediatric assessment unit (PAU) was co-located on the ward and consisted of six beds in total and was open Monday to Friday from 9am to 9.30pm. There were two single cubicles and one four bedded bay.

Services for children and young people had a dedicated outpatients' area for patients attending some appointments. Some patients were seen in adult areas, for example at the dedicated diabetes centre, ear, nose and throat (ENT) and maxillofacial clinics.

During the inspection we visited the NICU, paediatric ward, outpatients' area and theatres. We spoke with a 28 members of staff, including nurses, doctors, support assistants as well as eight patients and their relatives.

We observed interactions between staff, patients and parents. We reviewed 43 patient records and 10 policies and procedures as well as other documentation as necessary. We reviewed data provided by the hospital.

Services for children and young people

Summary of findings

Overall, we rated children and young people's services as inadequate because:

- Safety was not a sufficient priority. There was limited measurement and monitoring of safety performance.
- Incidents were not always reported on a timely basis and some had not been investigated within a reasonable period. Lessons learned from incidents were not always shared so that improvements were not made. Ligature audits had not been undertaken.
- Care premises were not safe. The environment was not safe and secure, particularly for patients who may be at risk of self-harm or suicide. The trust took actions to address this once we had raised it as an urgent concern.
- Staff did not assess, monitor or manage risk to patients so opportunities to prevent or minimise harm were missed. Assessments were not always made for patients with mental health conditions who required one to one care and this care was provided at times by the patient's parent or carer, rather than trained professionals.
- There was insufficient attention to safeguarding children. Safeguarding children and adult policies were not effective and not all staff had completed the required level of children's safeguarding training. Relevant safeguarding checks were not always recorded.
- Nursing staff had not completed training in Advanced Paediatric Life Support and only a small number had completed European Life Support. Not all shifts had a member of nursing staff trained to the required level in life support. Nursing staff had not received training in mental health needs of patients. Nursing staff had not been assessed for the competence in use of tracheostomy
- Staffing levels on Skylark ward and in the neonatal intensive care unit levels did not always meet patients' needs increasing risk to patients. The paediatric ward did not use an acuity tool to inform staffing levels and did not always meet staffing levels recommended in accordance with national guidance. There was inadequate medical staffing cover.
- The paediatric outpatient department was not always staffed by registered children's nurses.
- Patient's care was not consistently planned and delivered in line with evidence based guidance. Guidance had not been developed for all care requirements and some did not reflect the most up to date guidance. Audits were not used to effectively monitor the standard of care provided.
- The clinical audit plan was not suitable to ensure audits took place to monitor care provided against expected standards. Procedures and guidance available to staff was not always up-to date. Action plans following some audits lacked detail and were not monitored and it was unclear whether they had been implemented.
- Patient records were not always available on the ward and there was high usage of temporary notes. GP discharge letters were not sent out on a timely basis.
- Service planning had not used evidence based data and the needs of the local population had not always been considered. Patients and stakeholders were not involved in service development. Formal transition arrangements were not in place for all specialities when patients transferred from paediatric to adult services.
- Patients admitted to the ward with mental health needs or who required a musculoskeletal survey had long delays in waiting to be assessed and discharged.
- Some patients also experienced long delays waiting for treatment, specifically for urology, maxillofacial and ear, nose and throat (ENT). In some cases waits were in excess of 52 weeks.
- There was a significantly high conversion rate between patients who attended the emergency department and those admitted to the paediatric ward.
- There was limited support from a psychologist for patients diagnosed with long-term conditions. There was limited support for patients with a learning disability. Communication tools for patients who were unable to communicate verbally lacked detail.
- Not all complaints were responded to on a timely basis or in line with policy, but this was improving. There was limited learning from complaints.

Services for children and young people

- The delivery of high quality care was not assured by the leadership or governance in place. The service did not have a clear vision. Objectives in the business plan had been set but were generic and not specific to the service and were not supported by clearly defined actions. The majority of staff were unaware of the vision for the service.
- There was not an effective system for identifying, capturing and managing risks and issues at team, directorate and organisation level.
- There were delays in investigating and closing incidents. Learning from two serious incidents had not been embedded in the service to prevent the risk of harm to other patients.
- Significant risks identified on inspection that threatened the delivery of safe and effective care had not been recognised, assessed or mitigated by the service. There was not a holistic understanding throughout all staff teams of the risks in the service.
- Leaders did not always recognise the significance of risks throughout the service or weaknesses identified as part of audits or reviews. Quality and safety were not a top priority.
- The clinical audit plan lacked focus and failed to ensure the provision of care was adequately monitored. Complaints' management systems were not effective.
- There was limited evidence that the views and experiences of patients and those close to them were gathered and acted on to shape and improve the service. There was little innovation or service development.

However, we also found that:

- Good standards of cleanliness and hygiene were maintained.
- The paediatric department, including NICU, had adequate equipment to meet the needs of children and young people, which was maintained and portable appliances had been subject to relevant safety tests. Clinical waste was appropriately stored and disposed of.
- There were suitable arrangements in place for management of medicines, which included the safe ordering, prescribing, dispensing, recording, handling and storage of medicines.
- Most patient records contained accurate information, were legible and up to date; records were stored securely.
- Assessments were made of patient's pain levels and generally arrangements made to ensure their pain was managed effectively. Patients' nutritional and hydration needs were met during their stay in hospital.
- Most staff within the clinical business unit had received an appraisal and the hospital target of 85% had been met. All medical and nursing professionals had an up to date registration.
- Staff understood the relevant consent and decision making requirements of legislation and guidance and consent was obtained in line with legislation.
- Staff interactions with patients were positive and patients were treated with dignity and respect. Patients told us that staff were helpful and that they explained things to them in a manner they could understand and that their relatives or carers were involved.
- There was a play specialist who provided additional support for children on the paediatric ward who required support during their admission.
- The length of stay was in line with the national average.
- There were facilities to engage and occupy young children and teenagers admitted to the ward. There were overnight facilities for parents to stay on both the paediatric ward and NICU.
- Local leaders were visible and approachable. The service was supportive of staff and care provided was patient focused. Staff felt well supported and listened to, there was a strong culture of putting the patient first.

Services for children and young people

Are services for children and young people safe?

Inadequate

We rated the service as inadequate for safe because:

- Safety was not a sufficient priority. There was limited measurement and monitoring of safety performance.
- Incidents were not always reported on a timely basis and some had not been investigated within a reasonable period. Lessons learned from incidents were not always shared so that improvements were not made. Ligature audits had not been undertaken.
- Care premises were not safe. The environment was not safe and secure, particularly for patients who may be at risk of self-harm or suicide. The trust took actions to address this once we had raised it as an urgent concern.
- Staff did not assess, monitor or manage risk to patients so opportunities to prevent or minimise harm were missed. Assessments were not always made for patients with mental health conditions who required one to one care and this care was provided at times by the patient's parent or carer, rather than trained professionals.
- There was insufficient attention to safeguarding children. Safeguarding children and adult policies were not effective and not all staff had completed the required level of children's safeguarding training. Relevant safeguarding checks were not always recorded.
- Nursing staff had not completed training in Advanced Paediatric Life Support and only a small number had completed European Life Support. Not all shifts had a member of nursing staff trained to the required level in life support. Nursing staff had not received training in mental health needs of patients. Nursing staff had not been assessed for the competence in use of tracheostomy
- Staffing levels on Skylark ward and in the neonatal intensive care unit levels did not always meet patients' needs increasing risk to patients. The paediatric ward did not use an acuity tool to inform staffing levels and did not always meet staffing levels recommended in accordance with national guidance. There was inadequate medical staffing cover.
- The paediatric outpatient department was not always staffed by registered children's nurses.

However, we also found that:

- Standards of cleanliness and hygiene were maintained on the paediatric ward and NICU.
- The paediatric department had adequate equipment to meet the needs of children and young people, which was maintained and portable appliances had been subject to relevant safety tests.
- There were suitable arrangements in place for management of medicines, which included the safe ordering, prescribing, dispensing, recording, handling and storage of medicines.
- Most patient records contained accurate information, were legible and up to date; records were stored securely.

Incidents

- Staff understood their responsibilities to report incidents and patients were informed when things went wrong. However, incidents were not always reported or investigated on a timely basis and were not subject to a high quality review, although they had been reviewed by a manager within the seven day target. Evidence of decisions and discussion around incidents at meetings was not consistent. Lessons learned were not always shared so that improvements could be made.
- There was a total of 106 incidents reported within the children and young people's acute services from May to October 2016. Minutes of the Women and Children's Health CMT Governance Meeting held in September 2016 reported that there were no themes or trends in incidents reported.
- The hospital had not reported any never events for children and young people in the period November 2015 to October 2016. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- The hospital used an electronic incident-reporting tool to record incidents. The staff we spoke with were confident in the use of this system and told us that they always reported incidents where it was appropriate to do so.
- The hospital had an incident reporting policy, which was ratified in January 2016. The policy stated, 'all incidents are graded on submission by the staff member

completing the form. Incidents graded moderate or above will be reviewed by the Quality and Compliance Manager to ensure the grading is correct. All incidents graded major or catastrophic will be considered to be a potential Serious Incident (SI)'. The policy also provided a brief definition of each categorisation. As an example, we saw that two patient deaths had been reported during a six-month period on the paediatric ward, one of these had been initially categorised as an outcome for the patient as catastrophic and the other as negligible. Although in each of these cases the incidents were being investigated as a serious incident, the policy did not reflect that all incidents should be reviewed for categorisation. After the management review, one incident had been categorised as extreme and the other remained uncategorised by the management team.

- The hospital incident reporting policy informed staff that all incidents, including a near miss should be reported as soon as a member of staff becomes aware of the incident and before the end of the working day. The policy also stated that the incident should be opened and reviewed within 72 hours by the ward matron, and moderate incidents and above would require review at the Serious Incident Review Group (SIRG). Those referred back to the service would require investigation within 10 working days from the SIRG decision. All others would be investigated under the hospital's Management of Serious Incident policy.
- Those determined as serious incidents by the SIRG had set timescales for completion of investigation, depending on whether the incident was reportable externally in accordance with set criteria. For SIs reportable internally a target of 45 days was set and those which required an external report to the commissioners was 60 days for completion. Serious incidents which required an independent investigation, a period of six months was allocated for completion of the report. All external serious incidents had to be reported within 24 hours and all potential SIs must have had a 72 hour report.
- The hospital had also set a target of seven days for all reported incidents to be reviewed by a manager. The nursing quality indicators for June 2016 demonstrated that the hospital was 100% compliant with this target.
- From our analysis, we saw that 10% of incidents had taken between two and 14 days to be reported and there was no justification for a delay for most of these. For example, one member of staff had turned up and worked a shift with diarrhoea and vomiting, another related to a morbidity case which had already been discussed at the mortality and morbidity group. Both of these examples had taken 14 days to report. These included one patient death, which had taken four days to be reported. From the data provided, it was not possible to determine whether the management team had reviewed all incidents within 72 hours, however, we noted that 5% were still pending management review and had exceeded this timescale by at least two weeks.
- We also saw that of 41 incidents had been classified as minor following the management review, of these only 21% had been subject to a local investigation within the required 10 day timescale specified in the hospital policy. For the remainder, 10% had not been subject to a local investigation and were overdue, 36% had taken between 11 and 30 days, 16% between 31and 60 days and 17% between 61 and 151 days.
- We requested the investigation reports for the three serious incidents, which had occurred since December 2015 along with accompanying action plans, meeting minutes where reports were presented, as well as evidence of lessons learned. We were provided with the investigation reports. Two reports were detailed and showed recommendations and evidence of an action plan to ensure learning was applied from the incidents. One report was not dated and was incomplete, there was no action plan. This report lacked detail and failed to identify some of the issues which were apparent, such as not having 1:1 care from an appropriately qualified professional. Although some learning was identified, we saw that further incidents of a similar nature had occurred; therefore demonstrating that learning had not taken place. We raised this with the trust at the time of inspection and action was promptly taken to develop and introduce a new risk assessment form with the support from the Child and Adolescent Mental Health Service (CAMHS) as well as to ensure registered mental health nurses (employed by another provider) are requested to provide 1:1 care as required.
- Concerns from serious incidents were not translated onto the departmental risk register.
- We were told by the management team that shared learning took place and that staff were kept informed about lessons learned in the communication book as well as the staff noticeboard.
- We found that information about incidents was recorded in the book and on the board for some

incidents but not all. For example, there had been two SIs of a similar nature which related to the deteriorating patient: both patients had poor outcomes and lessons learned were recorded on the board. However, lessons learned from recent patient deaths as well as an attempted suicide incident had not.

- We asked staff about learning from incidents. Most of the staff we spoke with told us that there was very little learning or feedback. They told us about the deterioration of patient incidents, but said they were unaware of the outcomes, however, we observed that the outcomes were detailed on the staff notice board. This may have indicated that staff were unaware or staff did not feel confident sharing this information with us. None of the staff, with exception of manager, were able to tell us about a recent patient suicide attempt incident which had happened on the ward. Following the inspection, we were provided with evidence of two serious incidents which had occurred shortly before the inspection. None of the staff we spoke with told us about these incidents.
- There were weekly paediatric / perinatal mortality and morbidity meetings, which were attended by medical staff as well as those presenting a case investigation. Discussions were held around each case presented.
- From November 2014, NHS providers were required to comply with the Duty of Candour Regulation 20 of the health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person.
- All of the staff we spoke with understood what duty of candour meant and told us that they would share information with patients and their parents or carers as soon as practicable following an incident. We saw evidence where duty of candour had been put into practice, in the investigation report we reviewed but as some incidents hat not been categorised effectively, we were not assured duty of candour had always been applied.
- Patient safety alerts were presented to the women and children's clinical business unit paediatric divisional meeting and cascaded to staff as necessary.

Cleanliness, infection control and hygiene

- Standards of cleanliness and hygiene were maintained on the paediatric ward and NICU.
- We observed the paediatric ward, outpatients' department and NICU to be visibly clean during our inspection.
- There were cleaning schedules, which outlined the frequency each area required cleaning. Nursing and support staff we spoke with told us that the cleaners did an excellent job and that they had no concerns.
- All staff were required to compete infection control training. We were provided with data for staff who had completed level one infection control training for the clinical business unit, 'Women and Children's', 88% of staff within this unit had completed infection control training against a hospital target of 85%.
- We saw that toys were cleaned as required and they did not use soft toys in the children's play areas.
- There was a sticker system in place, which indicated equipment had been cleaned and we observed that stickers had been placed on equipment.
- We observed that staff were 'arms bare below the elbows' and that they wore personal protective equipment (PPE) as required and this was available throughout the ward areas. Hand gel was available at each doorway on the wards and we observed staff using these. All taps were sensor operated.
- The flooring on wards was smooth and curved around the wall to minimise the risk of bacteria collection.
- Isolation facilities were available on both the paediatric ward and NNU. Signs to inform staff of the need for isolation procedures were visible.
- During our inspection some of the sinks on NNU were out of use due to pseudomonas (pseudomonas is a bacterium commonly found in soil or water and can cause infections in people with a weakened or under developed immune system). The unit had carried out a risk assessment and managed the risk by using water only from taps which did not have pseudomonas. We were told that the estates department were managing and monitoring the situation and that there was no longer pseudomonas in the taps. Monitoring was ongoing to ensure a sustained period of no bacterium. There had been no infections reported because of pseudomonas.
- Monthly hand hygiene audits were undertaken in each clinical area: the paediatric ward and NICU achieved 100% in April, May and June 2016.

- Cleaning audits were also carried out for each area and both units consistently achieved compliance of 95% or above. Data had not been obtained for the paediatric outpatient area.
- There had been no reported cases of MRSA or Clostridium difficile in the preceding 12 months.
- Clinical waste was appropriately stored and disposed of.

Environment and equipment

- The paediatric department including NICU had adequate equipment to meet the needs of children and young people which was well-maintained. Portable appliances had been subject to relevant safety tests. However, some environmental aspects of the unit were unsafe and not monitored or managed; we raised this with the trust urgently who took immediate actions.
- There were ligature risks within the department, for example, shower rails. We were told that a ligature audit had been undertaken by staff when the paediatric ward was opened three years ago. We requested a copy of this audit but it was not provided. Patients with mental health problems including those who had self-harmed or made suicidal attempts were regularly admitted to the unit. Such patients were not always provided with one to one care and staff had not received training in mental health needs. Therefore, ligature points presented an increased risk for these patients. We raised this as an urgent concern with the trust, who provided us with assurance promptly to mitigate the risks. Action taken included introducing a new risk assessment to ensure the level of care required by patients was assessed on admission; this was developed in conjunction with the Child and Adolescent Mental Health Service (CAMHS). The service had also spoken with CAMHS regarding training and competency assessments which were being developed and we were told the lead matron would review all CAMHS assessments daily.
- The paediatric ward was on level two of the main hospital site. Outside the ward was a balcony, which overlooked the ground floor. There was a barrier above waist height to prevent accidental injury or death by falling. However, the barrier was not sufficiently effective to prevent someone who may intentionally plan to climb over the barrier. This also presented a risk to patients admitted to the ward with mental health concerns. During the inspection, we were told that a health and safety assessment had been undertaken when it was built and it had been agreed that the balcony was safe. Whilst this original risk assessment was not available, once we raised concerns about the potential risks the balcony presented, the trust carried out risk assessments urgently . We raised this as an urgent concern as on our unannounced inspection, as there had been an incident the previous weekend when a patient had attempted to climb over the balcony and was restrained by staff. The service and took immediate action to ensure the doorway was manned by a security guard 24 hours a day, seven days a week until the area could be 'made safe'. We were given a copy of the revised risk register, which was updated following our inspection and included the balcony as an identified risk. The service took immediate actions to ensure the doorway was manned by a security guard 24 hours a day, seven days a week until the area could be 'made safe'. Longer term plans were drawn up to ensure this risk was addressed for all patients admitted to the ward.
- The resuscitation equipment in the paediatric department including the outpatient centre and NNU contained varied sizes of equipment to cater for the potential range in ages and sizes of the children. Daily checks were performed to ensure the required equipment was available and that emergency medicines on the resuscitation trolley remained in date.
- There was a dedicated area within the post-operative recovery room to care for paediatric patients.

Security

- Skylark ward was not adequately secure to ensure intruders did not enter the ward. There were no arrangements in place to minimise the risk of a baby or child abduction or children / young people absconding from the department.
- There was a buzzer entry system for both NICU and Skylark ward and we observed staff asking visitors who they were visiting before entering the ward. On Skylark ward access was gained via a set of double doors, once the door had been released open through the buzzer entry system, the doors opened and took a full 20 seconds to close which meant it was easy for someone to tailgate into the department sometime after the original requesting visitor had entered. This meant that someone could access the ward without being challenged. This had not been identified as a risk on the risk register.

- If patients or their visitors wanted to exit the ward staff had to push a button to exit the ward. We were informed that patients and visitors were expected to leave the ward by staff pressing the door release, located at the nurses' station. This took up staff time and also presented a fire risk. We raised our concerns regarding the entrance and exit of the ward with the trust who took prompt action. Action taken included installing a buzzer entry and exit system as well as CCTV. A security guard was also placed outside the ward 24 hours per day, seven days per week.
- The hospital did not have an abduction policy and there were no clear guidelines on what action to take. The midwifery service had an internal crisis plan which included a flow-chart for the abduction of a baby. The staff we spoke with on the paediatric ward and NICU were unsure how they would respond to an abduction or attempted abduction and each member of staff we spoke with told us varying ways they would manage or respond to this scenario. We raised this with the trust which took immediate action and revised the flowchart for the missing/abducted child and we were told this had been displayed in all areas with communication of this undertaken at each handover.
- The staff we spoke with during the inspection were unclear what arrangements were in place for security guard cover. Some of the staff we spoke with told us security guards provided cover during the day, others were of the opinion security guards were available at night only. Due to the concerns that we had regarding patients with mental health needs that we raised with the trust, prompt action was taken and a security guard employed to sit outside the paediatric ward 24 hours a day, seven days a week.
- The hospital did not have a policy on restraint or supportive holding and staff had not been trained. Staff had not received 'break away' training (break away training is used for managing challenging behaviour in care environments). In the event of a patient or their parent presenting with challenging behaviour staff told us they called the police who responded promptly.
- There was no policy or agreed protocol should a young person abscond from the unit and staff were unclear of action to be taken other than to report this to the police. There was no protocol for 'lockdown' arrangements and risks of potential threats or hazards which may prompt a lockdown had not been considered.

Medicines

- There were suitable arrangements in place for management of medicines, which included the safe ordering, prescribing, dispensing, recording, handling and storage of medicines. However, we noted that the temperatures for the fridge on paediatric ward were not consistently documented and checks on controlled drugs not always recorded and the disposal of unused controlled drug ampules were not recorded.
- We found that medicines were securely stored in the paediatric ward and NICU and that controlled drugs were stored in accordance with the required legislation.
- We saw that room and fridge temperatures were checked and that these had all been within the required range although we noted that checks had not been performed consistently on the paediatric ward. A controlled drug (CD) register was used to record the details of the CDs received, administered as well as CDs that had been disposed. Some prescription medicines are controlled under the Misuse of Drugs legislation (and subsequent amendments). These medicines are called controlled medicines or controlled drugs. Stricter legal controls apply to controlled medicines to prevent them being misused, being obtained illegally and causing harm
- We reviewed a sample of controlled drugs and found that accurate records had been maintained, although we noted that when only part of an ampule was prescribed and administered, the disposal of the amount unused was not documented. We also saw that daily stock checks for controlled drugs on the paediatric ward had some dates missing. We raised this with the matron who took actions to address this.
- Medication records were completed for patients. A medicine administration record specific for children was used to record medication prescribed and administered and we saw that these had been completed appropriately for the patient files we reviewed. Each patient had their weight checked and prescriptions were written accordingly. There had been a recent incident where a member of staff had recorded prescribed medication using an unconventional weight measurement, which resulted in a child being prescribed an incorrect dosage. The unit had taken action and nurses were required to double sign administration charts to ensure medical staff had recorded the correct dosage.

- If patients were allergic to any medicines, this was recorded on their prescription chart.
- There was a dedicated pharmacist for Skylark ward and NICU who came to the ward daily Monday to Friday. Checks were made on stock levels as well as audits of the controlled drugs registers; pharmacists also undertook checks on patient medication records.
- A total of 26 medication errors (15 administration and 11 prescribing) were reported in the six-month period May to October 2016. This had not been identified as a risk on their risk register but was recorded on the corporate risk register.
- Monthly medication audits were undertaken and reported on as part of the Nursing Quality Indicators. Data was collected on the number of medication incidents and errors. Between the period April to August 2016 NICU reported a total of 11 medication incidents with peaks of five and four incidents in May and July respectively. Skylark reported a total of eight incidents and errors during the same period with a peak of six in August 2016. It was noted that there was no recorded threshold for the number of medication incidents per month, which would cause concern. Therefore, there was no prompt for managers to consider whether the number of incidents and errors were in excess of expectation.

Records

- Patient's individual care records were generally written and managed in a way that kept patients safe. Records were stored securely and contained accurate information, were legible and up to date. However, there were issues with accurately tracking patient records and there were a high number of temporary patient notes.
- Patient records were stored in trolleys and these were kept in a locked room when not in use.
- Records we reviewed were legible and up to date and contained an appropriate level of information.
- There were flags on the system to identify patients, for example patients who were on the child protection register or patients with additional support needs.
- Monthly record audits took place on the quality of patient notes for both neonates and paediatric patients. Findings were reported as part of the monthly nursing indicator dashboard. In addition, a one off audit had taken place on the storage and availability of notes on the paediatric ward in July 2016.
- The monthly nursing indicator audit included quality measures to ensure documentation had been adequately completed for paediatric early warning scores (PEWS). PEWS is a tool used to monitor and manage deteriorating paediatric patients. Some of the measures audited were; checking vital signs, checking for tissue damage, baby discharges notified to the midwife or health visitor, hospital passports completed for patients living with a learning disability, allergy status and medication errors.
- We reviewed the audit data from April to September 2016. We saw that the target had been achieved by NICU and the paediatric ward for most of the indicators. There were some exceptions to this, for example, in July 2016, checking vital signs for paediatric patients was below the 98% target at 83%. 100% had been achieved in each of the other months reported on. We also noted that a situation, background assessment recommendation (SBAR) communication tool had not been used consistently in the months of May, July and September 2016. Compliance of 94%, 89% and 83% had been achieved each month respectively. The SBAR tool should be used to ensure accurate information is escalated as required.
- In July 2016, the medical record audit identified issues with the tracking of notes and high usage of temporary notes; for example, 245 were tracked to the paediatric ward but 81 could not be located there. In the report, it was agreed that an action plan would be developed.

Safeguarding

- There were not always effective systems in place to ensure safeguarding concerns were identified and that referral details were recorded in all patient notes. Safeguarding policies lacked detail of some types of abuse. There were no routine processes to check if safeguarding concerns had previously been identified or that relevant checks had been undertaken.
- The Director of Nursing and Quality was the hospital lead for safeguarding adults and children. This was further supported by named nurse leads for adults and children and a children's safeguarding paediatrician.
- The hospital had a safeguarding vulnerable adult policy (revised in 2014) and a policy for safeguarding children (revised 2016). Both policies defined what abuse was and the safeguarding children policy made reference to child sexual exploitation, although neither policy described what this was or made reference to female

genital mutilation. The referrals process was clearly outlined in the safeguarding children policy. The safeguarding vulnerable adult policy made mention of this and that the full referral and investigation process was detailed in the Northamptonshire interagency safeguarding adult procedures with a link to the document.

- The staff we spoke with were confident in talking about the types of concerns that would prompt them to make a safeguarding referral including; neglect, physical, emotional and sexual abuse, female genital mutilation and sexual exploitation. Staff understood the referral process and how to make a referral. We reviewed a sample of patient files and found that safeguarding referrals had been made appropriately and in accordance with hospital policy.
- There was an alert field in patient notes to alert staff that there may be safeguarding concerns relating to the child. However, this was not routinely checked and there was no checklist to complete to confirm whether the system had been checked for safeguarding alerts. We raised this with the ward manager who was already aware.
- Most safeguarding referrals, which related to self-harm were made by the emergency department (ED) prior to the child being admitted to Skylark ward and this was recorded in the child's notes. Staff who worked on the paediatric ward checked to ensure a referral had been made in ED, and completed a referral if not.
- We reviewed a sample of seven files and found that a safeguarding referral had been made as appropriate in each case. However, there was no evidence of this referral having been made on one patient's file: it was subsequently confirmed with the hospital that a referral had been made.
- There are four levels of safeguarding training, levels 1, 2, 3 and 4. The Intercollegiate Document, 'Safeguarding children and young people: roles and competences for health care staff 2014' states that, 'all clinical staff working with children, young people and/or their parents/carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/ child protection concerns must be trained to level 3. Named lead professionals must be trained to level 4.
- Review of staff training data for August 2016 confirmed that 93% of staff who worked within the clinical business unit 'Women's and Children's' had completed adult safeguarding, which was above the hospital's target of 85%.
- Level 3 safeguarding children training had been completed by 93% of nursing staff, but compliance rates were much lower for medical staff as well as health care assistants and 'other' staff who required level 3 at 78%, 40% and 56% respectively.
- The hospital's mandatory training target for adult safeguarding level 2 had been met for staff who worked on NICU and the paediatric ward, both achieving over 90%. Paediatric medical staff however had very low attendance at 28%, although they had achieved the level 1 adult safeguarding target of 85%.
- The hospital had a chaperone policy, which made specific reference to chaperone arrangements for children under the age of 16.

Mandatory training

- There was a structured induction programme in place for all new staff. The hospital's mandatory training target of 85% had been achieved for eight of the 10 training modules.
- There were 10 mandatory training modules, which each member of staff was required to complete in line with agreed frequency. These included equality and diversity, health and safety, information governance, fire safety, moving and handling, safeguarding adults, safeguarding children level 2, infection control, risk management and the Mental Capacity Act 2005.
- The staff we spoke with told us that they had completed their mandatory training, staff were allocated dedicated time to complete 'face to face' mandatory training. Some of the mandatory training was completed via e-learning modules and it was expected that staff complete this whilst working on the ward during quieter periods. The staff we spoke with told us that this did not pose any difficulties and that they found training provided by the hospital helpful.
- The hospital had a target of 85% compliance; this had been achieved for eight of the 10 mandatory training modules. The target attendance for manual handling and mental capacity act awareness had not been achieved, with a compliance rate of 83% and 76% respectively.

Services for children and young people

Assessing and responding to patient risk

- Risk to patient safety was not always appropriately managed. Arrangements for patients admitted with mental health needs were not suitable, acuity tools were not used and there was no criteria for which patients should be admitted to the high dependency unit (HDU) or a policy for their care and treatment.
- Risk assessments required completion for all patients on admission to the wards. We reviewed a sample of patient records and found these to be completed for their medical condition. There was a separate risk assessment for patients who had mental health needs and this was not always consistently completed and lacked detail. We raised our concerns with the service about the suitability of the risk assessment for patients with mental health needs. The hospital promptly revised their risk assessment with advice from a mental health nurse.
- Patients who were admitted to the ward with mental health concerns, for example, if the patient had self-harmed or attempted suicide, were not routinely provided with one to one care in accordance with hospital policy. During the announced part of the inspection, we identified that there was no formal risk assessment to determine whether one to one care was required, if the environment was suitable and whether adjustments were needed. It was expected this information was recorded in the patient's notes. However, we found from review of five sets of notes that such information had not been documented.
- When one to one care was required, it was provided by ward staff who had not received mental health training, or by the child's parent or carer. If the parent or carer provided one to one support, nursing staff provided care and treatment for any medical health needs.
- We raised our concerns with the trust at the time who took immediate action. A new risk assessment tool was devised. This was used to undertake an assessment of the child or teenagers risk of causing further harm to themselves, or others, as well as specialist one to one care requirements and environmental risks. The risk assessment was developed with the assistance of a mental health nurse and included an assessment of their environment as well as requirement for specialist one to one care. At this time, the hospital also promptly deployed a security guard to sit outside the paediatric ward 24 hours a day, seven days a week. The hospital reported that further assessments and actions were being considered in relation to the safety of the environment as well as providing nursing staff with some basic mental health training.
- The paediatric ward had two beds in a shared room which they used to care for patients who had 'higher dependency needs' although the hospital were not commissioned to provide high dependency care. We noted there was no paediatric HDU policy or set criteria for which patients could be admitted to the higher dependency room.
- We reviewed records of patients admitted to the HDU room and the reason for their admission. These patients could potentially meet HDU criteria; however, it was not possible to form a judgement without details of the acuity of the child and a clearly defined policy.
- Services for children and young people did not have an intensive care unit (ICU) bed, patients who required ICU level care were stabilised in the adult intensive care unit and transferred to a suitable tertiary centre. There were no paediatric patients admitted to an ICU bed during our inspection, however, we were told that if a patient was admitted a children's nurse would be requested from the paediatric ward.
- Children who required intensive care were transferred to a tertiary centre. Paediatric patients were collected by the another NHS acute hospital retrieval team and neonates transferred by the neonatal network retrieval team. There was a policy on care management of the critically ill child or transfer of critically ill child.
- NICU had four intensive care cots, six HDU cots and eight special care cots. There was a formal criteria for which babies could be admitted to each cot.
- A paediatric early warning score (PEWS) tool was used to monitor and manage deteriorating patients on the paediatric ward. A separate tool was used according to the child's age and we saw evidence of these used. Each patient's PEWS score had to be calculated on admission and subsequently at the agreed frequency in accordance with their latest score. However, we noted that observations were not consistently completed in line with the determined frequency and the age related PEWS chart had not been used for one child.
- There had been two serious incidents in 2015, which related to children developing sepsis and resulted in a poor outcome for both children. As a result, an action plan had been developed. A tool used to help identify

sepsis was not in use (sepsis, also referred to as blood poisoning or septicaemia, is a potentially life-threatening condition triggered by an infection of injury).

- The paediatric department carried out monthly audits on completion of PEWS, the results for June 2016 indicated that 100% of patients had a correctly added PEWS score, although only 83% of patients had their vital signs monitored every four hours, with 89% having their blood pressure checked on admission; against a hospital target of 90%. An action plan was developed to continue to monitor this each month and audit data demonstrated 100% compliance for the month of October 2016.
- NICU did not use an early warning score, such as the newborn early warning trigger and track (NEWTT). Although vital signs were monitored, an early warning trigger can be helpful to alert nursing and medical staff to a change in a baby's condition and trigger a timely response. The British Association of Perinatal Medicine (BAPM) NEWTT framework for practice in April 2015 recommends that the NEWTT tool should be used to support clinical assessment.

Nursing staffing

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

The RCN 'Defining Staffing Levels for Children and Young People's Services (2013)' on staffing levels states "At least one nurse per shift in each clinical area (ward/ department) will be trained in Advanced Paediatric Life Support (APLS)/ European Paediatric Life Support (EPLS), depending on the service need". In accordance with these RCN minimum standards, there should be one member of nursing staff trained in APLS or EPLS at all times. Some staff, but not all, were trained in European Paediatric Life Support EPLS, but as a minimum, there should be one nurse trained in APLS/ EPLS per shift.

- We reviewed a sample of 15 whole shifts, seven of the 15 did not have one member of nursing staff trained in EPLS, and there were no shifts with staff trained in APLS. The department recognised that planned staffing levels did not meet RCN guidance and this had been identified as a risk but this was not contained on the risk register.
- The trust provided information that staffing levels were based on the Royal College of Paediatrics and Child Health (RCPCH) 'High Dependency Care for Children – Time to Move On' (October 2014). This document made recommendations that there should be a minimum of one nurse on every shift, who is directly involved with caring for the critically ill child who must have completed a recognised paediatric resuscitation course, for example, PILS/PLS/EPLS/APLS (Resuscitation Council UK 2010/ALSG 2011). The service was meeting these recommendations in terms of having a PILS training nurse on each shift.
- 59% of neonatal nurses had completed their post registration qualification, which did not meet the British Association of Perinatal Medicine (BAPM) of 70%. We were told that there were additional staff completing the qualification as well as one new starter and based on this by September 2017 the hospital expected to achieve 66% of nurses with a QIS.
- Most of the paediatric nursing staff we spoke with told us that staffing arrangements worked well, but that on occasions the ward could become busy. Particularly when patients with a high acuity were admitted. Staff told us that sometimes this meant they did not get time for a break, but that patients were cared for safely.
- The paediatric outpatient department was run by adult nurses and was part of a different clinical business unit and were not line managed by and did not work closely with paediatric inpatients staff. There was a main paediatric outpatient department who saw the children and young people for most specialities. There was also a specialist diabetes centre. Children seen by the ear, nose and throat, ophthalmology and maxillofacial teams, were seen within the main adult outpatient department. A paediatric nurse from Skylark ward did attend several clinics including the paediatric asthma and allergy clinics, the paediatric gynaecology clinic and paediatric murmur clinics. The trust acknowledged the general paediatric clinics did not have the support of a paediatric nurse. However at the time of the inspection, there was a plan in place to recruit a paediatric nurse by the outpatient department in conjunction with paediatrics to ensure the percentage of paediatric nurses in paediatric clinic is increased. RCN guidance states that, 'a minimum of one registered children's nurse must be available at all times to assist, supervise, support and chaperone children'. This had not been identified as a risk for paediatrics but had been recorded on the outpatient risk register.
- Five nurses staffed NICU during the day and night shifts. The service aimed to have a minimum of three neonatal nurses qualified in speciality (QIS). The unit recognised that they were not compliant with the British Association of Perinatal Medicine (BAPM) guidance if the unit was at full capacity. BAPM guidance recommends a ratio of 1:1 for ITU cots, 1:2 HDU cots and 1:4 SCBU cots. This had been identified as a risk on the paediatric risk register and staffing levels and acuity of babies was monitored and reported on a daily basis. It is also recommends the number of nurses who should be (QIS) and this was monitored daily. We reviewed data collected by the hospital for 60 shifts over a 30-day period in September 2016 and found that seven shifts were short of nurses, with 10 shifts not meeting the number of QIS nurses required. It was the perception of the staff we spoke with that the unit was adequately staffed and that staff usually had time to take breaks.
- There had been a total of four incidents reported which related to staffing shortages from May to October 2016. These were equally split between the paediatric ward and neonatal unit. Immediate action taken included closing the unit on two occasions, and re-distribution of staffing resources for the other two. There was no recorded harm to patients.

- We observed nursing handovers on NICU as well as the paediatric ward which were detailed and effective. We observed that each child or baby on the unit/ward was discussed by the nurse in charge and each patient was allocated to a nurse for their shift.

Medical staffing

- Medical staffing levels and skill mix were not planned adequately in advance or in accordance with relevant guidance to ensure that patients received safe care and treatment.
- In August 2016, there were no vacancies; the turnover rate was 5.48%. Sickness reported in the previous year, 2015/16, was lower than the hospital's 5% target at 3%.
- There were eight consultants employed for children and young people's services. Consultant cover was provided Monday to Friday 9am to 5pm on the paediatric ward by one consultant, there was a second consultant who covered NICU from 9am to 1pm Monday to Friday. Outside of these hours, there was a consultant available on call and staff had the relevant contact details.
- During the day, there was one middle grade doctor who covered the paediatric ward and assessment unit and a second doctor based on NICU as well as a third based in clinic. Support was also provided by junior doctors: one was allocated to the paediatric ward, one allocated to NICU, a third was allocated to the paediatric assessment unit when open and a fourth covering NICU and postnatal wards. A FYI junior doctor was based on the paediatric ward during weekdays and a second was based in the assessment unit for afternoon and evenings. At night, there was one middle grade with support from a junior doctor and a consultant on-call.
- Each consultant had a 'hot-week' when they were responsible for the paediatric ward and NICU and they were the named 'consultant of the week' (COW).
- A review of a sample of rotas confirmed that the actual medical cover agreed to the planned staffing arrangements. Locums were used as required to ensure gaps in the rota were filled, for example, to cover sickness or annual leave. A standard checklist was used to induct locums into the service. Locums who worked for the service long term accessed the hospital induction as well as mandatory training.
- Staffing levels were not compliant with the British Association of Perinatal Medicine guidance, which refers to the Department of health toolkit 'Optimal arrangements for Neonatal Intensive Care Units in the UK 2014'. This states, 'The minimum staffing in any neonatal service is for resident out of hours care should include a tier one clinician or junior doctor ST1-3 and a tier two and experienced junior doctor ST4-8 or appropriately trained advanced neonatal nurse practitioner (ANNP)'. Guidance also recommends that all NICUs seek to extend consultant presence on the unit to at least 12 hours per day.
- According to the Royal College of Paediatrics and Child Health, 'Facing the Future: Standards for Acute Paediatrics' guidance, a consultant paediatrician must be present and readily available in the hospital during times of peak activity, seven days a week and in the case of very large hospitals this must be two consultants. In accordance with guidance there should be a minimum of one consultant present for 12 hours per day, seven days per week. For outpatient clinics, the trust told us that clinics only ran when a consultant or associate specialist doctor was present in clinic directly supervising junior staff.
- A business case had been drafted to expand the current paediatric service and open all available beds throughout the year. The business case identified the need for an additional consultant to support current activity and also identified there was a shortage of middle grades. Two options were proposed but these only included proposals for expansion and failed to bridge the gap to meet current activity levels in accordance with national guidance.
- We noted that the clinical business unit – Paediatric Divisional meeting minutes for September 2016, recorded that concerns had been raised that the registrar was not going to the NICU in the evenings. This was needed to meet Bliss Baby Friendly standards (Bliss is an organisation established to provide support to families and professionals whose baby's' were born prematurely or sick). Minutes recorded that concerns would be reported on as they arose. However, it was not recognised in the minutes that presence from the registrar might be needed for patient safety purposes.
- Handovers took place twice each day and were led by a consultant paediatrician. We observed a handover and found that these were appropriate, relevant and pertinent information was discussed.
- Consultant cover was provided eight hours a day Monday to Friday and on-call arrangements were in place. This did not meet the recommended BAPM guidance of 12 hours daily cover and meant that not all

children admitted to the ward with an acute medical condition could be seen by a consultant within 14 hours of admission as recommended by Royal College of Paediatrics and Child Health (RCPCH), 'Facing the Future' guidance. We reviewed 12 sets of notes and saw that most patients had been reviewed by a consultant within 14 hours, with exception of one child who had been admitted over a weekend.

- We saw from review of 12 patient records that all children admitted with an acute medical problem were seen by a middle grade doctor within four hours of admission.

Major incident awareness and training

- The hospital had a major incident plan which was ratified in June 2014 and due for review in June 2016. The policy had been approved by the hospital's strategic resilience group. We were told that there were action plans for each area and informed that action cards had been used within the last 12 months due to a major incident. However, the policy did not include action cards or state where they were located. Within the relevant section of the policy, it was stated 'will be included here once all action cards have been reviewed and all locations confirmed'. If action cards and their agreed storage locations were not written or included within the policy there was a risk that key individuals may be unclear of the appropriate action to be taken.
- There was a business continuity plan in place and this was published in January 2016. We were informed that there had been a flood in NICU earlier in the year and all cots had been transferred to another part of the hospital in accordance with the plan. We were told that this had worked extremely well, during this time external admissions were not accepted. The neonatal network was kept informed of progress.
- Fire safety training formed part of the mandatory training requirements. Staff who worked on the paediatric ward and NICU had exceeded the hospital's target of 85% achieving over 90% compliance. However, only 40% of paediatric medical staff had completed the training.
- A business case had been drafted to increase the number of nurses to support with winter pressures. Additional nurses were required during the winter to cope with increased demand, particularly due to respiratory related illnesses. There were two healthcare assistants expected two work each day shift and one at night. This meant that the recommended ratio of 70:30 qualified to unqualified staff was not met.
- There had not been any emergency drills for abduction scenarios.

Are services for children and young people effective?

Requires improvement

We rated the service as requires improvement for effective because:

- Patient's care was not consistently planned and delivered in line with evidence based guidance. Guidance had not been developed for all care requirements and some did not reflect the most up to date guidance. Audits were not used to effectively monitor the standard of care provided.
- The clinical audit plan was not suitable to ensure audits took place to monitor care provided against expected standards. Procedures and guidance available to staff was not always up-to date.
- Action plans following some audits lacked detail and were not monitored and it was unclear whether they had been implemented.
- Formal transition arrangements were not in place for all specialities when patients transferred from paediatric to adult services.
- Patient records were not always available on the ward and there was high usage of temporary notes.GP discharge letters were not sent out on a timely basis.

However, we also found that:

- Assessments were made of patient's pain levels and generally arrangements made to ensure their pain was managed effectively. Patients' nutritional and hydration needs were met during their stay in hospital.
- Most staff within the clinical business unit had received an appraisal and the hospital target of 85% had been met. All medical and nursing professionals had an up to date registration.
- Staff understood the relevant consent and decision making requirements of legislation and guidance and consent was obtained in line with legislation.

- Play specialists provided additional support for children on the paediatric ward who required support during their admission.

Evidence-based care and treatment

- Patient's care was not consistently planned and delivered in line with evidence based guidance. Guidance had not been developed for all care requirements and some did not reflect the most up to date guidance. Audits were not used to effectively monitor the standard of care provided.
- There were a range of hospital wide policies as well as those specific to neonates and paediatrics. We reviewed a sample of policies including 'early care of the pre-term infant, 'neonatal jaundice', 'neonatal sepsis', 'gastroenteritis in children younger than five years' and paediatric early warning system and found that they reflected relevant national guidance, for example, National Institute for Health and Care Excellence (NICE) and Resuscitation Council guidance. We noted that there were a number of policies available to staff on the intranet which had exceeded their review date. For example, the 'Guideline for Epilepsy management in Children', which had been developed in December 2011 and was due for review in December 2014. NICE guidance had been updated in January 2016: therefore, the hospital's policy had not taken this into account.
- The NICU was part of the Central Newborn Network. The group agreed guidelines for shared working and developed audit tools to assist consistency of approach, and to provide continual improvement of services. This showed participation in local groups and sharing of knowledge and learning.
- There was a clinic audit plan in place, although this only included two audits for 2016/17 and four for the previous year. Three of the 2015/16 audits had not been completed. One of the 2016/17 audits was in progress (diabetes paediatric audit), but the second audit had not commenced (improving the parental experience in the neonatal unit). We were told that audits had not received the attention they required due to insufficient medical staff.
- Audits were linked to national priorities and failed to consider local issues. For example, there had been a number of incidents, which related to patients with mental health needs as well as sepsis related incidents, but these had not been considered as potential clinical audit subjects.

- Play specialists provided additional support for children on the paediatric ward who required support during their admission.

Pain relief

- Assessments were made of patient's pain levels and arrangements were generally made to ensure their pain was managed effectively.
- For paediatric patients, pain assessments formed part of the paediatric early warning system (PEWS). Neonates' pain assessments were recorded on their observation charts. Children were encouraged to score their pain levels using a smiley face system to indicate the degree of pain they felt from zero to three, zero being no pain and three being severe. Through review of patient notes, we saw that pain assessments had been completed for most patients where it was applicable to do so. We saw that two of the 15 sets of notes reviewed did not have a completed pain assessment. This was supported by the data gathered in the wards nursing quality indicators for June which demonstrated that 83% of Patients pain has been assessed at least twice in the past 24 hours against a target of 90%. There was no action plan to address this.
- Pain relief was prescribed and administered as appropriate when pain assessments had been completed.
- Distraction techniques were used to distract children from painful procedures and anaesthetic cream was used when taking blood from children.
- Play therapists were available on the ward, Monday to Saturday. Play therapists provided communication between medical and nursing staff and patients and their parents to ensure the child's needs were catered for during procedures. Play therapists also provided additional support in distraction for younger children whilst undergoing procedures.

Nutrition and hydration

- Patients' nutritional and hydration needs were met during their stay in hospital.
- There was a multidisciplinary approach to provide support for children with their long-term nutritional needs to ensure well balanced meals were provided.
- Nutritional needs assessed were recorded in the patient's nursing notes and there was no separate tool, for example, the screening tool for assessment of malnutrition in paediatrics (STAMP). STAMP is a

validated nutrition screening tool for use in hospitalised children aged 2-16 years. Food and fluid charts were introduced as necessary, monitored appropriately and used effectively.
- The patients and parents we spoke with told us they were satisfied with the food and hydration provided.
- Foods to meet specialist dietary requirements were available on request, including gluten free and low allergen. Meals were also available to meet patient's cultural and religious needs. Staff said they could order specific foods if required and there were no problems obtaining them. This showed a variety of nutritional needs were catered for adequately.
- Staff who worked on NICU promoted breastfeeding without judgement. They offered support and advice and provided equipment to help mothers as much as possible.
- On both units, patients were weighed on admission and their weight assessed for their specific condition.
- Patients had access to speech and language therapists for swallowing assessments, advice and support, although we were told this was rarely required.
- Parents and carers could also make their own food in a designated kitchen so they could eat with their child.

Patient outcomes

- Outcomes regarding patient's care and treatment were collected and monitored in line with national requirements. Intended outcomes for some patients varied and some were better than the national average.
- The hospital took part in the national diabetes audit, which showed that the percentage of patients with controlled diabetes was slightly better than or similar to other hospitals in England for different aspects measured, although they performed worse than the England average for multiple admissions for patients with diabetes. The hospital had developed an action plan in response to the audit; four actions were identified: including initiating more user involvement and feedback, to hold regular events for young people with diabetes and to hold regular catch-up sessions. The actions lacked detail and had not been clearly defined; deadlines for completion had not been recorded.
- The national 'epilepsy 12' audit, which was a national clinical audit established in 2009, with the aim of helping epilepsy services, to measure and improve the quality of care for children and young people with seizures and epilepsy. The service last took part in this audit in 2014 where a total of 12 actions were agreed. Five of these were outstanding and no evidence these had been followed up. For example, one action was for 65% of children with convulsive seizures to have an electrocardiogram (ECG) within one year, there was no evidence whether this had been achieved or not. This had not been identified as a risk and placed on the hospital's risk register.
- The multiple emergency admission rates for March 2015 to February 2016, following elective surgery for children, had fewer than six readmissions per speciality and therefore comparisons against other hospitals could not be made. The overall readmission rate for paediatrics was 3% compared to the England average of 3%.
- The emergency admission rate for emergency surgery (general surgery) for the same period however, was worse than the England average at 4% for Kettering general hospital compared to 3% an average for all other hospitals. We requested a copy of the action plan from the hospital, an action plan was not provided and the hospital stated that recent data, April 2016 to June 2016 showed this had reduced slightly to 3.85%.
- From April 2015 to March 2016, the hospital did not have enough readmissions of children in the less than one age group for comparisons to be made with the England average for asthma, diabetes or epilepsy. The hospital performed similar to the rate of multiple admissions for children in the one to17 age group for readmissions related to asthma and better than the England average for epilepsy with a 15% multiple admission rate compared to an England average of 29%.

Competent staff

- Staff did not always have the right qualifications and experience to do their job. Most staff had received an appraisal and the hospital's target of 85% had been met.
- There is a practice development nurse in Neonatal Unit. However, CQC were not made aware of this at the time of inspection. We were subsequently informed by the trust that there was a plan in place to create practice development posts in early 2017.
- There were competency assessments for some key skills and use of certain equipment and these had been completed by some staff. Staff competencies assessed were recorded on the electronic rostering system. However, there was no defined list of what competencies were required for each staff group, for example, training for all relevant equipment and

essential clinical skills. We found there was no competency assessment for looking after a patient with a tracheostomy (a tracheostomy is an incision in the windpipe made to relieve an obstruction to breathing); therefore, we could not be assured that this group of patients were cared for appropriately.

- Monitoring did not take place to ensure staff had completed relevant competencies. Each member of staff was responsible for completing their competency assessment when they felt confident to do so this was then signed off by their supervisor and recorded onto the electronic roster.
- Staff who worked on the paediatric ward had not received training in caring for patients with mental health needs. Patients with mental health needs were regularly admitted to the ward through the emergency care pathway. We raised this with trust who took immediate action contact the CAMHS' team and involve them in a draft training programme.
- There were two beds on the paediatric ward used to care for patients with higher dependency needs. We were told that 15% of staff had completed training in HDU and this would increase to 17% by the end of January 2017. However, 81% of staff had received PILS training.
- Staff completed an annual appraisal as part of their personal development review. The staff we spoke with told us that they found the appraisal process helpful and had completed their appraisal within the preceding 12 months. Review of data provided, confirmed that in June 2016, 91% of staff who worked in Women's and Children's clinical business unit (CBU) had received an appraisal which exceeded the hospital's target of 85%.
- There was a process in place to ensure all medical and nursing professionals had their registration status checked, we confirmed through review that all staff listed as employed and registered had a valid registration.

Multidisciplinary working

- All necessary staff, including those in different teams and services were involved in assessing, planning and delivering patients' care and treatment.
- There was no psychological support for patients diagnosed with conditions other than diabetes and assessments and support for patients with mental health needs was limited out of hours.
- The staff we spoke with told us that there was good support from other services, including physiotherapy and dietetics. We were told that support from speech and language therapy (SALT) team was rarely needed but that they came on request.
- The Child and Adolescent Mental Health Service (CAMHS) were employed by another hospital and called the ward each morning Monday to Friday to ask whether anyone had been admitted overnight. The CAMHS team attended the ward as required to conduct assessments on patients. Out of hours, the adult crisis team made assessments if it was assessed that a child could not wait to be seen by a member of the CAMHS team within their working hours. There were no mental health nurses employed by the ward. We raised our concerns with the trust who took prompt action. A new risk assessment was developed and introduced with support from a CAMHS patient, 1:1 care from a registered mental health nurse was then arranged depending on the outcome of the assessment. Training on mental health for the ward staff was also being introduced.
- Multidisciplinary team involvement in care was documented in children's notes and we saw evidence of this.
- A dedicated pharmacist came to each ward to check supplies and review drug charts for patients on the ward.
- The department had support from a psychologist for patients diagnosed with diabetes.

Seven-day services

- Patients had access to most services seven days a week; some services had a reduced level of service provided by out of hours and there were long delays for some radiology reports, but arrangements were in place to keep patients safe.
- The consultants provided seven day a week cover, although this was not for 12 hours per day in accordance with 'Facing the Future: Standards for Acute Paediatrics' guidance, which recommends that there is consultant cover seven days per week, 12 hours per day and during hours of peak activity. There were on-call arrangements out of hours during the week and weekends.
- Pharmacy support was available on the ward each day; out of hours arrangements were in place.

Services for children and young people

- The hospital did not employ a paediatric radiologist; arrangements were in place with another NHS hospital to report on x-rays. We were told that this often resulted in delays, particularly for reporting on musculoskeletal surveys where a non-accidental injury needs to be ruled out. We were told that it frequently took a number of days for the surveys to be reported on which increased the patient's length of stay. We reviewed two patient files where musculoskeletal surveys were requested: for one patient this had taken seven days for the results to be reported and for the second patient the results had taken three days to be reported on. This meant that patients who may be otherwise fit for discharge may occupy beds unnecessarily. This had not been recorded as a risk on the departments risk register.
- Pathology services were provided seven days a week, 24 hours a day.
- Paediatric physiotherapy was available on weekdays. This service was provided by another local hospital. The physiotherapist attended the ward twice each day and assessed any new patients. An out of hour's service was provided by adult physiotherapists as required.

Access to information

- Information to deliver effective care and treatment to patients was not consistently documented or available.
- There was no documented policy for transition for children who were approaching an age where they would move to adult services. There were good transition arrangements for patients with diabetes as there was a joint diabetes clinic. Other transition arrangements varied depending on individual requirements but there were some formal pathways for renal patients, and there were joint arrangements with another local hospital for patients with cystic fibrosis or sickle cell. Transition arrangements for patients with other conditions were not structured.
- Patient records were requested as needed on admission or in advance for outpatient appointments. We were told that there were issues with a high number of temporary notes in use on the paediatric ward and that this remained a problem but that additional checks had been put in place to improve the situation. This had been identified as a risk on the women and children's risk register.
- A copy of the patient's discharge summary was given to the patient as well as sent to the patient's GP. We were also told that last winter there had been delays and a backlog of GP letters being sent following a patient's discharge and that delays were a number of weeks. We were told that resources had been dedicated to address the backlog and there had been huge improvements and that this was now being monitored closely; it remained a risk on the risk register.
- GPs were able to contact the service for telephone advice if they needed to.
- Test results were obtained promptly from the relevant departments to ensure clinical decisions could be made based on supporting pathology results. There were long delays in obtaining reports for some radiology services due to the hospital not having a paediatric radiologist in post.

Consent

- Staff we spoke with had a good understanding of gaining consent from children and the guidance around this with regard to a child's capacity to consent, including Gillick and Fraser competency. Gillick and Fraser competency is used to help decide whether a child is mature enough to make their own decisions. The Gillick competency and Fraser guidelines helps to balance children's rights and wishes with the hospital's responsibility to keep children safe from harm. Gillick competence is concerned with determining a child's capacity to consent. Fraser guidelines are used specifically to decide if a child can consent to contraceptive or sexual health advice and treatment.
- Staff understood the Mental Capacity Act 2005 and explained how they would assess a child's mental capacity and a decision would be made in their best interest and recorded in their notes.
- Patients and their parents were supported by staff to make decisions. Staff and patients we spoke with told us how the procedures and treatment were explained to them and that they were told about different options available.
- Written consent could be obtained by the child and / or their parents for certain medical and surgical procedures and we saw examples of these in the patient's notes we reviewed.

Are services for children and young people caring?

Services for children and young people

Good

We rated the service as good for caring because:

- Staff interactions with patients were positive and patients were treated with dignity and respect
- Patients told us that staff were helpful and that they explained things to them in a manner they could understand and that their relatives or carers were involved.
- Responses to the CQCs children's inpatient survey in 2014 were largely similar to other hospitals.

Compassionate care

- Staff, who worked in children and young people services, took the time to interact with patients and their parents in a manner, which was respectful and supportive.
- All of the patients and parents we spoke with told us that staff were kind and caring and that they felt well looked after. One parent told us that their baby had been transferred from another hospital and that they were very happy their child was cared for because they felt the care was exceptional for both their baby and they as parents had felt well supported.
- We observed staff supporting and treating patients in a kind and caring manner. We followed one child who was undergoing surgery that day on their journey to the operating theatre. We saw that they were supported by a play specialist and that good distraction techniques were used to minimise any distress to the child.
- Patient feedback was obtained using the NHS Friends and Family Test. The NHS 'Friends and Family' test is a method used to gauge patient's perceptions of the care they received and how likely patients would be to recommend the service to their friends and family. This is a widely used tool across all NHS hospitals. For October 2016, the response rate was very low at 1% compared to the England average of 24% and 100% of the people that did take part (five out of 479 eligible patients) would recommend the ward.
- We were told that comment cards were available to patients and their parents about the care they had received and we reviewed a sample of these including immediate action taken. We request summarised findings from feedback collated along with an action plan.
- Feedback from the children and young people's survey 2014 scored positively against the 14 questions asked in relation to staff care and was largely similar to other hospitals in England. For example, when asked, 'did you feel that your child was well looked after by hospital staff', an overall score of 9.08/10 was achieved and when asked, 'were you treated with dignity and respect by the people looking after your child' the hospital scored 9.22/10 overall.

Understanding and involvement of patients and those close to them

- During the inspection, we saw that staff communicated with people so that they understood their care and treatment and condition.
- The majority of the patients and parents we spoke with told us that communication had been good.
- Although one parent told us that they had been admitted via the emergency department and were waiting to speak with the doctor later that day and had received very little communication about what was happening with their child.
- The children and young people's survey reported that the paediatric ward had performed similar to other hospitals for communication except when asked whether they had been given a leaflet about their child's condition, they scored worse than other hospitals achieving 6.9/10.
- Patients and parents we spoke with told us they felt involved in their care and treatment and that they felt listened to.
- Parents were included in the escort of young children to and from theatre to reduce the distress to the child. The play therapist also supported younger children with this.

Emotional support

- Staff understood the impact that a patient's care, treatment and condition had on them and those close to them.
- Staff provided emotional support whilst caring for patients.
- Whilst there was limited formal support available, there was a professional psychologist available to provide counselling to patients with diabetes.

Services for children and young people

- For other patients and families, who may be distressed, support was provided by the medical and nursing team.

Are services for children and young people responsive?

Requires improvement

We rated the service as requires improvement because:

- Service planning had not used evidence based data and the needs of the local population had not always been considered. Patients and stakeholders were not involved in service development.
- Patients admitted to the ward with mental health needs or who required a musculoskeletal survey had long delays in waiting to be assessed and discharged.
- Some patients also experienced long delays waiting for treatment, specifically for urology, maxillofacial and ear, nose and throat (ENT). In some cases waits were in excess of 52 weeks.
- There was a significantly high conversion rate between patients who attended the emergency department and those admitted to the paediatric ward.
- There was limited support from a psychologist for patients diagnosed with long-term conditions. There was limited support for patients with a learning disability. Communication tools for patients who were unable to communicate verbally lacked detail.
- Not all complaints were responded to on a timely basis or in line with policy, but this was improving. There was limited learning from complaints.

However, we also found that:

- The length of stay was in line with the national average.
- There were arrangements in place to support patients with learning or physical disabilities.
- Translation services were provided to patients who were unable to speak English.
- There were facilities to engage and occupy young children and teenagers admitted to the ward.
- There were overnight facilities for parents to stay on both the paediatric ward and NICU.
- Patients and their parents were supported to make complaints.

Service planning and delivery to meet the needs of local people

- Patients and stakeholders were not consistently involved in service development during the year. There was limited patient involvement to provide feedback to the service. Services were not planned using operational performance data and although priorities had been identified, it was unclear how decisions had been made. Information about the needs of the local population had not always been considered.
- The paediatric ward had been purpose built and designed and was opened in 2013. We were told that relevant stakeholders including patients who regularly used the service at that time had been involved in its development. Since then patients and their parents or carers had not been involved in the service design or function.
- The business plans for the paediatric ward and the neonatal intensive care unit (NICU), formed part of the wider Women and Children's clinical business unit (CBU) business plan. The plan had four main sections, vision and objectives, current position, strategic priorities and actions to ensure delivery. The trust told us after the inspection that this CBU business plan was in draft and was a work in progress.
- The plan included a review of performance from 2014/15 and 2015/16; however, this was not separated between women's and children. For some areas it was not clear whether performance related to paediatrics or women's services. Achievement against plans for the previous two years lacked any meaningful detail, for example, under the heading, operational performance summary it was listed, 'current pressures with key KPIs due to organisational developments' there was no further detail as to what this meant. Under the heading, resource performance summary, an example listed was, 'estate and IT pressures' there was no further information or explanation as to what this meant.
- The plan had not considered data on planned activity against capacity for the previous year or whether activity was likely to increase in the future. The review from the previous year's performance had not considered whether the objectives had been met or the service safely managed.

- It was identified within the plan that there was a need to open additional beds on the paediatric ward going forward, but there was no evidence or justification to support why additional beds and resources were required.
- Priorities and proposed developments for paediatrics lacked detail and evidence and it was not always clear what the priority or aim was. For example one priority was listed as, 'neonatal block contract', aim to increase profitability, but there was no detail as to how this would be delivered, whether there was demand for this, there were no agreed actions or timescales. A proposed service development was to 'tailor paediatric work to accommodate medical/surgical demand'; there was no detail as to what the current issues were, why this was needed or how and when it would be delivered. For resources, equipment was listed for purchase, but there was no justification or reason as to why equipment was required. The plan included recognition to improve the care pathway for asthma patients, this also lacked detail and it was unclear from the information within the plan what had led to this as a priority.
- The plan did not include an analysis of capacity and demand for the previous year, or any assessment of operational data and performance for example, the number of emergency and non-emergency admissions, did not attend (DNA) rates, referral to treatment time (RTT) rates, length of stay (LOS) for specific conditions. Information which is essential in monitoring performance for the previous year as well as informing objective setting and agreeing suitable actions to develop and improve the service.
- A separate business case had been drafted to expand the current paediatric service and open all available beds throughout the year. The business case identified the need for an additional consultant to support current activity and also identified there was a shortage of middle grades. Two options were proposed but these only included proposals for expansion and failed to bridge the gap to meet current activity levels in accordance with national guidance. However the draft proposal failed to include details of current nursing shortages or adequately demonstrate the distinction between current medical shortages as well as additional staffing requirements should the unit expand.

Access and flow

- Patients admitted to the ward had access to timely assessment and treatment in most cases, although there were delays for some patients with mental health needs or those waiting for radiology reports. Some patients also experienced long delays waiting for treatment, specifically for urology, maxillofacial and ear, nose and throat (ENT).
- The paediatric service had a monthly dashboard, which included information on the patient experience, for example, the number of complaints and incidents during the month, as well as infection control data and record completion. The dashboard did not include operational performance information, for example, RTT times (unvalidated data), DNA rates, LOS, number of admissions, follow-up attendances, emergency re-admissions etc. With no central point for information to be reported on and monitored, there was a risk that there was a lack of overview of how the department was operating including access and flow. After the inspection, the trust told us that there was a separate dashboard covering operational performance information. Both of these were monitored by the CBU monthly. From our review of the CBU meeting minutes in August and September 2016, there was no there is no evidence of circulation or presentation of an operational dashboard.
- The paediatric ward had 26 inpatient beds open Tuesday to Friday evenings and 18 beds open from Friday night until Tuesday mornings. There were an additional six beds in the paediatric assessment unit, which was co-located. Paediatric patients were admitted to the ward, either via a planned admission process, or through an emergency admission from a direct referral via their GP or through ED.
- There were 4,926 admissions to the paediatric ward from 1 April 2015 to 31 March 2016, of which 95% were emergency admissions, compared to the England average of 65%. This may indicate a lack of senior decision making because consultant cover is only provided eight hours per day Monday to Friday, compared to the recommended 12 hours a day, seven days a week.
- From April 2015 to March 2016, the average Length of Stay (LOS) for the paediatric ward was less than one day for elective admissions for all age groups and one day for emergency admissions for all age groups, which was similar to the England average.

- Some of the nursing staff we spoke with who worked on the paediatric ward, expressed concern over the number of patients admitted overnight or at weekends due to self-harm, attempted suicide or suicidal intent. The local Child and Adolescent Mental Health Service (CAMHS) did not provide a service out of hours, which meant patients had to be admitted until a formal mental health assessment had been completed. Patients could be assessed by the Adult Crisis team if there was an urgent need.
- Some patients with mental health needs could remain in the department longer than planned if they were waiting for a bed in a mental health unit, but most patients were discharged back to the community team. From April 2016 to October 2016, there had been 115 CAMHS patients admitted to the paediatric ward, which averaged 16 per month.
- We were told by the staff that there were long delays for patients waiting for radiology results because there was no dedicated paediatric radiologist employed by the hospital. Some radiology reports were sent to another local hospital for review. We were told that delays frequently occurred for patients who had undergone a musculoskeletal survey for a potential non-accidental injury and that children could be admitted to the ward for several days due to delays in receiving results. We saw examples of these in patient records, where delays to report on results had been between three and seven days.
- At the time of the inspection, all the RTT data produced by the trust was being validated so therefore was subject to validation or was unvalidated. The unvalidated data for referral to treatment times (RTT) for incomplete pathways were worse than the 92% target and there were significant delays for children waiting for surgery, particularly for ENT, urology and maxillofacial. The trust We requested data for the RTT performance measure and saw that for November 2016, 85 ENT patients were waiting in excess of 18 weeks, with seven patients waiting for over one year, 68 patients waiting for maxillofacial treatment in excess of 18 weeks with five patients waiting in excess of one year, 40 patients waiting for urology treatment in excess of 18 weeks with two patients waiting longer than one year. The hospital's forecast trajectory was for no patients to be waiting in excess of 18 weeks by March 2017. We requested a copy of the hospital's action plan for RTT for paediatrics, however, this was not provided, but the hospital included a statement that an action plan was in place, It stated, 'Patients are dated in line with the Hospital Access Policy, accounting for their clinical urgency and their length of wait. The length of time paediatric patients have waited has caused the hospital concern and a series of actions and plans have been implemented to reduce the waiting times in these areas'. After the inspection , the trust told us that not all those patients highlighted as waiting over 18 or 52 weeks were really waiting that period of time as the data cleansing process had not been completed.
- The trust also told us that, "the hospital has serious concerns around the accuracy and quality of its RTT data and reported position, with the correction of this being a hospital priority. The hospital is working on a plan of data improvement including education, training, changes to systems and process and validation of patient pathways with the aim to return to reporting in November 2016".
- We also saw that the Women's and Children's clinical business unit (CBU) – Paediatric division meeting minutes for September 2016 recorded that concerns had been raised with regards to delays in all cranial ultrasound requests as these had been returned. It was stated that a risk assessment was needed and an urgent meeting with radiology was required. This risk had not been transferred to the risk register.
- The NICU had 18 cots. There were four cots for babies who required intensive care, six cots for babies who required higher dependency care and eight cots for babies who required special care. Neonates were admitted via maternity as a planned or emergency admission. Transfers from other hospital were also accepted as well as some neonates who had returned from the community.
- The average LOS for neonates for the period April 2015 to March 2016 was 10 days.

Meeting people's individual needs

- Services were generally planned which took into account the needs of different people. Consideration had been given to the patients' age and gender as well as disabilities: however information about patients with complex needs was inconsistent and communication aids lacked detail.
- The paediatric ward had a dedicated sensory room, which was used for patients with visual impairment as

well as other patients who may benefit from this. We observed children and their parents in this room and the children found this a wonderful and exciting experience.

- The paediatric consultant body had experience in general paediatrics and neonates, and some had their own specialist interests, running specialist clinics, sometimes jointly with a tertiary specialist from the surrounding area.
- There was a dedicated diabetes centre, which was run by a multidisciplinary team, which included joint working with staff from another local hospital. The paediatricians ran clinics at the centre supported by nurses from another hospital.
- The hospital used a 'patient passport': these were completed for patients who had complex health needs and may require support with communicating their needs. The passports were used to record information about a patient's communication preferences, equipment they may require, sleeping preferences and daily routines as well as details about their mobility, general health and eating arrangements. We reviewed passports for three patients and found that these had been completed for two of the patients, but one passport lacked detail including information about the patient's general health and the reason a passport was required. There was a risk therefore that if the patient's parents or carers were not available, staff may not understand the patient's preferences.
- A basic communication booklet and flashcards had been developed to support patients who may be unable to verbalise their needs. The communication book consisted of two pages and pictures for certain illnesses and simple instructions, for example, cough, ear, constipation, stop, more, help, look. The tool lacked a lot of basic information, for example, food and drink items, pictures of toys and games. The April 2011 report, supported by the department of health and written by Improving Health and lives, Learning Disabilities Observatory – "Reasonable Adjustments for People with Learning Disabilities – Implications and Actions for Commissioners and Providers of Healthcare" recommends that providers of healthcare should:
  - Have a policy or strategy about accessible information.
  - Put links on the Hospital website to other accessible websites and resources.
  - Audit the information currently available.
  - Have a working group including people with learning disabilities and family carers to rectify any gaps in information.
  - Monitor the availability and use of accessible information.
  - Provide staff with the appropriate skills and support to take an individualised approach to communicating with individuals.
  - Commission liaison nurses or equivalent support if this is not already in place.
  - The hospital had a specific site on the intranet for learning disability awareness, and the trust told us the service also had a range of pictorial guides and leaflets, some of which were designed by the play specialists. There was a learning disability working group within the trust who monitored the availability and review information for accessibility. The Learning Disability Liaison nurse provide staff with appropriate skills and was available within the organisation. The service had two staff that were representatives on the Learning Disability forum.
- Translation services were available, although we were told that these were rarely needed. There was also a list of staff members who spoke other languages and were happy to translate for patients. 'Language line' was also used and worked sufficiently well, although this was not the preferred option.
- There was a psychologist available to support patients who had been diagnosed with diabetes and this was funded by the commissioners. There was no psychological support for patients with other conditions who may also benefit from specialist support.
- Children and young people used the main hospital chaplaincy for support in the event of a bereavement. We were told that there were very few deaths for paediatrics as these were mostly out in the community. The paediatric and neonatal team used bereavement boxes for parents to save memories of their baby or child.
- There were arrangements in place with the Child and Adolescent Mental Health Service (CAMHS), which was provided by another local NHS hospital. CAMHS telephoned the ward each morning (Monday to Friday) to establish whether children had been admitted overnight or during the weekend. A member of CAMHS staff then visited the ward to make a psychological assessment of the child.

- Leaflets were not readily available in other languages. We were told that the Patient Advice and Liaison Service (PALS) team could produce leaflets in other languages if requested; however, they were not frequently needed.
- There was a playroom for young children, which contained toys and books and a separate room for adolescents with DVDs, books and a computer gaming system.
- Parents had the option to stay overnight with their child and on the paediatric ward, there were pull-down beds in each side room with the exception of the HDU room and the shared bays; there were chair beds available for parents whose child was admitted to an HDU bed or bay.
- There was also a parents' room on paediatric to accommodate parents in a more comfortable setting if required. The parents' room had a toilet and shower as well as tea and coffee making facilities and a fridge and microwave.
- There were suitable bathroom facilities for patients with physical disabilities and adequate space on the ward to accommodate patients who used wheelchairs.
- NICU also had parent bedrooms; there were three designated bedrooms, as well as a quiet room / counselling room, which could be used as a fourth bedroom in an emergency. The neonatal toolkit standards recommend that there is one bedroom for each intensive care cot. Bliss standard recommend there is also a quiet room /counselling room within the unit.
- There are two prayer rooms within the main hospital, the main chapel of peace as well as a small multi-faith prayer room. Chaplaincy is provided by Christian faith; however we were told that there was a multi-faith contact list, which patients or their parents can access.
- There was a hot meal served as an evening meal, the choices included healthy options as well as more traditional children's foods. The meals were designed to cater for a variety of ages. A choice of sandwiches were available as a lunchtime meal and typical choices were available for breakfast such as toast or cereal.
- Snacks were available on the paediatric ward 24 hours a day. These included fruit, sandwiches, crisps and cereals. This meant that patients could have food at any time outside of meal times.

Learning from complaints and concerns

- There was a process in place for responding to complaints and information was available to make patients aware of how to complain.
- Leaflets informing patients how to make a complaint or contact the PALS service were available in the paediatric ward and NICU.
- We were told that most complaints were resolved and responded to immediately and that these were mostly due to communication issues from nursing and medical staff. Formal complaints were rarely received.
- There were six complaints made from April 2016 to September 2016. We were provided with a summary of these complaints, which included details of immediate action taken, as well as lessons learned. The lessons learned lacked detail about how things would be improved, for example, the lesson learned for one complaint about medication and observations on the paediatric ward was, 'Identified need for medical and nursing staff to communicate effectively'. There was no further detail about how this would be actioned, when or by whom. Lessons learned did not feed into the local governance meetings.
- Complaints were not responded to on a timely basis or in line with policy. Each of the six complaints took between 37 and 62 days for the complainant to receive a response, which exceeded the target set out in the hospital's complaints policy of 25 days. As only a brief summary of the complaint was provided, it was not possible to determine whether the complaint was complex and required longer than the 25 days as per policy. The main theme was care and treatment on the paediatric ward.
- Complaints formed part of the monthly paediatric short report which was circulated with the minutes of the Women and Children's clinical business unit – Divisional meeting – Paediatrics. The monthly short report detailed the number of complaints received in month, the number ongoing and details delays in responding to the complainant; no delays were reported. Details of the complaint were not always shared and there was no evidence of lessons learned. Although the paediatric short report was circulated with the minutes, there was no evidence recorded in the August 2016 or September 2016 minutes that discussion had taken place.

Services for children and young people

Are services for children and young people well-led?

Inadequate

We rated the service as inadequate for well-led because:

- The delivery of high quality care was not assured by the leadership or governance in place.
- The service did not have a clear vision. Objectives in the business plan had been set but were generic and not specific to the service and were not supported by clearly defined actions. The majority of staff were unaware of the vision for the service.
- There was not an effective system for identifying, capturing and managing risks and issues at team, directorate and organisation level.
- There were delays in investigating and closing incidents. Learning from two serious incidents had not been embedded in the service to prevent the risk of harm to other patients.
- Significant risks identified on inspection that threatened the delivery of safe and effective care had not been recognised, assessed or mitigated by the service. There was not a holistic understanding throughout all staff teams of the risks in the service.
- Leaders did not always recognise the significance of risks throughout the service or weaknesses identified as part of audits or reviews. Quality and safety were not a top priority.
- The clinical audit plan lacked focus and failed to ensure the provision of care was adequately monitored. Complaints' management systems were not effective.
- There was limited evidence that the views and experiences of patients and those close to them were gathered and acted on to shape and improve the service.
- There was little innovation or service development.

However, we also found that:

- Local leaders were visible and approachable.
- The service was supportive of staff and care provided was patient focused.
- Staff felt well supported and listened to, there was a strong culture of putting the patient first.

Leadership of service

- Leaders did not always recognise the significance of risks throughout the service or weaknesses identified as part of audits or reviews.
- The department had a documented accountability structure. Ward matrons reported to the lead nurse, medical staff reported to the clinical director; there was a general manager for the CBU. All leaders were well established in their role. The lead nurse, clinical director and general manger reported to the CBU director, who in turn reported to the medical director and director of nursing.
- There were consultant leads for specific services within paediatrics. For example, there was a lead for neurology, diabetes, cardiology, cystic fibrosis and endocrinology. It was recognised that there was a need for additional clinical leads, for example haematology, although this had not been included in a business case.
- There were specialist nurses for diabetes but not for any other specialty within paediatrics.
- Leaders were aware of some risks in the service, which had been identified and recorded on the risk register. However, leaders failed to recognise the significance and seriousness of some significant risks and of the incidents which had occurred and the possibility of them reoccurring and the need to ensure that these had been escalated and added to the CBU risk register. For example, the risk of a patient climbing over and falling from the landing outside the paediatric ward as well as the deteriorating patient. Leaders failed to tell us about some of the serious incidents which had occurred shortly prior to our inspection.
- We saw that there were delays in actions being progressed and actioned promptly or in line with agreed timescales. For example: It had been identified through the Epilepsy 12 national audit, undertaken in 2014, that a specialist epilepsy nurse was required to enhance patient care and achieve best practice tariff. The action plan which stemmed from the audit included an action to prepare and submit a business case for an epilepsy nurse by March 2015. We were told that there was an business case presented to NHS England and that funding was being considered.
- Job plans were in place for all consultants; the number of programmed activities for each consultant was between 10 and 12. Programmed activities (PA) are a way of informing and monitoring the allocated time a

consultant has for direct clinical care, additional NHS responsibilities, external duties, supporting professional activities as well as additional activities (time which exceeds the standard 10 PAs)
- The staff we spoke with told us that they had good working relationships with their managers and felt able to raise concerns if they needed to and that on the wards they regularly saw their local managers.

Vision and strategy for this service

- The service had a vision, which was supported by objectives; however, the vision and objectives were not service specific and lacked clarity. They were not linked to clear actions or an operational plan and the majority of staff were unaware of the vision for the service.
- The hospital's five year strategy included as an objective 'to continue to provide a comprehensive range of general secondary care services on the Kettering General Hospital site'. It stated this would include paediatrics.
- A business plan had been developed for the Women and Children's clinical business unit (CBU) which set out the CBU's vision and strategic aims.
- The CBU vision was, 'provision of outstanding care that reflects patient needs and delivers a quality service time and time again and to be provider of choice for the local and surrounding areas, to be a safe, responsive, quality service which is family friendly that continually delivers and puts women and children's on the map to be a clinically led service that is responsive to patient needs/ choice's delivered by an empowered skilled workforce, to provide efficient service with positive contribution both clinically and financially that patients can feel. The vision lacked clarity and was not specific to the CBU or division.
- The vision was supported by three objectives, 'to engage local population and clinicians to drive future service provision, to support, engaged skilled workforce to deliver quality care and to future proof developments to ensure sustainability'. The objectives were general and lacked insight into the service and it was unclear how these linked to the actions within the business plan.
- The staff we spoke with were unclear of the vision or aims of the service.

Governance, risk management and quality measurement

- There was a committee structure in place, however, the committee meeting minutes lacked detail and did not include discussion around some pertinent issues including reports circulated for the meeting. Significant risks identified on inspection, including the safety and security of Skylark ward, had failed to be considered and added to the risk register. The audit planning process lacked focus and most audits listed on the plan were not completed.
- There was a clinical business unit (CBU) - Divisional Paediatric Meeting (DPM) which met monthly. The CBU – DPM reported to the Women and Children's CBU Governance meeting (WC-CBU-GM) which also met monthly.
- The CBU – DPM were responsible for reviewing and discussing performance, finance, governance and staffing arrangements for Skylark ward as well as NICU; this did not encompass paediatric outpatient routinely. Paediatric outpatients fell under another CBU. This meant that services for paediatrics was not considered or discussed holistically.
- Review of the CBU-DPM minutes for August and September 2016 confirmed a range of issues were discussed and reports circulated, however, the minutes lacked detail and most of the reports circulated were not recorded as discussed on the agenda. For example, the finance report was circulated and there were overspends in some areas, there was no discussion of this in the minutes. Governance update reports were circulated but not discussed, these included medical devices alerts, as well as progress made with monitoring compliance on NICE guidance. There were seven guidelines relevant to the paediatric service which the CBU were required to report back and confirm whether they were compliant with. These remained outstanding and some dated back to January 2015. The report was circulated but not discussed. The paediatric business report was also circulated but not discussed; the report included an update on the risk register, incidents, six overdue SI investigation reports, and clinical audits not progressing.
- Operational performance data was not discussed at the CBU-DPM, for example, referral to treatment (RTT) times, emergency readmissions, length of stay (LOS), did not attend (DNA) rate. Although it was noted that the

business update discussed at the August 2016 meeting stated that there was a need to hold additional clinics to reduce waiting times, however, data on waiting times was not reported on in the minutes.

- The hospital's forecast trajectory was for no patients to be waiting in excess of 18 weeks by March 2017. We requested a copy of the hospital's action plan for RTT for paediatrics, however, this was not provided, but the hospital included a statement that an action plan was in place, It stated, 'Patients are dated in line with the Hospital Access Policy, accounting for their clinical urgency and their length of wait. The length of time paediatric patients have waited has caused the trust concern and a series of actions and plans have been implemented to reduce the waiting times in these areas'.
- A paediatric monthly short report was produced for circulation to members of the Women and Children's clinical business unit – Paediatric Divisional meeting. The September 2016 report highlighted key themes with the top reported incident type for August 2016 being medication incidents. It also noted that 74% of incidents (20 out of 27) were overdue being reviewed or closed. Minutes also reported that there were six serious incidents (three of which were externally reported) all awaiting urgent evidence. The paediatric short report did not state whether the serious incidents had exceeded their deadline for completion of the investigation reports.
- The WC-CBU-GM were responsible for reviewing and managing risk, quality and performance, governance, infection control and service improvement. We reviewed the minutes for July, August, and September 2016 and found that summary information was presented, but again lacked detail and the infection control lead had not attended or presented updates during the three-month period we reviewed.
- The risk register was circulated but its content not discussed, data on incidents and complaints were presented but lacked detail regarding themes, detail of serious incidents were discussed. Safeguarding matters were discussed, as well as progress with the number of audits completed, in progress and overdue. The CBU-PDM minutes were circulated but not discussed.
- The women and children's CBU risk register had identified eight risks in relation to the paediatric ward and NICU. These included, staffing issues, lack of space, temperature in the pantry, and delay in muscular skeletal surveys. There was a description of each risk, risks had been scored for the likelihood and impact, control measures recorded and residual score re-calculated; each risk had been assigned to a lead. However, we noted that some significant risks which we identified during the inspection had not been included on the risk register and the CBU were not referring to their own serious incidents to use as a source of risk identification. For example, during our inspection we identified the following risks which had not been considered: the risk of a child absconding from the department, ligature risks, relevant staff not completing safeguarding level three training, lack of appropriate care for patients with mental health needs, risk of sepsis not being identified, escalated and acted on, that staff were unaware of what action to take in the event of an abduction or attempted abduction.
- The August 2016 paediatric short report included an update on progress made with audits, the report stated there were four paediatric audits overdue. From review of the 2015/16 and 2016 /17 plan, there were six audits in total; three of those overdue were from 2015/16. The audit process should be used as a tool to assess whether care provided is being delivered in line with relevant standards. Therefore, there is service does not have an effective process to make necessary assessments. Review of the diabetes audit and action plan indicated that actions lacked detail and had not been clearly defined; deadlines for completion had not been recorded.
- The September 2016 paediatric short report highlighted key themes with the top reported incident type for August 2016, being medication incidents. It also noted that 74% of incidents (20 out of 27) were overdue being reviewed or closed. Minutes also reported that there were six serious incidents (three of which were externally reported) all awaiting urgent evidence. The paediatric short report did not state whether the serious incidents had exceeded their deadline for completion of the investigation reports.
- We noted that there were a number of policies available to staff on the intranet which had exceeded their review date. For example, the 'Guideline for Epilepsy management in Children', which had been developed in December 2011 and was due for review in December 2014. NICE guidance had been updated in January 2016: therefore, the hospital's policy had not taken this into

account. We also noted that policies had not been written for some aspects of care, for example, a policy for patients who required high dependency care or management and transfer of the critically ill child.

Culture within the service

- There was positive teamwork between medical, nursing and support staff and staff were patient focused. However, some staff did not feel supported by senior management when things went wrong.
- The staff we spoke told us that local leadership worked well and staff felt listened to. Staff had mixed perceptions about how supportive senior management was and whether concerns escalated were always acted on.
- It was the perception of some staff that they did not feel supported when things went wrong and this affected staff morale. When we asked staff about serious incidents which had occurred within the unit, most of the more junior members of staff were unable to recall serious incidents. There were two serious incidents of a similar nature, which had occurred some months apart. Most of the staff we spoke with recalled these incidents but informed us they were unaware of the outcome or lessons learned because patients had been transferred to another local hospital. Both of these incidents resulted in serious and long-term impact for each of the patients involved. We saw that these incidents, lessons learned as well as the patient outcomes were recorded on the staff notice board.
- Staff told us there were good working relationships amongst their peers as well as other disciplines. Staff at all levels told us how there was excellent teamwork throughout. Nursing and support staff told us that medical staff always took time to listen to their concerns.
- Most of the staff told us that they were encouraged to report incidents and that they felt confident in doing so and the importance of sharing information with patients and families when an incident occurred which involved them.

Public engagement

- There was limited evidence that the views and experiences of patients and those close to them were gathered and acted on to shape and improve the service.
- Patients were given the opportunity to provide feedback as part of the children and young people's survey 2014. Survey findings indicated that the hospital scored similar to or better than other hospitals, compared to the England average for all questions posed, apart from one question. The hospital performed worse than the England average for the question 'were you given any written information (such as leaflets) about your child's condition or treatment to take home with you?' scoring 6.5 / 10. We requested a copy of the action plan from the hospital but this was not provided.
- Patients were given the opportunity to provide feedback using the NHS Friends and Family Test. In April 2015, it became compulsory for patients under the age of 16 in line with those over the age of 16 to be offered the opportunity to provide feedback via the NHS Friends and Family test. The Friends and Family Test (FFT) is an important feedback tool that gives patients the opportunity to feedback on the service and ask whether they would recommend the service to their friends and family.
- We were told that there were comment cards were available to patients and that patients could also provide feedback using NHS Choices. Child friendly comment cards were also handed out to children to gauge their perception of the care and treatment they had received. We reviewed a sample of comment cards and found that immediate actions taken were recorded. However, we requested a copy of an overarching action plan, this was not provided.
- The unit had not established a service user forum or an ambassador group, therefore, once discharged and after clinic attendances, there was no active voice for patients.
- Young people's Healthwatch had recently undertaken a review of the paediatric ward. Healthwatch is an external consumer champion for health and social care. A report was produced in July 2016 which included some suggestions for actions, for example more comfy chairs for parents and carers as well as magazines for adults.

Staff engagement

- Staff felt generally well supported and listened to.
- An annual staff survey took place each year to gauge staff perception on a range of matters. We were provided with a copy of the action plan for the 2015 survey results for the Women and Children's CBU. The

action plan stated that 132 responses had been received, with five responses reporting they were unlikely to recommend, one response was extremely unlikely to recommend. An action plan was developed to address the six negative responses.

- The issues identified in the survey highlighted that some staff had reported that there was a lack of flexible working, that they felt overworked, unsupported and unappreciated and that managers were not visible. Actions to address the issues raised lacked detail and were unclear how they linked to feedback. For example one action was, 'improved communication of back to basics on mandatory day' and another, 'clinical commitment on call rota'.
- We were told that staff were able to raise issues as part of the daily handover or as part of their annual appraisal.
- The staff we spoke with told us that they felt confident in raising concerns with their immediate line manager and that they felt listened to and supported.
- Staff we spoke with told us that they were encouraged to provide patient centred care and inform patients and parents immediately if something went wrong.

Innovation, improvement and sustainability

- There was little innovation or service development.
- There were two paediatric hot clinics each week which were held on the paediatric outpatient unit. Referrals could be made by the patient's GP into the hot clinics, which were used for rapid access including one emergency slot at each clinic. The lead paediatrician utilised the clinics for both clinical and teaching purposes.

End of life care

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

Information about the service

Kettering General Hospital NHS Foundation Trust provides end of life care to patients with progressive life-limiting conditions including cancer, advanced organ failure, such as heart and renal failure, and neurological conditions.

Kettering General Hospital is a 613 bed district general hospital in Kettering and serves a population of 300,000. The hospital reported there had been 1090 in-hospital deaths between April 2015 and March 2016. This represented 51% of the deaths in their catchment area.

There are no dedicated wards for the provision of end of life care at Kettering General Hospital.

The Care Quality Commission (CQC) carried out a comprehensive inspection between 2 and 4 September 2014, which rated end of life care as inadequate due to a lack of leadership and effective outcomes for patients within the service. Access to services was poor and constrained by the agreement of a third party provider. Improvements were required to safety and to be responsive to patient's needs.

We returned to inspect the service on 11 October 2016 to carry out a comprehensive inspection of the end of life service.

Significant numbers of people are cared for in the hospital at some time during the last year of their life. The specialist palliative care team (SPCT) received 923 referrals between April 2015 and March 2016. The hospital was unable to provide a breakdown of referrals for people with or without cancer or preferred place of death.

The SPCT supports patients, giving advice on symptoms such as pain control, sickness and poor appetite. The team also offers emotional and psychological support and helps families and carers in all settings. The SPCT provide a 9am to 5pm service from Monday to Friday excluding bank holidays and are employed by the hospital. A 24 hour telephone line to the local hospice provides out-of-hours palliative care support.

A service level agreement is in place with a local hospice for two specialist palliative care consultants (four sessions) a week.

The hospital employs 2.7 whole time equivalent (WTE) chaplains, who with the support of 60 volunteers cover all Christian denominations. The chaplaincy team has access to contacts in the local community for support for other religions. The hospital provided appropriate multi faith and no faith facilities, a chapel of peace, a multi faith room, and mortuary and bereavement facilities. A discharge service supports the rapid discharge of patients in the last eight weeks of life to die in the place of their choice.

During our inspection, we spoke with eight patients and five relatives. We also spoke with 50 members of staff which included ; the SPCT, mortuary and bereavement staff, members of the chaplaincy, volunteers, clinical leaders, nurses, medical staff, a resuscitation officer, medical devices staff, support workers and porters. We observed care and treatment and looked at care records. We reviewed 17 Do Not Attempt Cardio Pulmonary Resuscitation forms (DNACPR). We received comments from our focus groups and we reviewed the hospital's performance data.

End of life care

Summary of findings

We rated the service as good for the safe, caring, responsive and the well-led and requires improvement for effective because:

- There were systems in place to protect patients from harm and a good incident reporting culture.
- Medicines were provided in line with national guidance. We saw good practice in prescribing anticipatory medicines for patients who were at the end of life.
- The hospital had a replacement for the Liverpool Care Pathway (LCP) called the 'Guidance to implement care for the dying patient, and their family and friends'. The document was embedded in practice on the wards we visited.
- Do not attempt cardio-pulmonary resuscitation (DNACPR) records we reviewed were signed and dated by appropriate senior medical staff. There were clear documented reasons for the decisions recorded.
- Patients were happy with the care they received and felt involved in their care planning at the end of their life. Nurses, doctors and the specialist palliative care team (SPC) demonstrated compassionate patient centred care throughout the inspection.
- Relatives rated end of life care provided by nurses and doctors to their relative at the end of life, as 'excellent to good'.
- Sixty volunteers supported the chaplaincy service through a hospital wide patient-visiting programme, which included support to patients at the end of life.
- Care and treatment was coordinated with other services and other providers. The specialist palliative care team (SPCT) had good working relationships with discharge services and their community colleagues. This ensured that when patients were discharged their care was coordinated.
- All adult wards had end of life care champions who were trained in specialist end of life care and were a direct link to the SPCT.
- The SPCT had a target to see patients that were referred to it within two working days. The compliance with this target was 100%.
- The hospital had an executive and a non-executive director on the board with a responsibility for end of life care.
- There was a clear vision and strategy for end of life care supported by an outcome based work plan, led by the transformational lead nurse and medical lead for end of life care.
- Risks regarding the management of bariatric patients in the mortuary were identified on the support services risk register.
- Risks associated with end of life care were recorded within individual clinical business units (CBU) and recorded on the corporate hospital risk register. Staff had taken action to mitigate against risks.

However, we also found that:

- The hospital performed worse than the England average for the five clinical outcomes in the End of Life Care Audit: Dying in Hospital (NCDAH) 2014/15, published 2016. The hospital had scored particularly poorly for the multidisciplinary recognition of patients dying, communication regarding plans of care, and meeting the spirituality and religious needs of patients. However, clear action plans were now in place to drive improvements in the service.
- The hospital had scored particularly poorly for the multidisciplinary recognition of patients dying, communication regarding plans of care, and meeting the spirituality and religious needs of patients.
- The hospital was not collecting information on the percentage of patients discharged to their preferred place of death within 24 hours.
- The service did not provide face-to-face access to specialist palliative care for at least 9am Monday to 5pm to Sunday. This did not meet the recommendations from the National Institute for Health and Care Excellence (NICE) guidelines for end of life care for adults.
- There was no practice educator post in the SPCT in line with national guidance.

End of life care

Are end of life care services safe?

Good

We rated the service as good for safety because:

- Staff reported incidents appropriately. Incidents were investigated, shared, and lessons learnt.
- Staff understood their responsibilities and were aware of safeguarding policies and procedures.
- Medicines were provided in line with national guidance and we saw good practice in prescribing anticipatory medicines at end of life.
- The hospital had addressed issues around the lack of end of life care pathway, which was now in place, and written in line with hospital policy.
- The trust had addressed inconsistencies around Do Not Attempt Cardiac Pulmonary Resuscitation (DNACPR) documentation and records were signed and dated by appropriate medical staff.
- All wards had end of life champion trained in specialist end of life care, who acted as a link to the Specialist Palliative Care team (SPCT).
- Mandatory training was provided for staff and compliance was 100%.
- Equipment was visibly clean, well maintained and fit for purpose.
- Patients had access to appropriate equipment such as syringe drivers and pressure relieving equipment.

However, we also found that:

- Permanent fridges for deceased bariatric patients were not available in the mortuary. However, temporary arrangements were in place and a capital development plan was under development.
- Medicines for coroner's cases in the mortuary were appropriately secured but there were no records of the receipt and transfer of medicines.

Incidents

- Staff understood their responsibilities to raise and record safety incidents, concerns and near misses using the hospital's electronic reporting system (the system to collect and report incidents).
- There were no never events or serious incidents reported by the SPCT between April 2015 and March 2016. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- The SPCT were informed of incidents through attendance at daily safety huddles, attended by clinical staff from wards and clinical departments in the hospital. We saw evidence of incidents discussed at SPCT meetings through review of the minutes, this ensured lessons were shared beyond the affected team or service.
- Staff knew when to apply duty of candour and the hospital was open and honest, and apologised to people when things went wrong. The Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 is a regulation, which was introduced in November 2014. This regulation requires the hospital to be open and transparent when things go wrong in relation to their care and the patient suffers harm or could suffer harm, which falls into defined thresholds.
- Whilst the SPCT, chaplaincy team and mortuary and bereavement team had not reported any incidents that meet the requirements for the duty of candour regulation, staff we spoke with were aware of their responsibilities and principles with regard to this. They were aware they would be required to inform the patient or their relatives of the incident, make an apology and they explained how the hospital should respond to any incidents.

Cleanliness, infection control and hygiene

- Standards of cleanliness and hygiene were maintained throughout the inspection and there were reliable systems in place to prevent and protect people from infections.
- Relatives and patients told us "the wards are very clean and we often see the cleaners around the wards".
- The mortuary and viewing areas were visibly clean and well ventilated. We observed designated staff undertaking cleaning duties. Completed cleaning schedules were available for each area. The mortuary adhered to the hospital's standard precautions policy. Cleaning audits for January, April and July 2016 reported 97% compliance, which demonstrated standards of cleanliness and hygiene were maintained to a high standard in the mortuary and viewing areas.

- The mortuary had sufficient facilities for hand washing, separate bins for general and clinical waste, and appropriate signage. We saw staff in the mortuary area wearing the correct personal protective equipment (PPE), such as gloves, aprons and over shoe protectors as required by hospital policy. PPE was accessible throughout the department.
- Mortuary staff explained the safety precautions and systems in place to prevent and protect patients and staff from a healthcare-associated infection. Mortuary staff were able to explain the standard of practice document for the receipt of bodies (suspected infection) and were able to direct us to the policies necessary for their practice.

Environment and equipment

- The maintenance and use of equipment kept patients free from avoidable harm.
- The SPCT told us syringe pumps were used to provide a continuous dose of painkillers. Other medicines were available to help with symptom control in a timely manner. Only one type of syringe pump was used at the hospital since March 2015, following recommendation from the National Patient Safety Agency. All End of Life care champions had been trained as a trainer for the syringe driver that was in use in the hospital. All new nursing staff received training on this equipment as part of their induction.
- Syringe pumps were maintained in accordance with professional recommendation in the medical electronics department and we saw records of the electrical testing of syringe pumps. The mortuary was equipped to store 54 deceased patients, 49 in fridges and five in long-term storage, maintenance logs for these were available. Staff told us these facilities were usually sufficient to meet the needs of the hospital and the local population. The mortuary had additional portable storage facilities available during times of high demand, for example, during bank holidays. However, it had not been necessary to use temporary facilities in the last four years.
- During our inspection in September 2014, we noted the environment within the mortuary had not been updated for some time. It has not been updated in the intervening period. There were no permanent fridges for bariatric patients. The service had purchased cooling blankets and utilised a room cooled down to an appropriate temperature to safely care for deceased bariatric patients. The service had good links with the local undertakers to ensure patients were moved to an appropriate facility as soon as possible. Although the previous arrangements for storage of bariatric patients remained unchanged, the service had done what they could and the issue would not be resolved until the area was redeveloped. The risk was recorded on the hospital corporate risk register.
- Fridges in the mortuary were monitored electronically and were manually recorded every day by mortuary staff. Changes to the required temperature of 4 to 8°C, would trigger alarms in the mortuary and on the hospital switchboard. Mortuary staff provided a 24 hour, seven day, on call arrangements and could be contacted out of hours. The mortuary department had a 24 hour, seven day, service level agreement (SLA) should urgent repair be required of essential equipment.
- The Human Tissue Authority (HTA) had licenced the mortuary to carry out post mortem examinations and storage of bodies. The licence was renewed annually, following a self-assessment audit; the trust had successfully renewed their licence in 2016.
- Patients had access to appropriate equipment such as syringe drivers and pressure relieving equipment.

Medicines

- Specialist palliative care nurses worked closely with ward based medical, nursing, and pharmacy staff to support the prescription of anticipatory medicines for patients receiving end of life care (anticipatory medicines are medications that patients may need to make them more comfortable). During our last inspection in September 2014, staff had told us they were not aware of hospital guidance in relation to anticipatory prescribing. Clear arrangements were now in place for anticipatory prescribing. Medical staff told us they knew about the guidance and were confident in prescribing anticipatory medicines. We reviewed five medication administration records and found all patients were receiving medication when they should have done.
- The SPCT told us medication could be accessed in a timely manner for patients who had expressed a wish to die at home.
- Medications of deceased patients referred by the coroner for post mortem were stored in a locked drug cabinet in the mortuary. Medicines were transported in secure containers to the pharmacy for disposal when

they were no longer required. There was no documented record of medicines entering and leaving the mortuary. This was raised with staff at the time of the inspection.

Records

- Medical records were stored in lockable cabinets. Cabinets were locked when we visited the wards, which reduced the risk of people who did not have appropriate authority for accessing the notes.
- We reviewed five end of life care pathways and supporting care records. Records were accurate, complete, legible, up to date and stored securely. In medical notes for patients approaching the end of their lives, we saw clear descriptions of their conditions and the rationale behind the decisions to stop active treatment, whilst still supporting the patient and their families.
- During our inspection in September 2014 'do not attempt cardio-pulmonary resuscitation', (DNACPR) forms were not completed appropriately. For example, some forms had not been signed by a consultant and it was not always clear whether discussions had taken place with the patient and their representative. We reviewed 17 DNACPR forms. All documentation had been signed and dated by the appropriate senior medical staff and there were clear documented reasons for the decisions recorded. Discussion with families was documented in the medical notes.

Safeguarding

- Arrangements were in place to safeguard adults and children from abuse. Staff told us they understood their responsibilities and adhered to safeguarding policies and procedures. The chaplaincy team, the SPCT and the mortuary/ bereavement team were 100% compliant with child safeguarding level two training and adult safeguarding level one training. Porters, who transferred deceased patients between the wards and the mortuary, undertook safeguarding training as part of staff induction and ongoing mandatory training requirements at the hospital.
- There was one safeguarding concern relating to a patient receiving end of life care between April 2015 and March 2016. The safeguarding concern related to a DNACPR decision put in place without discussion with the patient or their family during a previous hospital admission. The family were advised of the DNACPR by the transport service following the patients discharge from hospital. The named nurse for safeguarding adults at the hospital, undertook an investigation and identified there was an apparent misunderstanding at the time of discharge between hospital and transport services. The investigation identified a DNACPR was in place (during the previous admission) and consultation had taken place with the family who were present when the DNACPR decision was made. The safeguarding concern was not substantiated.

Mandatory training

- All staff in the hospital were required to attend mandatory training, which included moving and handling, infection prevention, information governance, health and safety and fire. The chaplaincy team (including volunteers) and the SPCT were 100% compliant with their mandatory training requirements.
- Nurses, doctors, support workers and health care professionals attended staff induction.
- This included an awareness training session on end of life care in response to the recommendations from the National Care of the Dying Audit (NCADH) in 2014 to 2015.

Responding to patient risk

- The hospital used the National Early Warning Score (NEWS) system for monitoring acutely ill patients. This system alerted staff of patients who were clinically deteriorating. The tool allowed staff to monitor patient functions, such as their heart rate, blood pressure, temperature and oxygen levels at the bedside and staff calculated a NEWS score for each patient. It was used appropriately to alert the appropriate clinician to patients who may be deteriorating and a trigger to involve the SPCT. This meant there was a system in place to monitor patient risk of clinically deteriorating including those patients receiving end of life care.
- The SPCT had a triage and prioritising system for referrals. Staff made referrals via email, telephone calls or directly to the SPCT when they attended the hospital wide safety huddles and visited the wards. The SPCT made telephone contact with wards on receipt of a referral and would visit the patient within 24 hours.
- Risk assessments were in place for pain control, tissue viability, moving and handling and risk of falls were

completed and filed in patient's care records. Actions were documented to take place where risks were identified. For example, changes in pain medication when the SPCT had reviewed a patient's pain control.
- Intentional rounding was in place on the wards to monitor people's needs. Intentional rounding is a structured approach whereby nurses conduct checks on patients at set times to assess and manage their fundamental care needs. Staff monitored care needs such as changes in a patient's position or the need to commence additional fluids during these checks.

Nursing staffing

- The transformation end of life care lead nurse represented the hospital locally and at countywide forums to work collaboratively to deliver improved patients pathways and service. This was a whole time equivalent post (WTE), funded for two years by Macmillan Cancer Services. A business case for continued funding of the post was being developed by the hospital.
- Following the CQC inspection in September 2014, the hospital had implemented the recommendation to directly employ the specialist palliative care nursing service, previously provided through a third party agreement with another NHS provider. The SPCT, led by the deputy director of nursing, was established for 2.7 whole time equivalent (WTE) specialist palliative care nurses and 0.43 WTE administrative support.
- The SPCT had experienced periods of sickness and a vacancy. They currently employed 1.7 WTE specialist palliative care nurses. The SPCT would be up to establishment by November 2016. Staffing levels met the NICE recommended guidance for staffing in palliative care for the provision of a service Monday to Friday 9am to 5 pm. The SPCT held daily handovers with the palliative care consultants to discuss new referrals, review their workload, discuss patients seen, and allocate new referrals. The SPCT attended the hospital daily safety huddles to identify patients on the end of life care pathway.

Medical staffing

- There had been a designated medical lead for end of life care in the hospital since 2015. Two specialist palliative medicine consultants (through a third party agreement with a local hospice) provided care for patients at the end of life. The consultants visited the hospital for four to five hours, four days a week and for a minimum of two hours on the fifth day. A specialist registrar (from the hospital) provided additional support over two to four days a week. Out of hour's advice and symptom control was provided by a local hospice.
- Doctors across the hospital told us they were aware of the referral process for the SPCT and sought their advice on the care of patients in the last weeks and days of life.

Major incident awareness and training

- The hospital had a major incident plan in place. There were clear instructions for staff to follow in the event of a fire or other major incident. SPCT and mortuary staff we spoke with were aware of this.
- The mortuary had contingency plans in place for the additional storage of deceased patients. Additional storage was available using a temporary portable method for 12 deceased patients in the mortuary viewing area and 16 to18 deceased patients in the post mortem room.

Are end of life care services effective?

Requires improvement

We rated the service as requires improvement for effective because:

- The hospital performed worse than the England average for the five clinical outcomes in the End of Life Care Audit: Dying in Hospital (NCDAH) 2014/15, published 2016.
- Face to face access to specialist palliative care was not available for the minimum recommended time of 9am to 5pm Monday to Sunday, in line with national guidance.
- There was no practice educator post in the specialist palliative care team (SPCT) in line with national guidance
- Documentation audits had identified poor compliance on the completion of patient documentation at the end of life.

However, we also found that:

End of life care

- The hospital had addressed issues around the replacement of the Liverpool End of Life Care Pathway, had instigated and embedded a new end of life care pathway.
- Staff understood the relevant consent and decision-making requirements of legislation and guidance including the Mental Capacity Act 2005 (MCA).
- Policies and procedures were accessible and based on national guidance.
- The SPCT were competent in their roles and supported by effective processes to ensure ongoing professional development.
- There was evidence of effective multidisciplinary working across all services.

Evidence-based care and treatment

- The hospital participated in the End of Life Care Audit: Dying in Hospital (NCDAH) 2014/15, published in 2016. The hospital scored worse than the England average in all five of the clinical audit key performance indicators (KPIs). The hospital could not demonstrate there was documented evidence that:
  - Within the last episode of care that it was recognised the patient was likely to die in the coming hours or days. The hospital scored 73% against an England average of 83%.
  - Health professionals recognised the patient was likely to die in the coming hours or days. The hospital scored 71% against an England average of 79%.
  - Patient's concerns had been listened to. The hospital scored 73% against an England average of 83%.
  - The needs of the person important to the patient were asked about. The hospital scored 41% against an England average of 56%.
  - The holistic needs of patients were documented in the last 24 hours of life. The hospital scored 41% against an England average of 66%.
- The hospital had produced an action plan to address the shortfalls and issues raised by the NCDAH 2016, monitored by the transformation lead nurse and the SPCT and reviewed bi-monthly by the End of Life Care Forum (EoLCF).
- Following the CQC inspection in September 2014, the hospital had implemented and embedded an end of life care pathway to replace the Liverpool Care Pathway (LCP), 'Guidance to implement care for a dying patient and their family and friends'. The multidisciplinary care record was in line with the recommendations published in June 2014 by the Leadership Alliance for the Care of Dying People (LACDP 2014), National Institute for Health and Care Excellence (NICE) QS13 End of Life Care for Adults and the Palliative Care Formulary (2011).

Pain relief

- Medication for pain relief was prescribed following the Palliative Care Formulary and guidance from the Northamptonshire Specialist Palliative Care Service. There were tools in place to assess and manage pain. The service used comprehensive prescription and medication administration charts for patients. These charts facilitated the safe administration of medicines.
- Patients under the care of the SPCT, had their pain control reviewed at least daily, and ensured 'as required' medication was prescribed to manage any breakthrough pain (this is pain relief given in between regular, scheduled pain relief). During the inspection, patients and their families told us their pain was managed well and there were no incidents reported by ward staff concerning poor management of pain at the end of life.
- The NCDAH 2016 identified patients reviewed in the last 24 hours of life, had their pain controlled in 73% of cases. This was 14% lower than the national average of 87%. The service used comprehensive prescription and medication administration record charts for patients. These charts facilitated the safe administration of medicines delivered via syringe pumps and were prescribed appropriately and were completed accurately, legibly and in a timely way.

Nutrition and hydration

- The NCDAH 2014/15 found 48% of patients had received a review of their nutritional requirements; this was worse than the England average of 61%. The NCDAH 2014/2015 also identified that 46% of patient's hydration requirements had been reviewed which was worse than the England average of 67%. Following the audit, the hospital had implemented a dedicated lead for nutrition/hydration management on all adult wards.
- Patients risk of malnutrition was routinely assessed using the Malnutrition Universal Screening Tool (MUST). We saw two out of six nutrition and fluid charts were not always completed in full on the adult wards. This was addressed at the time of the inspection.

End of life care

Patient outcomes

- The SPCT had received 923 referrals in the reporting period April 2015 to March 2016. The hospital had broken this down into patients with cancer and patients without cancer related referrals. Of the 923 people referred to the SPCT, 100% were seen in the hospital target time of two working days from referral between April 2015 and March 2016.
- The hospital participated in the NCDAH 2014/15, published in 2016. The results were published in March 2016. The hospital achieved seven out of eight organisational indicators. The one not achieved related to the lack of face to face care from the specialist palliative care team seven days a week.
- In all five of the clinical audit KPIs of the NCDAH, 2014/15 the hospital had performed worse than the England average.
- The service undertook a clinical audit in August 2015 to identify if end of life care documentation was being used correctly at the hospital. Records were submitted of 69 cases from 100 qualifying cases which had been selected. The service used the audit to evaluate the quality of information collated in end of life care documentation to target training needs. For example:
  - The word dying was recorded in 43% of patients' notes.
  - Relatives/friends were informed in 84% of cases that a patient was dying and 42% of patients were informed.
  - Spirituality questions on the prompt sheet were completed for 10% of patients.
  - There were individualised care plans written for 10% of patients.
  - Every part of the end of life care prompt sheet had been completed in 25% of patient's notes.
- Audit findings were shared at the bi-monthly End of Life Care Forum (EoLCF), the monthly patient safety advisory group and the monthly integrated governance meetings.
- The deteriorating patient and resuscitation steering group carried out routine compliance audits on the cardio pulmonary resuscitation of adult patients in the hospital. In the reporting period January 2016 to May 2016, 31(32%) patients with a valid DNACPR in place had received inappropriate CPR.
- Nurses told us improved communication and training by the resuscitation team had decreased the number of inappropriate DNACPRs. There was a reduction in inappropriate CPR from June to August 2016 from a monthly average of five to two. Audit themes were communication and DNACPR documentation (from the community) which was identified as not being valid in the hospital. Minutes of the August 2016 meeting, reported the implementation of combined DNACPR documentation. This was agreed with the clinical commissioning group and the hospital and implementation was planned for November 2016, supported by a training programme. An audit to monitor compliance of the updated form and hospital policy was planned for January 2017.

Competent staff

- The SPCT, mortuary and chaplaincy teams had arrangements in place for supporting and managing staff. All staff had undergone appraisal in the last 12 months. The SPCT received monthly clinical supervision.
- The SPCT had monthly team meetings where staff were updated on changes within the hospital and caseload reviews were carried out. All staff had undertaken additional training relevant to their role in palliative or end of life care.
- The SPCT provided training on using the multidisciplinary care record (end of life care pathway) document. They provided education and training on communication skills. For example: skills for supporting families and those close to the dying patient. The team also provided end of life care training at junior doctors' induction.
- National guidance for the commissioning of specialist palliative care, states "given the high level of specialist palliative care involvement in education and training (both to SPC teams and to provide specialist support to general palliative care), educators and trainers are often part of the SPC team". There was no dedicated practice educator post within the SPCT.
- End of life care champions had information folders on all the wards we visited, containing information on the Five Priorities of Care for the person who is thought to be in the last weeks and days of life. Information folders contained train the trainer records for staff who had attended the training sessions run by the champions.

- The mortuary manager provided training for porters in the hospital's procedures for transporting bodies to the mortuary and the use of equipment. For example, the trolley used to transport the deceased from wards to the mortuary. The porters told us they felt they had the necessary training; they supported each other with training needs. An experienced porter accompanied new staff to ensure they were confident and were able to follow the required protocols.

Multidisciplinary working

- The transformation lead nurse, medical lead and the SPCT had established close links with other providers of end of life care in the local area, including the local hospice, charitable organisations, primary care providers and community nurses. The aim of this was to improve patient's experience as they moved across care settings. We saw documented evidence of a multidisciplinary approach to care. We reviewed 10 sets of notes and saw documented examples of communication around care planned between health care professionals. Medical staff told us they sought guidance and acted upon advice from the SPCT.
- The SPCT regularly attended the specialist teams' multidisciplinary team meetings such as respiratory care, to provide support and guidance. Referrals to the SPCT came from most wards across the hospital. The SPCT told us they worked hard to build up good relationships with all ward teams. They told us staff on all of the wards and the clinical departments had been supportive of their roles particularly when the SPCT had experienced periods of sickness and a vacancy in recent months.
- The mortuary/ bereavement services main professional contacts were doctors, nurses, the SPCT, coroner's officers, police, registrar of births deaths and marriages, hospital chaplains and funeral directors. The mortuary/ bereavement service reported good working relationships across all services.

Seven-day services

- The hospital did not provide face-to-face access to specialist palliative care 9am to 5pm, Monday to Sunday. This did not meet the recommendation from NICE guidelines for 'End of life care for adults', which states, "Palliative care services should ensure provision to visit and assess people approaching the end of life face-to-face in any setting between 9am and 5pm, seven days a week". The out of hours palliative care advice service was a telephone advice service provided by a local hospice, available 9am to 5pm Saturday, and Sunday and bank holidays seven days a week. Therefore, the hospital did not achieve this NCDAH 2014/15 organisational key performance indicator. However, the transformation lead nurse was undertaking a pathway mapping exercise of the role and function of specialist palliative care services at the hospital. This was outlined in the end of life strategy 2015-2020, which aimed to provide a seven-day face-to-face palliative care service. The mapping exercise was due to be completed by November 2016.
- The mortuary and bereavement service had a shared function at the hospital. Mortuary/bereavement staff worked Monday to Friday. The bereavement office was open from 10am to 4pm and the mortuary was open from 8.30am to 4pm. The mortuary provided an on-call rota that covered the 24 hour period. The mortuary manager told us they rarely had to come in out of hours.

Access to information

- Hospital policies, procedures and guidelines were available to nurses, doctors and support staff who were able to access them when necessary. Documents such as policies, standards for practice, SPCT referral documents and information about the Five Priorities of Care were available on the hospital intranet. Staff we spoke with on all the wards were able to direct us to this information and stated that they used it to support their practice.
- The Healthier Northampton End of Life Care Strategy 2014-2019 identified the need to develop an electronic palliative care coordination system (EPaCCS) for Northamptonshire. EPaCCS would provide an electronic version of care planning and advanced care planning for all providers and end of life services in the county.
- The DNACPR forms were at the front of the patients' notes, allowing easy access in an emergency.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- DNACPR documentation on all wards we visited had improved since the previous inspection in September 2014. At the last inspection, three DNACPR forms were

not completed appropriately. For example, forms had not been signed by the consultant and it was not always clear whether discussions had taken place with the patient and their representative.

- During this inspection, we reviewed 17 DNACPR forms from across all ward areas. All forms were completed in line with national guidance published by the GMC and the Resuscitation Council UK. All the forms reviewed included a summary of why cardio-pulmonary resuscitation was not in the patient's best interests and were completed in line with the hospital's policy and the Mental Capacity Act (MCA).
- All DNACPR forms had evidence that patients, or where appropriate their relatives, were aware of or involved in the DNACPR decision.
- In 12 of the 17 cases, we saw decisions had been made that the patient lacked capacity and staff had made 'best interests' decisions in accordance with legislation.
- All clinical staff received training on the MCA policy at induction and then annually within essential skills training. Staff we spoke with demonstrated knowledge of consent and decision making requirements of legislation and guidance including the MCA.

Are end of life care services caring?

Good

We rated the service as good for caring because:

- Feedback from patients and those who were close to them was consistently positive and said how caring staff were to their needs.
- Patients were supported to make decisions and plan their care and were treated with dignity, respect and kindness.
- Families told us they were involved in planning their relatives care and had positive relationships with the specialist palliative care team (SPCT).
- Patients and those close to them were involved in the planning of their care.
- The SPCT, nurses and doctors helped patients and relatives to cope emotionally with their care and treatment.
- Patients were responded to compassionately, and supported by staff to meet their personal care needs.
- Incident reports were raised for patients who experienced bed moves (without consent) at the end of life of ensure patients were cared for in appropriate care settings at all times. The chaplaincy team offered spiritual support to patients of all or no faiths.
- Bereavement and mortuary services staff supported families of the bereaved with kindness, sensitivity and respect.

Compassionate care

- Nurses, doctors and the SPCT demonstrated compassionate patient centred care throughout the inspection. Patients said staff were caring and compassionate and treated them with dignity and respect. Patients told us staff discussed pain relief and their nutritional requirements with them regularly. They told us the SPCT had been approachable and friendly and had spent time with them and their relatives to answer any questions and concerns they had.
- Patients said the nurses had a good understanding of their care needs and were very 'kind.' Nurses would spend time with them whatever time of day or night it was and went the 'extra mile' to ensure care was meeting their needs. A patient said, "The nurses and doctors are very caring and kind and are always available to answer my questions. If they cannot answer them straight away, they will find someone who can and always come back to me with an answer".
- We observed a patient and their relative undergoing a consultation with a specialist palliative care nurse (SPCN) following their urgent readmission to the hospital. The patient was distressed and in pain due to a sudden deterioration in their clinical condition. The patient and their relative expressed relief at meeting the SPCN, as they were already known to them, which helped to allay their anxieties. The SPCN carried out an assessment of the patient's condition. The patient's pain was managed with appropriate analgesia and their anticipated medications were updated on their drug chart.
- The SPCN answered the patients and relatives questions and provided reassurance about their pending discharge. The SPCN discussed the benefits of providing additional support to the patient and there family, provided by the community palliative care team when they were discharged home. The SPCN

demonstrated a good level of knowledge around the end of life care needs of the patient and showed compassion and empathy to the needs of the patient and their relative.
- Mortuary staff were observed to handle bodies of the deceased in a professional and respectful way.
- Porters told us ward staff handle bodies of the deceased with dignity and respect before they were transferred to the mortuary. Nursing staff were provided with training regarding how to perform procedures respectfully.
- Relatives rated dignity and respect shown by doctors to patients receiving care at the end of life, as excellent 71% of the time and 19% as good. The hospital performed better than the National VOICES survey (2014) scores of 59% for excellent and 25% for good.
- Relatives rated dignity and respect shown by nurses to patients at the end of life, as excellent 66% of the time and 23% of the time as 'good'. The hospital performed better than the national survey (2014) of 53% for excellent and 27% for good. This demonstrated that patients at the end of life were treated with dignity and respect by doctors and nurses and performed better than the national average.

Understanding and involvement of patients and those close to them

- We looked at 12 patients' notes which demonstrated that patients were kept actively involved in their own care and documented conversations with relatives. Patients and their relatives we spoke with told us staff communicated with them so they could understand their care, treatment and condition.
- A relative said "The SPCT have been wonderful and are keeping me involved in the care of my relative so I know what is happening which takes some of my anxieties away".
- The results of the National Care of the Dying Audit of Hospitals (NCDAH) 2014/15 and published in 2016 showed that 71% of patients had been recognised as dying at the end of their life and this had been discussed with the patient's nominated individual. This meant in most cases there was documented evidence that a professional had informed a relative that the patient was expected to die in the coming hours or days. However, this was worse than the England average of 79%.
- The hospital had undertaken a bereavement survey from 2014 to 2016. 12 replies received in the autumn of 2014 and 58 replies from September 2015 to August 2016.

Emotional support

- The hospital bereavement survey 2014 to 2016 identified that 23% of relatives reported their family member's spiritual needs were being met; 5% of relatives said, no their family members spiritual needs were not being met but wished they had been, and 49% of relatives said no, as it had not been required. Twenty six per cent of relatives said they would find a bereavement follow up service helpful, 64% said it had not been necessary in this instance but they would find it helpful in the future. The chaplain said he was exploring the possibility of developing a bereavement service for relatives at the hospital.
- Staff understood the impact that a patient's care, treatment or condition had on their wellbeing and on those close to them emotionally. The SPCT told us emotional, psychological and bereavement support and advice for families was an important part of the service. Patients and relatives we spoke with told us the SPCT had provided them with emotional support.
- The chaplaincy team offered spiritual support to patients of all or no faiths. We saw patients who did not have family, friends or carers to support them, had received end of life care and had been supported emotionally by the staff. The chaplaincy team provided company and support to patients who had limited social support.
- A thank you card to the bereavement service, said, "I can never thank you enough for supporting me and my family at such a difficult time. My relative's hair was styled in line with my wishes when I came to view them. Heartfelt thanks go to you all".

Are end of life care services responsive?

Good

We rated the service as good for responsiveness because:

- The specialist palliative care team (SPCT) saw all referrals within 24 hours.

End of life care

- A rapid response service discharge service enabled patients in the last eight weeks of life to be supported to die in their preferred location.
- There were no visiting time restrictions for family or friends visiting a patient in the last days or hours of life.
- The SPCT, chaplaincy, mortuary/bereavement team had not received any complaints in the reporting period April 2015 to March 2016.
- The end of life champions had received general training on dementia and learning disabilities during their extended nursing induction.
- The chaplaincy service had a trained team of 60 volunteers who supported patients (including those at the end of life).
- Relatives and staff gave consistently positive feedback on the mortuary/bereavement service.

However, we also found that:

- The hospital did not routinely collect separate data on patients who did or did not have cancer. However, this was captured in the SPCT monthly referral data.
- The hospital did not collect data on the percentage of patients discharged within 24 hours to their preferred location.

Service planning and delivery to meet the needs of local people

- The SPCT saw 923 patients in the reporting period April 2015 to March 2016. The hospital did not routinely collect separate data on patients who had cancer or did not have cancer. However, data was captured by the SPCT and recorded on monthly referral sheets. In June 2016, of 43 referrals to the SPCT, 29 had a diagnosis of cancer.
- All patients were seen within 48 hours of referral to the SPCT in the reporting period, April 2015 to March 2016 as per the hospital's policy. Patients who were identified as requiring end of life care were referred to the SPCT by individual consultants, ward staff or the lead chaplain.
- The hospital did not have any designated beds for end of life care, staff delivered end of life care in most wards and were supported by the SPCT.

Meeting people's individual needs

- Patients reaching the end of their life were nurses on general wards in the hospital. The hospital did not provide a designated ward area for those patients requiring end of life care. Staff told us, that whenever possible, patients were cared for in side rooms in order to offer quiet and private surroundings for the patient and their family. However, they also said some patients at the end of their life were cared for in open wards, as they did not want to die in a side ward.
- In the 2014 to 2016 bereavement survey there were 70 respondents, 68% said they thought the environment where their relative had died, for example: single room, ward or in critical care was a suitable environment. However, there were five deaths in the medical admissions unit and four out of the five respondents were unhappy with the environment.
- Nursing staff told us there were no visiting time restrictions for family and friends visiting a patient in the last days or hours of life. This allowed family and friends unlimited time with the patient. Designated overnight accommodation facilities were available for families in the intensive care unit. Nurses supported relatives through the provision of recliner chairs where they were available, and there was free access to tea and coffee making facilities in all the wards we visited.
- Patients at the end of life had experienced more than one bed move in the last weeks and days of life 49% of the time. The hospital was addressing these concerns by incorporating guidance around the management of patients at the end of life in the review of the hospital escalation policy. The transformation lead nurse told us patients at the end of life would not be moved to another ward to die unless they requested to do so. An incident report would be raised if a patient at the end of life were moved. There were no incidents of a patient being moved during end of life care in the reporting period April 2015 to March 2016 which ensured patients were cared for in appropriate care environments.
- The hospital provided information to families and people important to the patient, while the patient was dying and when the patient had died. Also, a leaflet outlining the changes to be expected at the end of life was in production. We did not see information in any other language other than English. In the leaflet: What Do You Do Now? provided following bereavement it was stated that the booklet could be provided in other languages and had a direct dial telephone number to access it.

End of life care

- The end of life champions had received general training on dementia and learning disabilities during their extended nursing induction. We saw evidence of where that training had been cascaded by the end of life care champion to staff on wards and in clinical departments.
- The hospital provided a 24 hour interpreting service to patients whose first language was not English. Staff were aware of the service and told us it worked well.
- The hospital provided a combined mortuary and bereavement service and staff arranged visits, both in and out of hours, for relatives who wished to view the deceased. They ensured that people could take the time they needed to say goodbye to their relative and ask any questions they may have.
- The mortuary and bereavement office operated the combined functions of offering services to the hospital, relatives of the deceased and the local HM Coroner. The department was licenced to store the deceased, assist with the preparation of all documentation required by relatives for the registration of deaths and to carry out post mortems by the Human Tissue Authority.
- The bereavement service was available from Monday to Friday 10am to 4pm. They provided relatives with information on how to register a death as well as other useful information, such as cremation papers and the coroner's office. They returned property to family and carers and liaised with them around the issue of death certificates.
- The mortuary was open from Monday to Friday from 08.30 am to 4pm. An out of hour's service was in place to provide a viewing facility for relatives of the deceased. Viewings of babies and children were undertaken discreetly and in the most appropriate of the three bereavement suites. Babies, if small, were placed in a Moses basket or bassinet and brought into the dedicated family room. This enabled parents to view their child in a homely environment.
- Nurses and porters spoke highly of the kindness and sensitivity shown to relatives of the deceased by the mortuary/ bereavement staff. Relatives, and those close to the deceased, expressed their thanks through letters and cards, which we saw in the mortuary office.
- Staff in the bereavement office made appointments with doctors following receipt of the deceased person to ensure death certificates were completed promptly. This ensured distress to relatives was kept to a minimum. There was an information booklet available on the end of life care services provided through bereavement. This booklet detailed the support offered to families by the mortuary/ bereavement service.
- Following the previous inspection in September 2014, concerns were raised about the suitability of the multi-faith room for Christian worship. There was no evidence of the Holy Bible or a cross, either fixed or moveable for Christian worship.
- A chapel of peace, situated in the reception area of the hospital, provided two Christian services a week. Christian symbolism was present but minimised to enable people of all faiths and none to use the chapel. The chapel was well used by patients and staff, was always lit, and open to anyone who wanted to use it.
- The multi-faith prayer room was set up for people practicing the Muslim faith, in that screens were available for separation of genders, and copies of the Koran were seen on a shelf. Washing facilities were available and in need of decoration. However, we observed the location of the multi-faith room enabled staff to use the facilities during their breaks. A permanent solution to relocate the room had yet to be agreed by the trust.
- The chaplaincy service was supported by 60 volunteers who provided a programme of daily and weekly visits to wards and clinical departments. Volunteers attended a 10 week training programme, which included awareness sessions on end of life care, dementia, and hearing and visual impairment.

Access and flow

- The SPCT told us there was no formal process to identify end of life care patients admitted to the hospital. The team accessed the electronic patient record system in primary care where information for patients at the end of life was available.
- Patients at the end of their lives were documented on the daily emergency status sheets completed by each ward and shared at daily safety huddles. This ensured the hospital had an overview of all patients at the end of life.
- A CQUIN (national framework for quality and performance) was in place for end of life care to identify the reasons patients receiving end of life care did not die in their preferred place of death. Ten sets of notes from patients at the end of life were sampled between January and April 2016. Data for the first reported

period, April to June 2016, identified 10% of patients had died in their preferred place of death. The notes review identified, two patients had died in hospital as were unable to return to their residential care home, as they required additional end of life care, and a third patient died awaiting continuing care funding which was an emerging theme from the two NHS hospitals involved in the CQUIN for Northamptonshire.

- The hospital had commissioned a discharge service for adult patients who are in the last eight weeks of life and live within Northamptonshire. This rapid response service provided one primary care link nurse at the hospital Monday to Friday 8am to 4pm. The link nurse identified patients at the end of life (in partnership with the SPCT and the ward nurses) and expedites discharge to the community, where this is the preferred choice of patients.
- Where needs were complex, the primary care team undertook an initial visit on discharge of the patient to ensure a seamless transfer of care to the community nursing teams and/or specialist palliative care team as appropriate and ensure links to the relevant GP practice. End of life care took priority over other patient transport arrangements on the day.
- The discharge service had received 117 referrals in the reporting period April 2016 to July 2016. Of the patients, who had participated in the discharge service, 79% had died in their preferred place of death. There were eight inappropriate referrals to the service, due to patients either being outside the geographical area or referrals being too close to end of life and patients had died suddenly. 21 patients had died at the hospital, of which four had chosen the hospital as their preferred place of death. 13 patients had unexpectedly died and four patients had died awaiting packages of care.
- The hospital did not collect data on the percentage of patients that were discharged to their preferred place of death within 24 hours. The discharge service collected information on patients who were fast tracked for care packages or care home placements but did not collect information on time from referral to fast track discharge. Without this information the hospital were unable to monitor effectiveness of the rapid discharge process or if they needed to improve it.

Learning from complaints and concerns

- Between August 2015 and July 2016, there was one complaint about end of life care, this related to care in the critical care service (ICU). ICU had followed the hospital complaints' policy and procedure appropriately. An investigation had been completed and learning had been shared with staff.
- The chaplain said that following the bereavement survey in 2014 to 2016, four people of 70 responses had raised concerns around end of life care at the hospital. The people were contacted and offered a chance to meet with the lead nurse and chaplain to discuss their concerns. Two people attended a meeting and two people chose not to respond to the request.

Are end of life care services well-led?

Good

We rated the service as good for well-led because:

- The hospital had executive and non-executive board representatives for end of life care, which provided representation and accountability for end of life care at board level.
- The specialist palliative care team (SPCT) told us there was clear and consistent leadership for end of life care at the hospital and were actively supported to improve end of life care.
- The hospital had an end of life strategy and work plan for end of life care from 2015 to 2020.
- There were effective governance arrangements in place to ensure the delivery of the strategy and good quality end of life care.
- There were effective plans in place to address the outcomes of audits such as the National Care of the Dying Audit of Hospitals (NCDAH) 2014/15 and published in March 2016.
- Since the last inspection in September 2014, the hospital had addressed a number of issues that were identified including:
- The hospital had recruited a medical lead for end of life care.
- We saw an improvement on do not attempt cardio-pulmonary resuscitation (DNACPR) documentation.
- The SPCT were directly employed by the hospital and not a third party provider.

End of life care

- A transformation lead nurse had been appointed in partnership with Macmillan Cancer Services to lead the implementation of the end of life care strategy.

However, we also found that:

- The hospital provided a Monday to Friday specialist palliative care service excluding bank holidays. However, a 24-hour telephone helpline to the local hospice provided out of hours palliative care support.
- The hospital was unable to provide a breakdown of referrals for patients with or without cancer.
- Outcomes from local audits were not yet available as this was an ongoing piece of work.

Leadership of service

- The deputy director of nursing managed the SPCT team following their transfer to the hospital in May 2016. Staff told us there was good local leadership in the SPCT. Staff felt their line manager, the transformation lead and medical lead for end of life care, had the capacity and capability to lead the service effectively. They felt well supported by matrons, lead nurses, lead clinicians and directors in the hospital.
- The medical director and director of nursing and quality (DoNQ) were the board representatives for end of life care. There was also a non-executive director lead that provided representation and accountability for end of life care at board level.
- All staff we spoke with were aware of who their immediate managers were and were aware of the roles of the senior management team.
- The mortuary and bereavement staff and the chaplain told us that they felt supported and listened to by their line management.
- All the ward staff we spoke to knew who the leads were for end of life care.

Vision and strategy for this service

- At the time of the last inspection in September 2014, there was no clear vision and strategy for end of life care at the hospital. There was no medical lead for end of life care in post and there was a lack of direction and co-ordination with no documented end of life care priorities documented for 2014/15.
- Since the last inspection in September 2014, a medical lead for end of life care had been appointed at the hospital.
- The transformation lead nurse and medical lead for end of life care and the SPCT, told us their work was now a high priority for the hospital.
- At this inspection, we saw end of life care had executive and non-executive board representation and we saw evidence of issues around end of life care raised at board meetings. The board, non-executive directors and the integrated governance committee had attended presentations on the progress of the implementation of the end of life care strategy. This was recorded in minutes of meetings. (November 2015).
- The end of life care forum (EoLCF) led the implementation of the end of life care strategy through an outcome based work plan. The EoLCF met bi-monthly and we saw progress evidenced in the minutes of May and July 2016 meetings. EoLOF membership was from health and social care organisations and included executive and non-executive board representation.
- The strategy, 2015 to 2020, was initially set for the first 13 months in November 2015. As milestones were reached, outcomes were reflected upon and lessons were learnt which informed future outcomes. For example, dying patients in the hospital to be recognised in a timely way and to have an individualised care plan consistent with national guidance, designated end of life care champions on all adult wards.
- The multidisciplinary care record document (care pathway) and the associated training ensured end of life care services were assessed, monitored and managed on a day- to- day basis and reviewed regularly.

Governance, risk management and quality measurement

- The specialist palliative care team (SPCT) were directly employed by the hospital. This had enabled end of life care to become more integrated into the hospital.
- The SPCT in partnership with the transformation lead nurse and medical lead for end of life care led the implementation of the end of life care strategy. They planned, delivered and monitored in-service end of life care training, led the implementation of the multidisciplinary care record for patients in the last weeks and days of life, and implemented the work plan to address shortfalls in the NCDAH 2014/5 and published in 2016.

End of life care

- We reviewed the hospital's corporate risk register, which contained one risk for end of life care services. This was rated as a high risk for the hospital as it was related to the CQC rating of 'inadequate' for the end of life care service following the inspection in September 2014.
- We saw evidence of how the implementation of the end of life care strategy and work plan was monitored to mitigate the level of risk to the hospital. The EoLCF, chaired by the director of nursing and quality (DoNQ), met bi-monthly. Wards and departments reported end of life care activity within their clinical business units (CBU). Lead nurses reported into the EoLCF, and reports from the DoNQ (chairs) were presented to the integrated governance committee and to the board. The chair of the hospital board was also a member of the EoLCF.
- The work plan was risk rated using a recognised rating tool of red, amber and green (RAG) The status of the work plan (up to December 2016) was amber and green against the outcomes for 2016. This meant the work plan was being delivered in line with agreed outcomes and timescales.
- The transformation lead nurse was undertaking a service review of the current service level agreement for specialist palliative care consultants at the hospice. As well as a pathway review of patients in the 12 months of life. This included the acute dying phase at the end of life. This would help to inform discussions with commissioners around the provision of face-to-face specialist palliative care support from Monday to Sunday 9am to 5pm. This was not currently being provided at the hospital. However, a 24-hour telephone helpline provided by the hospice was in place.
- Outcomes from local audits were not yet available as this was an ongoing piece of work.
- We saw evidence of regular supervision, appraisals and professional development in the SPCT, the chaplaincy and mortuary team.

Culture within the service

- Nurses, doctors and support staff told us they felt respected and valued. They were committed to provide safe and caring services and spoke passionately about the changes in the delivery of end of life care.
- Nurses and doctors told us they were much more confident around their knowledge and abilities to care for patients at the end of life. They praised the training and support they had received from the SPCT and the transformation lead nurse for end of life care.
- The SPCT were respectful and maintained patient's dignity; there was a person centred culture. We saw staff going out of their way to respond to patients wishes.
- Staff told us how proud they were to work in the hospital and felt supported in their roles.

Public engagement

- The SPCT organised an event within the hospital during the National Dying Matters Awareness Week in May 2016. This was marked by a two-day awareness event, which involved relatives of patients whose loved one had died at the hospital.
- The transformation lead nurse was planning to run a further public event in November 2016. The team planned to ask people about what they would like for themselves and their relatives at the end of life.

Staff engagement

- All hospital staff had received a leaflet about the five priorities of care for the dying patient.
- Staff who had attended end of life care training told us the communication skills training had been particularly helpful, as it had enabled them to communicate more confidently with patients and those close to them in the last days and weeks of life.
- With the launch of the hospital's End of Life Care strategy in November 2015, the hospital engaged with the public to inform them of what it was doing to improve care. In February 2016, an article was printed in a local paper entitled 'New approach for end of life care at Kettering Hospital' and this was also shared by senior staff during interviews on a local radio station.

Innovation, improvement and sustainability

- Nurses, physiotherapists, dieticians, occupational therapists and support workers became end of life care champions in 2016. Champions acted as a resource for information related to end of life care. They also contributed to the development and implementation of the end of life care strategy across the hospital.
- Daily safety huddles highlighted patients who were dying within in each ward so additional support and guidance could be provided. For example, by the SPCT.
- The hospital was developing a mobile telephone application to provide guidance and information to staff around end of life care.

End of life care

- The chaplain was exploring the possibility of developing a bereavement follow up service for relatives following the death of a person close to them. The outcomes of the bereavement survey 2014-2016, identified 49% of relatives would find a follow up service to be beneficial.
- The hospital had agreed a county wide CQUIN (national framework for quality and performance) to identify themes that potentially impacted on whether a patient did or did not achieve their preferred place of death. This collaboration had resulted in real changes in day to day practice and had enhanced education about the early recognition of dying and referrals to community palliative care. This work had resulted in a joint bid for educational funding to be delivered collaboratively across the county.

Outpatients and diagnostic imaging

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

Information about the service

Kettering General Hospital NHS Trust has outpatients departments at four sites, Kettering General Hospital, Nene Park outpatients' clinic, Corby diagnostic centre (Nuffield centre) and Isebrook outpatients. These are satellite services managed by the department based at the hospital. Each year this hospital facilitates over 250,000 outpatient appointments.

The majority of clinics at Kettering general hospital are provided from a central outpatients department. However, specialities such as obstetrics and gynaecology, trauma and orthopaedics, diabetes, pain management and anticoagulation services are provided from satellite departments on site.

There are consultant and nurse-led outpatient clinics across a range of specialities, which are provided in the outpatients department. Outpatient clinics are held from Monday to Friday from 8am until 6pm.

The diagnostic imaging department was within the clinical support services business unit within the hospital. The department provides a full range of diagnostic imaging modalities, including general radiography, computerised tomography (CT), ultrasound, magnetic resonance imaging (MRI), nuclear medicine and interventional radiology. They perform approximately 20,000 examinations each month.

The announced inspection took place over three days, from the 12 to 14 October 2016, during which we visited a range of services and clinics at both Kettering general hospital and Nene Park Outpatients' Clinic. We inspected ophthalmology, the cardiac unit, ENT clinic, rheumatology, blood transfusion, diabetes clinic, imaging and x-ray, radiotherapy, dermatology, fracture clinic, medical oncology, chronic pain, blood department, urology, respiratory clinics and Nene Park outpatient's clinic. Throughout our inspection, we spoke with 36 patients and relatives and 40 members of staff, including nurses, health care assistants, receptionists, the service manager, business unit manager, medical director for radiology, radiology staff and medical staff. We observed interactions between patients and staff, considered the environment, and looked at five care records.

We undertook unannounced visits on 24 October 2016 to both Kettering general hospital and Nene Park outpatients' clinic, so the findings in this report do not reflect the other two sites (Corby diagnostic centre and Isebrook outpatients). We checked and reviewed five patient medical records and visited additional outpatient areas. We observed interactions between patients and staff, and reviewed care and treatment. We inspected the environment where services were provided. We reviewed information provided by stakeholders and by the hospital.

Outpatients and diagnostic imaging

Summary of findings

Overall, we rated the outpatients and diagnostic imaging services as inadequate. It was rated as inadequate for safe, responsive and well led, and good for caring. We inspected but we do not rate effectiveness for outpatients because CQC do not currently have the methodology to rate the effective key question. We found that:

- Whilst the service had taken action to manage the delays in image reporting and the waiting list for outpatient appointments, comprehensive risk assessments were not always carried out for people who were waiting to use services in outpatients. Whilst the service had a harm review process in place, not all patients waiting over 40 weeks had been reviewed at the time of the inspection.
- Not all staff had the necessary training and competencies to minimise risks to patients. Only 58% of radiologists were up-to-date on basic life support training which was below the hospital's target of 85%.
- Radiographers had poor awareness of radiation dose levels for plain film x-rays. This had been rectified by our unannounced inspection.
- Not all staff treating children in outpatient clinics at both the phlebotomy department in Kettering general hospital and Nene Park outpatient clinic were able to evidence that they had paediatric competencies in line with national guidance. The trust took actions to address this once we raised it as a risk.
- There was insufficient attention to safeguarding children and adults. Arrangements were not always in place to safeguard adults and children from abuse that reflected relevant legislation and local requirements. Not all staff that directly saw and assessed children in some of the main outpatients' clinics (for example, ophthalmology and phlebotomy) had had the required level of safeguarding children's' training.
- There were not always effective systems in place regarding the storage and handling of medicines. We found gaps in documentation where fridge temperatures were recorded in some outpatient areas. Medication that had expired was found on the cardiac unit outpatients at Kettering general hospital. Contrast media was not stored securely and could be accessed by unauthorised staff and patients.
- Care premises were not always safe. There were not always reliable systems in place to protect patients and staff from the risks of radiation exposure. In the radiology department, we found controlled areas left unsecured with doors left open and unsupervised for a long time with the small potential exposure of patients and relatives to doses of ionising radiation. This had been rectified at the time of our unannounced inspection.
- Not all cleaning materials at Nene Park outpatient clinic were stored in line with control of substances hazardous to health (COSHH) regulations.
- Patient records were not always stored securely in accordance with hospital policy.
- Medical records were not always available in time for clinics and the service had cancelled appointments at short notice as a result.
- Patients were unable to access the majority of services in a timely way for initial assessments, diagnoses or treatment. At the time of inspection in October 2016, the service had 18,816 patients on the waiting list for new appointments in outpatient services. There were 413 patients waiting over 52 weeks. The services' own figures from October 2016 showed that 69% of patients were seen within 18 weeks (for incomplete pathways) against the national standard of 92%.
- There were delays in reporting diagnostic images. There were 11,733 images awaiting a radiology report. These were was classified as non- urgent images and scans. The service was meeting performance standards for urgent images and scans.
- The "did not attend" (DNA) rate remained above the England average and at the time of inspection was 10%.
- The hospital had a number of clinic cancellations. This was 3% of clinics in October 2016.
- Services were not always provided in an environment that met people's needs.
- Patients told us that it was difficult to contact the department to book, rearrange or cancel appointments.

Outpatients and diagnostic imaging

- The service had not met the trust's timescales for responding to complaints in the period August 2015 to July 2016, but following the introduction of a revised complaints' policy in July 2016, with longer timescales for a response, improvements had been made in responding to complaints with an average response timescale of 26 days (in the period April to September 2016).
- The delivery of high quality care was not assured by the leadership or governance in place. There was a failure to make improvements following the last inspection. Risks identified at the last inspection had not been addressed.
- The service strategy for achieving priorities and delivering good quality of care was not fully embedded and understood by all staff. Staff could not clearly articulate the strategy to improve performance. Not all staff were aware of the strategy to improve RTT performance. Most of the staff in the service had no clear oversight on actual clinic backlogs in the diagnostic and imaging department.
- Some, but not all, leaders understood the challenges to good quality care and identified actions needed to address them but they lacked capacity to drive improvements in a timely way.
- There was a lack of an effective governance framework to support the delivery of quality patient care. The information used to monitor performance or make decisions was not always reliable.
- Significant issues that threatened the delivery of safe and effective care had not been identified. There was not a holistic understanding and management of risks in the service. The risks in the service identified were not always managed appropriately. Some risks found on inspection in some outpatients clinics and the imaging department had not all been recognised by the service or assessed, and included on the risk register. Effective mitigations were not always in place.
- Staff at Nene Park outpatients' clinic told us that they felt separated from the hospital and that they were isolated from the main hospital.
- There was limited evidence of engagement with patients beyond feedback being sought from the Friends and Family Test. The was limited evidence of innovation or improvement.

However, we also found that:

- Care and treatment was explained in ways that patients and relatives could understand and patients were encouraged to make their own decisions.
- Staff generally understood their roles and the need to raise concerns using the electronic incident reporting system.
- Cleanliness and infection control procedures were adhered to and potential risks to the service were anticipated and responsive actions planned.
- The hospital had an action plan for reducing the waiting list for outpatient services and was working ahead of its trajectory. Data quality issues were being addressed.
- Some specialities had introduced one-stop clinics, which reduced the number of appointments patients had to attend and facilitated timely access to care.
- The hospital had taken action to minimise the delays in urgent diagnostics and imaging reporting by outsourcing their radiology reporting.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services safe?

Inadequate

We rated the service for safe as inadequate because:

- Whilst the service had taken action to manage the delays in image reporting and the waiting list for outpatient appointments, comprehensive risk assessments were not always carried out for people who were waiting to use services in outpatients. Whilst the service had a harm review process in place, not all patients waiting over 40 weeks had been reviewed at the time of the inspection.
- Not all staff had the necessary training and competencies to minimise risks to patients. Only 58% of radiologists were up-to-date on basic life support training which was below the hospital's target of 85%.
- Radiographers had poor awareness of radiation dose levels for plain film x-rays. This had been rectified by our unannounced inspection.
- Not all staff treating children in outpatient clinics at both the phlebotomy department in Kettering general hospital and Nene Park outpatient clinic were able to evidence that they had paediatric competencies in line with national guidance. The trust took actions to address this once we raised it as a risk.
- There was insufficient attention to safeguarding children and adults. Arrangements were not always in place to safeguard adults and children from abuse that reflected relevant legislation and local requirements. Not all staff that directly saw and assessed children in some of the main outpatients' clinics (for example, ophthalmology and phlebotomy) had had the required level of safeguarding children's' training.
- There were not always effective systems in place regarding the storage and handling of medicines. We found gaps in documentation where fridge temperatures were recorded in some outpatient areas. Medication that had expired was found on the cardiac unit outpatients at Kettering general hospital. Contrast media was not stored securely and could be accessed by unauthorised staff and patients.
- Care premises were not always safe. There were not always reliable systems in place to protect patients and staff from the risks of radiation exposure. In the radiology department, we found controlled areas left unsecured with doors left open and unsupervised for a long time with the small potential exposure of patients and relatives to doses of ionising radiation. This had been rectified by our unannounced inspection.
- Not all cleaning materials at Nene Park outpatient clinic were stored in line with control of substances hazardous to health (COSHH) regulations.
- Patient records were not always stored securely in accordance with hospital policy.
- Medical records were not always available in time for clinics and the service had cancelled appointments at short notice as a result.

However, we also found that:

- The hospital used a radiology information system (RIS) and picture archiving and communication system (PACS). This meant patients radiological images and records were stored securely and access was password protected.
- Both nursing and medical staff were familiar with the electronic incident reporting system and eight out of ten could clearly articulate changes made when things went wrong.
- Investigation of incidents had contributed to changes in practice as improvements were made and learning shared because of incidents.
- Hand washing facilities and hand sanitising gel was available throughout outpatients and we observed staff using these regularly. All staff we saw were 'arms bare below the elbow' in all clinical areas.

Incidents

- NHS hospitals are required to report any unnecessary exposure of radiation to patients under the Ionising Radiation (Medical Exposure) Regulations 2000 (IR (ME) R). There had been one radiation incident reported to the CQC from October 2015 to September 2016. We saw the trust had carried out a thorough investigation and root cause analysis and appropriate measures had been taken to minimise the risk of re-occurrence. The incident presented no immediate harm to the patient. We saw that lessons were shared to make sure action was taken to improve safety within the affected team or service. For example, we saw evidence that learning from incidents was disseminated to staff at the radiation protection committee and departmental staff meetings.

Outpatients and diagnostic imaging

- Staff understood their responsibilities to raise concerns, record and report safety incidents, concerns and near misses, and how to report them. When things did went wrong, thorough and effective reviews were carried out. The service was focused on learning lessons to make sure action was taken to improve safety.
- The service used the hospital wide electronic incident reporting system to report incidents. Staff we spoke to were all aware of the system and how to use it and found it easy to manage. Nursing and other clinical staff we spoke with described the system they used and the investigating process and externally to the National Reporting and Learning System (NRLS). The National Reporting and Learning System (NRLS) is a central database of patient safety incident reports.
- From August 2015 to July 2016, the service reported no never events. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- In accordance with the Serious Incident Framework 2015, the service reported one serious incident (SI) in outpatients, which met the reporting criteria set by NHS England from August 2015 to July 2016. The incident related to delays in treatment meeting the SI criteria. Lessons were learned from this incident.
- The electronic reporting system showed that in the year to August 2016, 144 total incidents had been reported under the category 'radiology infrastructure'. These included all clinical and non-clinical incidents for radiology. Of the 144 incidents reported, 23 were related to backlog or delayed reporting of diagnostic scans. Three cases were reported into the hospitals' serious incident (SI) panel. Prior to the inspection, CQC had raised serious concerns about delays in diagnostic reporting and sought assurance from all seven NHS trust members of the East Midlands Radiology Consortium (EMRAD). The hospital introduced both a new picture archive and communication system and radiology information System on 5 June 2016. The development of a dashboard formed part of the EMRAD consortium roadmap.
- Staff reported patient safety incidents, via their local risk management systems. Incidents were discussed in governance meetings and minutes of the governance meetings from July 2016 to October 2016 confirmed there were action plans in place to drive improvement.
- Common themes of incidents reported were around waiting times, poor care and lack of communication.
- Radiologists had recently recommenced undertaking discrepancy meetings (a recommended meeting from the Royal College of Radiologists where reporting errors were discussed for learning and reflective purposes). During the summer months, there was limited opportunity to partake in these meetings due to staff shortages, annual leave and clearing the backlog of unreported images. The reporting radiographers did not participate in discrepancy meetings nor were there peer-reviews of their work either with the radiologists or within their own teams. The radiographers recognised this was a risk. However, this was not included in the risk register. Audits of their competency were performed when they first qualified and audits were completed up until 2014 at which point the consultant radiologist team deemed them to be no longer required. The service had a policy governing the audit processes.
- Medication errors were reviewed, analysed for themes and learning extracted within the medicines safety group and fed back hospital wide through the medicines safety bulletin.
- From November 2014, NHS providers were required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person. Staff generally understood their responsibilities and provided examples of when the duty of candour process would be used. We saw guidance within the service, which staff could refer to. For example, we saw in radiology department that where things went wrong, patients would be informed and apologies given to patients. We checked the recent incidents reported and saw that staff had followed the hospital policy and staff we spoke with could clearly articulate when to trigger the duty of candour to patients and their relatives. However, the inconsistency

in the management of delayed images and harm reviews meant that we were not fully assured the principles of duty of candour were being consistently applied.

- Clinical governance and departmental meetings provided staff with the opportunity for discussion of incidents. All incidents were investigated using a root cause analysis tool, taking into account the factors which may have contributed to the incident. The managers we spoke with confirmed information relating to reported incidents was collated and discussed during clinical governance meetings. We reviewed the minutes of governance meetings from June 2016 to July 2016 and this was confirmed.

Radiation Protection

- There were not always reliable systems in place to protect patients and staff from the risks of radiation exposure.
- Medical physics support was under a service level agreement with two other hospitals to provide a magnetic resonance physics expert, radiation protection advisor and medical physics expert as required under UK law. The medical physics teams provided scientific support to radiology departments in a number of areas such as monitoring of the specialist radiology equipment, monitoring staff radiation doses, and providing guidance on the various specialists' regulations surrounding the use of imaging equipment.
- The imaging department utilised three radiation protection supervisors in line with IRR99 requirements, one in computerised tomography (CT), one in the cardiac catheter labs, and one in x-ray. The purpose of these roles was to ensure that staff followed local rules and adhered to radiation protection procedures in the department. Thelocal rulessummarise the key working instructions intended to restrict exposure in radiation areas.
- During our inspection, we noted that IR(ME)R employers' procedures were in place and all documentation was available on a shared drive. The employer's procedures are required by the regulations to ensure that staff working in imaging departments provided safe care and gave the least amount of radiation to patients necessary for each examination. On review of these procedures, we saw that there was confusion over staff entitlements and whose responsibility it is to justify imaging examination to be undertaken. We saw that these procedures were largely out of date and reviewing of the procedures done on a bi-annual basis was not constructive, for example, there was a reference to films, the physical copy of images that were used a number of years ago.
- There were annual radiation protection committee meetings chaired by the general manager. We saw minutes from the meeting held in August 2016. A variety of topics were discussed, which included the latest radiation protection advisor audit which was carried out in 2014. In this audit, the radiation protection advisor had recommended that the lead aprons (protective equipment for staff and visitors from radiation) were due checks to ensure they were fit for purpose and not damaged. The meeting minutes stated that the annual screening had still not commenced. This meant that some lead gowns had not been tested for a number of years for wear and tear, and that there was a risk that they did not offer the protection required when working with ionising radiation.

Cleanliness, infection control and hygiene

- Generally, standards of cleanliness and hygiene were generally well maintained. Reliable systems were mostly in place to prevent and protect people from a healthcare associated infection.
- The majority of the outpatient and radiology areas that we visited were visibly clean. We saw cleaning schedules had been completed and domestic staff were visible across the department. Staff working in clinics where specialised equipment was used, such as the cardiac unit and ultrasound, cleaned and maintained their own equipment to ensure safety.
- We saw visibly dirty washable curtains in a consultation room in outpatients. We raised this with senior staff in main outpatients and were told that there was no regime for curtains to be changed unless they were visibly soiled.
- Hand washing facilities and sanitising gel was available throughout the department and we observed staff using these regularly. All staff we saw were 'arms bare below the elbow' in clinical areas, in line with national guidance. We saw evidence of hand hygiene audit from June 2016, which showed 100% compliance for diagnostic imaging department.
- Although there were no designated waiting areas for patients with communicable diseases, senior staff informed us that these patients would be seen in a

separate treatment room, which would be deep cleaned after use. Precautions were taken in the outpatients for patients with either known or suspected communicable diseases like infectious diarrhoea, tuberculosis or seasonal flu were placed at the end of the lists and deep cleaning was carried out when they left the room.

- Standards of cleanliness and hygiene were generally maintained within the outpatients department. For example, we saw cleaning schedules in various departments and observed cleaning of equipment on ophthalmology ward.
- There was sufficient personal protective equipment (PPE) throughout the department and it was mostly used appropriately. However, we observed some poor practice around lack of use of PPE and compliance with infection control protocols. For example, phlebotomists at Kettering general hospital and Nene Park outpatient's clinics were not always changing their gloves after patient contact and were not wearing aprons when taking bloods. This was not in line with national guidance for infection prevention and control. We raised this to the nurse in charge who addressed the issue with staff members. When we returned to the department, we observed staff wearing aprons when taking bloods and changing gloves between patients.
- The service followed guidance outlined in the management and decontamination of flexible endoscopes (Health Technical Memorandum 01-06: Decontamination of flexible endoscopes). An endoscope is used to examine and conduct procedures on internal areas of the body. For example, endoscopes used in the ear, nose and throat (ENT) clinic were cleaned in day care with the scopes checked for air leaks and this was in line with national recommendations. Cleaning of endoscopes was carried out throughout the day if demand was high with a tracking system for cleaning of scopes in place.
- The service had dedicated infection prevention and control nurses and we observed that "I am clean labels" were used on all equipment in ENT rooms and daily cleaning checks were documented.

Environment and equipment

- The design, maintenance and use of facilities and premises did not always meet patients' needs. The maintenance and use of equipment generally kept people safe from avoidable. Not all risks had been identified by the service and actioned.
- Resuscitation equipment was available throughout the outpatients department and checks were completed daily to ensure equipment was in date and fit for purpose.
- The arrangements for managing waste and clinical specimens in outpatients generally kept people safe from avoidable harm. For example, at Kettering outpatients' department, we saw clinical specimens and waste stored in line with national guidance. However, in Nene Park outpatients' clinic, we found that arrangements for managing waste and clinical specimens in the pathology department did not ensure clinical samples were labelled, recorded or stored appropriately. There was a small domestic bin in the waiting area of the walk-in pathology clinic where patients put their clinical specimens, such as urine samples. Staff did not monitor what was left in the bin to ensure samples were labelled appropriately or that containers were securely closed to prevent leakage. We raised this to the nurse in charge who moved the bin into a nurse's room so that staff could monitor what patients' were putting in.
- There were two sharps bins that were not labelled and signed appropriately at Nene Park; one in the staff room in the pathology department and another in the dirty utility in a urology clinic. We raised this with staff at the time of inspection. When we returned on the unannounced inspection, we observed that there was one sharps bin that did not have the appropriate labels. We raised this with the senior nurse on duty.
- We found some equipment that was out of date in the storage room at Nene Park outpatients' clinic. There were six syringes that were out of date by one month and six surgical instruments, such as dermatology scrapers, that had expired. We raised this to nursing staff on site who removed the items from the store cupboard. Out of date equipment was noted in the previous CQC report published in November 2014. We found a scale in the diabetic unit, which was due for service testing in May 2013. We also found two blood pressure machines in the same department that were due for service testing in July 2016. During our unannounced visit, we found that the scale and two blood pressure machines had been serviced tested and the next service due date was in October 2017.
- In Nene Park outpatients' clinic, we found that the domestic storeroom had been left unlocked and a range of cleaning materials were not stored securely in line

with the Control of Substances Hazardous to Health Regulations 2002 (COSHH). COSHH is the legislation that requires employers to control substances which are hazardous to health. The cleaning materials included chemicals that could be hazardous to health if not handled correctly. This meant that vulnerable patients and visitors could access these and this could lead to potential harm to patients. We raised this as a concern and the trust took action to ensure this room was locked when not in use.

- The environment in the fracture clinic was cramped with a lack of storage space. Each clinic saw between 70 to 80 patients per day and staff told us that they felt the facilities were not suitable for this number of people. The department consisted of a small corridor with four consulting rooms on one side and drug cupboards and staff rooms on the other. At the time of inspection, the area was crowded with people and equipment, making it difficult for staff to pass through. This had been recognised as a risk and was on the risk register at the time of the inspection.
- We observed two oxygen cylinders were not stored securely and were on the floor in main outpatients at Kettering hospital; this represented a trip hazard to staff and oxygen cylinders should be stored securely in a specific secured area with clamps or chains when not in use according to the health and safety executive (HSE) guidelines 2013. We discussed this risk with a senior staff member who said this would be addressed. During the unannounced visit, we found that the oxygen cylinders were securely stored.
- The chairs in ENT, dermatology and maxillofacial clinics were in good condition with washable material.
- Clear signage and safety warning lights were in place in the x-ray department to warn people about potential radiation exposure. The design of the environment within diagnostic imaging kept people safe from avoidable harm. Waiting and clinical areas were clean. There were radiation warning signs outside any areas that were used for diagnostic imaging. Illuminated imaging treatment room no entry signs were clearly visible and in use throughout the departments at the time of our inspection.
- The imaging service did not always ensure that ionising radiation in plain film and fluoroscopy rooms had arrangements in place to control the area and restricted access. For example, we found controlled areas (a limited access area in which there was a small potential exposure to doses of ionising radiation) left unsecured with doors left open and unsupervised for approximately ten minutes. This meant that patients and visitors were able to access the rooms unsupervised with equipment left in a position were radiation might be emitted. When challenged, radiographers were unaware of the significance of this issue. This was not included on the risk register. Even though we did not think this was an immediate health and safety risk, we felt that staff were not appropriately shutting doors and reducing access to rooms as appropriate. We raised this as a concern and found this had been addressed on our unannounced inspection.
- The imaging department had recently installed two new magnetic resonance imaging (MRI) scanners. All equipment was in working order and fully functioning. The gamma camera in the nuclear medicine department was installed in 1999. This meant that the equipment was close to its end of life. Regular quality assurance and servicing was in place to ensure that the equipment was still functioning safely. The general manager told us that there were plans in place to replace the camera in the near future.
- The waiting area for inpatients awaiting an x-ray was not fit for purpose and consisted of a corridor and a space in the main waiting room. There was limited space to manoeuvre beds and trolleys and patient's privacy and dignity was compromised. The department had been given permission and funds to undertake building works to improve this which was due to commence shortly after the inspection.
- The imaging department in Isebrook was due to have a new x-ray system installed and the department in Kettering General had recently had funding agreed to purchase two new digital mobile x-ray machines to replace old analogue machines
- The MRI scanners were kept secure behind coded doors. Radiographers performed safety questionnaires to ensure anybody entering these areas were kept safe from the high magnetic field.
- We saw evidence that risk assessments had been carried out on all imaging equipment. Staff wore radiation badges to monitor any occupational doses.

Medicines

- There were not always effective systems in place regarding the storage and handling of medicines.

- Most medicines were stored in locked cupboards or lockable refrigerators. Nursing staff held the keys to the cupboards to prevent unauthorised personnel from accessing the medication supply. There were no controlled drugs or IV fluids held in the outpatient areas.
- Not all medicines were stored safely in the pathology department at Nene Park outpatients' clinic, however. We observed a local anaesthetic cream and a box of 100 tablets of paracetamol being stored in unlocked cupboards and fridges in a room with the door propped open. The room was accessible to the general public as it was adjoined to the waiting area for the walk-in pathology clinic. Therefore, there was risk of theft, damage, tampering or misuse of these medicines. We escalated it to the nurse in charge who removed the paracetamol, locked the door and advised staff nurses to ensure this was maintained. When we returned on the unannounced inspection, a keypad lock had been installed on the door in the pathology department but it had been propped open so the room and medicines therein were not secure. This was raised with the senior nurse on duty.
- We also found prescription pain relief medicine in the medicines cupboard in cardiac unit at Kettering hospital with expiration date January 2016. We reported this to the nurse in charge.
- Fridges used to store medications were checked by staff in line with hospital policies and procedures. Temperature records were complete and contained minimum and maximum temperatures to alert staff when they were not within the required range.
- Prescription pads were stored securely. Monitoring systems were in place to ensure their appropriate use.
- All medicines we saw at Nene Park outpatients' clinic were in date and FP10 prescription pads were stored appropriately in locked cupboards.
- Following best practice guidance, contrast media was prescribed by radiologists before administration avoiding the need to utilise Patient Group Directives. However, radiographers were still able to inject contrast in CT and MRI because radiologists prescribed the contrast when justifying the imaging requests and recorded the prescription of contrast media on the request cards, which was subsequently scanned on to Radiology Information System (RIS).
- In February 2016, a risk was added to the risk register due to a national shortage of contrast media. This meant it had been difficult to fulfil orders. The service had bulk ordered the contrast media. This was found stored insecurely in boxes in the CT corridor, in an open area where patients, staff, and visitors could access. At the time of the inspection, the department was looking for more appropriate places to store these.
- Radiation dose awareness in plain film by the radiographers was poor. We spoke with three members of staff and they were unable to describe a typical dose to a patient for a chest x-ray. Radiation doses in plain film were not manually inputted into the Radiology Information System (RIS) and were only recorded directly to the Picture Archiving and Communication System (PACS). At the time there was no way that this information was able to be collected or analysed. This meant that there was no evidence of optimisation of patient doses within the department in line with IR(ME)R. Doses of ionising radiation should be audited on a regular basis to ensure that patients are only exposed to radiation doses as low as reasonably possible. Dose audits were however being undertaken by the medical physics team through a small sample size of manually recorded doses, however due to the small sample sizes these would not be representative of all the examinations carried out nor would the medical physics dose audits be carried out often enough for the hospital to monitor doses locally. At the unannounced inspection this was seen to be implemented.
- During the last inspection, we found that fridge temperatures were not always recorded and gaps were found in documentation where fridge temperatures had been recorded. During this inspection, we also found gaps in documentation where fridge temperatures were recorded in some outpatient areas. For example, we noticed that temperatures checks were missed for one to two days in the main outpatients unit and Lilford ward. The cytotoxic drug fridge was not checked for two consecutive days and occasionally for three days. Cytotoxic drugs (sometimes known as antineoplastics) describe a group of medicines that contain chemicals which are toxic to cells, preventing their replication or growth, and so are used to treat cancer. These drugs are usually supposed to be stored at recommended temperatures. This meant that if the fridge temperature went above the recommended temperature, this could go unnoticed and was not in line with the storage of cytotoxic drug guidance.
- We found that a blood sample (Haemoglobin sample) and a box of 10mls normal saline were stored in a fridge

in the diabetic unit with no fridge thermometer and no record of fridge temperature checks. This meant there was a risk that the blood sample was not stored at the right temperature as the fridge temperature was not recorded. During our unannounced visit, we found a new thermometer had been fitted to check the fridge and room temperature. However, we observed that the fridge temperature exceeded the normal recommended fridge temperature of between 2 to 8 degrees centigrade and was between 13 to 13.5 degrees centigrade. We saw that blood samples had been removed however, we found 5mls normal saline in the fridge that had expired in 2014. We also found some bottles with solution in the fridge and as per instruction on the bottles; they are supposed to be stored at fridge temperatures between 2 to 8 degrees centigrade.

- We saw in ophthalmology and dermatology clinics that stock medication was checked regularly by a pharmacist.
- Nursing and medical staff were aware of policies on administration of controlled drugs as per the Nursing and Midwifery Council (NMC) – Standards for Medicine Management (CSF).

Records

- Patients' individual care records were generally written and managed in a way that kept people safe from avoidable harm. Records seen were accurate, complete, legible, and up to date. Patient records were not always stored securely in accordance with hospital policy.
- Patients' confidential notes were not always stored securely in some clinic areas we visited. For example, in the radiology department we found notes left unattended in a radiology room. In haematology ward (Lilford ward), we found day patients' notes left unattended in the multidisciplinary team (MDT) meeting room with no keypad or locks. Patients and their relatives could easily access these notes. We also found medical notes stored in an unlocked treatment room in the cardiac unit. We raised this with senior staff and were told during the unannounced visit the digital locks were on order and due to be fitted that day.
- We looked at five records and saw that patient's individual care records were written and managed in a way that kept people safe from avoidable harm.
- Outpatients used paper records for patients' records, which were stored off site and were delivered to clinics three times a day. Medical records were not always available in time for clinics and they had cancelled appointments at short notice as a result. The electronic reporting system showed two incidents that related to missing patient records and five incidents that related to misfiled patient records.
- Figures from July 2016 show that 5% of patients were seen in outpatient clinics without their full medical record available. The trust mitigated missing notes by using letters from the last clinics and electronic systems to obtain relevant results. However, this was not always possible at Nene Park outpatients' clinic due to problems with the internet connection, meaning appointments could be cancelled at short notice. The hospital conducted audits on the availability of notes in outpatient appointments twice a year. In February 2016, their audit showed that 92% of patients' medical notes were available for their appointments at Nene Park and five patients had their appointments cancelled due to missing notes. In September 2016, 94% of patients' notes were available at Nene Park. The action plan from this audit was to continue to report missing notes as incidents and conduct another audit in March 2017.
- In Nene Park outpatients' clinic, we found that a computer terminal in an unoccupied staff room had been left unlocked and patient confidential records were clearly visible. We raised this with the nurse in charge who took action to address this.
- The hospital used a radiology information system (RIS) and picture archiving and communication system (PACS). This meant patients radiological images and records were stored securely and access was password protected.

Safeguarding

- Across the main outpatients department, nurses and healthcare assistants who were involved in the assessment and treatment of children did not all have the appropriate level of safeguarding children training. Medical staff and senior nurses were trained to Level three but all other nursing staff were trained to Level two only. This was not in line with the intercollegiate document on safeguarding children and young people (March 2014) which recommends that all nursing and medical staff who have direct contact with children and young people should attain level three safeguarding training. Therefore, we could not be sure that all staff had the sufficient knowledge and skills to safeguard children.

- Staff in outpatients department who had level two safeguarding training received information regarding recognition of potential or actual abuse and how to escalate concerns. Arrangements were in not always in place to safeguard adults and children from abuse that reflected relevant legislation and local requirements. Not all staff that directly saw and assessed children in some of the main outpatients clinics had had the required level of safeguarding children's' training.
- Clinical leads were aware of the guidance for safeguarding level three training for children and told us that safeguarding level three was required for all nursing staff dealing with children. However, we found that not all staff directly dealing with children and young people had level three training in place. For example, adults and children were seen in the maxillofacial clinic and we were told by staff that three staff members had safeguarding level 3 training. Each outpatient setting had a senior nursing staff who had level three safeguarding competency. The overall compliance rate for Corby outpatients, Nene Park outpatients' clinic, Isebrook, the fracture clinic and ophthalmology was 88%.
- Ophthalmology clinics were conducted for adults and children with full paediatric clinics running on Tuesdays and Wednesdays. We were told that nursing staff had had safeguarding level two training. No nursing staff had attained safeguarding level three training. We raised our concerns to the trust regarding the level of safeguarding training in specific groups, for example, phlebotomy staff. We were told by the hospital that 81% of the hospital phlebotomy staff had undertaken safeguarding level two training. However, we found that 19% of phlebotomists only had level one safeguarding training but had been booked to receive level two training. The trust took actions to address this when we raised it as a concern.
- Staff generally understood their responsibilities and were aware of safeguarding policies and procedures.
- Staff had regular training in safeguarding of vulnerable adults and child protection. Those interviewed were able to provide definitions of different forms of abuse and were aware of safeguarding procedures, how to escalate concerns and relevant contact information. Information on safeguarding was seen on staff noticeboards and in public areas with relevant contact numbers.
- Staff said they received feedback from the hospital's safeguarding team if they made a safeguarding referral.
- Safeguarding mandatory training for both adults and children was well attended by non-medical staff in the imaging department. In MRI and CT, 91% of staff completed both adult and child level two training, with 100% of staff in nuclear medicine completing them. 100% of ultrasound staff had also completed adult and child level one and child level two training, with only adult level two at 91%, still above the hospital's targets.
- Safeguarding training was not as well attended by the medical staff in the imaging department. 79% and 86% of radiologists had completed adult level two and child level two training respectively.

Mandatory training

- Staff received effective mandatory training in the safety systems, processes and practices. For example, staff told us they completed training in a range of mandatory subjects, including fire safety awareness, safeguarding (both adult and children), basic life support, infection prevention and control, information governance, mental capacity act (MCA), deprivation of liberty safeguards and equality, diversity & human rights.
- We saw examples of staff training records showing completed training. We also saw examples of the monitoring, which showed staff had undertaken all mandatory training, such as health and safety, infection prevention and control, moving and handling, safeguarding and basic life support.
- Staff were positive about the training provided and were confident they would be supported to attend additional training if required.
- Mandatory training rates amongst the medical staff in the imaging department did not meet the hospital's target. 58% of radiologists employed by the hospital had attended training sessions in basic life support, 64.3% in information governance, and 71.4% for fire safety, health and safety, and infection control. Other clinical staff in the imaging department performed better, however still below hospital target on basic life support (85%) information governance (80.5%) and mental capacity act awareness (80%).

Assessing and responding to patient risk

- The hospital ceased reporting the Referral to Treatment Time (RTT) in November 2015 due to the hospital data quality concerns. The data quality concerns were

investigated and corrective actions taken. In October 2016, the service reported a reduction of patients waiting over 52 weeks from 25,000 to 413 and improvements in the incomplete RTT pathway target from 30% to 69%. This demonstrated that service had been taking action to address this issue. This was being monitored through an assurance group involving regulators and reported directly to the hospital board.

- Those patients who had been waiting for longer than 40 weeks had a comprehensive clinical harm review undertaken by a consultant clinician, and this process was overseen by the hospital medical director. The outcome of this process was included in the reports to the assurance group and board.
- Comprehensive risk assessments were not always carried out for people who were waiting to use services. We found that some patients were waiting over 52 weeks for non-urgent appointments with no clear oversight yet in the service on the potential risks that could be posed to patients.
- For example, we found in ophthalmology outpatients that some patients were waiting for longer periods with the service not yet having a clear oversight on potential deterioration of patients' vision. During our unannounced visit, we spoke to staff who were unable to clearly articulate the process for managing deteriorating patients on the waiting list who had been referred to treatment. For example, the hospital relied on patients to contact their GP in case of any concerns. At the time of our inspection, there were approximately 300 children with problems with their tonsils, adenoids and grommets on ENT waiting list and the current waiting time was 52 weeks.
- Patients who had been on the waiting list for outpatient services for over 40 weeks were reviewed by consultants and prioritised as appropriate. The hospital were conducting clinical harm reviews of these patients. At the time of inspection, 978 patients had been reviewed with 397 outstanding. Of those reviewed, 533 had suffered no harm, 47 had suffered low harm and one patient had suffered moderate harm. This patient was sent for treatment at another local NHS hospital and a serious incident review took place. Whilst the service had a harm review process in place, not all patients waiting over 40 weeks had been reviewed at the time of the inspection.
- The outpatient clinics had systems and processes in place for responding to patient risk on the day of their appointments. Staff were noted to be available in all the waiting areas of the clinics so that they would detect patients who appeared unwell and needed assistance. Staff we spoke with demonstrated knowledge and understanding of patient risk, particularly for people living with dementia or learning disability, and elderly or frail patients with more than one medical condition. Patients were assessed during their first visit to the department and recorded in patient's notes.
- In the radiology department, there were signs and information displayed informing people about areas where radiation exposure took place. There were signs in the diagnostic imaging department reminding women who were or may have been pregnant to inform staff members before they were exposed to radiation. The service had identified radiation protection supervisors and we observed these displayed on a list in each department.
- There were clear procedures in place for the care of patients who became unwell or patients who deteriorated while waiting at the clinic. Staff could clearly articulate emergency procedures and the escalation process for unwell and deteriorating patients using the national early warning scores (NEWS). However, they stated these had not been used often, as the department did not often have acutely unwell patients. There was a protocol in place to manage deteriorating patients in the outlying clinics and a system was in place to transport unwell patients to the emergency department at Kettering hospital if required Staff in Nene Park, Corby and Isebrook outpatient clinics could call 999 when required to transfer unwell patients to Kettering general hospital..
- Patients who were at risk of breaching cancer waiting times were reviewed and prioritised by the cancer services team. Patients who were not on the two-week waiting list but had a positive diagnosis from a routine or urgent investigation were flagged to the cancer team in daily emails.
- The service had taken actions to address significant concerns about historical delayed reporting of diagnostic images and scans, coupled with recent concerns about post "go-live" difficulties in transition to the new radiology information system (RIS) and picture archiving and communication system (PACS).
- The reporting backlog had been on the risk register since 2012. The imaging department had performed a risk assessment in 2012. Actions identified included

reviewing of radiologist job planning, outsourcing to external reporting companies and increasing a hospital-wide agreement, where more images were reported outside of radiology, but referring clinicians. This was limited to ward and outpatient plain film x-rays where a formal radiology report would only be perform if specifically requested.

- The was a reporting backlog in October 2015 with an estimated 22,000 delayed images. An action plan to reduce this backlog and reduce risk to patients from delayed diagnoses. Initiatives included a business case to increase sonographer establishments, which would free up radiologists to undertake more reporting sessions. There had also been an increase in the number of images outsourced to external reporting companies.
- Following an upgrade of the RIS and PACS, the hospital had experienced a large backlog of unreported images. In September 2016, the department reported a backlog of around 15,612 imaging examinations. This was closely monitored within the clinical business unit and the integrated governance committee.
- During the recent upgrade of the RIS and PACS, there was a period of approximately 6 weeks where there was some periods of disruption to the overnight tele-radiology service. The department had a work around and the service was maintained throughout, even though efficiency was reduced during this time.
- In September and October 2016, the service started undertaking a review of potential harm caused to patients due to a delay in image reporting. In October, the review had identified 56 patients where a pathology was found upon the reporting of images after a significant time period. The data we received gave use limited assurance of the effectiveness of the harm audit process and 29 of the identified patients had not been rated for harm. The data showed:
  - 11 possible harm which required further clinical input.
  - 2 inconclusive.
  - 4 low harm.
  - 17 no harm.
  - 1 resulted in a serious harm review after an unknown lung cancer was detected on a routine CT scan.
- Systems were in place to monitor the time taken to report each examination and ensure that urgent and high-risk examinations were reported as a priority. Radiology management also told us that the trust had contracted three of external reporting companies to assist with addressing the backlog.
- Staff working in MRI had emergency plans in place for when patients collapsed or suddenly deteriorated on the table whilst undergoing a scan or after MRI contrast media was delivered. These were recently practiced when the scanner was installed. These emergency plans differed from that across the hospital due to the high level of magnetism, which prevent normal emergency teams and equipment from entering into the scanning rooms.
- The World Health Organisation (WHO) 'Five Steps to Safer Surgery' checklist, designed to prevent avoidable harm, was in use for patients undergoing invasive procedures and diagnostics. These checklists were used for patients undergoing angiography (procedures involving the injection of contrast into a major vessel) and image guided biopsies and drainages.
- The fracture clinic was trialling a 'virtual clinic' where medical staff would clinically review referrals to prioritise those with the most urgent needs. Appointment times would then be scheduled based on the consultant's recommendation, for example the following day. This was being piloted for emergency referrals with the aim of introducing virtual clinics for all fracture clinic patients.
- There was a clear process in place in outpatients and diagnostic imaging departments to check the identity of the patient by using name, address, and date of birth. We observed staff obtaining this information from patients that attended for appointments.
- Resuscitation equipment was available in the outpatient and diagnostic areas.
- Patient appointments were managed through a central electronic booking system (hospital wide). The service used the Medway booking system and prioritised appointments according to referral requests from GPs with urgent requests and cancer referrals booked within two weeks.

Nursing staffing

- There are no agreed national guidelines as to what constitutes 'safe' nursing staffing levels in outpatient departments. Staffing levels and skill mix were planned based on the number of clinics and patients attending. The hospital reported a total of 1079 nursing and

midwifery staff at band seven and below for the period of August 2016 and 48 nursing and midwifery staff. Nurses were flexed to provide cover within other outpatient clinics.

- At the time of our inspection, nurse staffing met the needs of patients. We found across the outpatient departments that agency and bank staff were not frequently used to fill vacancies. In the event where agency staff was required, a local induction would be given to the agency staff. We looked at two sample induction records for both agency staff and a new starter and both were accurate.
- We looked at nursing rotas up to two months before our announced inspection and no gaps were identified.
- Where additional staffing was required to cover extra clinics, sickness or annual leave, this was covered by bank staff or permanent staff who volunteered to work over and above their contracted hours. Hospital bank employed staff on an ad hoc basis.
- The outpatient clinics were staffed by registered nurses and health care assistants. Each clinic was consultant led and was run by registered nurses supported by health care assistants.
- As of August 2016, the hospital reported a vacancy rate of 12.2 % in outpatient for both staff nurses and healthcare assistants. While the highest rate was seen in blood transfusion (50%), this unit only had a staff of 1.19 WTE. There were ongoing recruitment plans.
- The nursing vacancy rate for Nene Park was 13% at the time of inspection. They had vacancies for 1.28 WTE Band 5 nurses. Senior nursing staff we spoke with told us that they found it difficult to recruit to that location. They told us that the recruitment process took months and candidates often found jobs elsewhere in that time. Managers and matrons worked clinically every week to cover the vacant posts. Nurses from Kettering main outpatients department were also flexed to Nene Park to provide cover.
- There were no registered children's nurses at Nene Park. Nene Park had a minimum of three general paediatric clinics per week that were staffed by consultants and healthcare assistants. They also saw children in some adult clinics, such as ENT. This was a risk as it meant nurses who were not specifically trained to do so were caring for children. The service recognised that this was a risk and it was included on their local risk register. Their mitigating actions were to run paediatric clinics from Kettering general hospital where they had registered children's nurses; however, this did not always happen.
- Not all staff treating children in outpatient clinics at both the phlebotomy department in Kettering general hospital and Nene Park Outpatients' clinic were able to evidence that they had paediatric competencies in line with national guidance. The hospital took actions to address this once we raised it as a risk.

Medical staffing

- Staffing levels and skill mix were planned based on the number of clinics run within the service. Medical staffing was provided by the specific specialities that were holding the clinics such as rheumatology, cardiology, ophthalmology, and ENT (ear, nose and throat). Consultants had job plans and reviewed patients in clinics from 8am until 8pm from Monday until Friday. Some clinics were covered by locum consultants and we saw evidence of local induction and training.
- Medical staffing was provided by the specific specialities that were holding the clinics such as rheumatology, cardiology, ophthalmology, and ENT. Consultants arranged outpatient clinics directly with the outpatients department to meet the needs of their speciality.
- The hospital reported 146.63 WTE consultants or equivalent and 258.17 WTE medical staff (other grades) in August 2016. Where appropriate, consultants were supported by junior doctors and locum doctors in some clinics.
- Medical and specialist consultants arranged outpatient clinics directly with the outpatients department to meet the needs of their speciality.
- Radiology had an establishment of 11.4 WTE consultant radiologists, with two specialist registrars working in the department. One locum radiologist was being utilised to assist with the reporting backlog. Radiologists provided onsite cover from 8am until 8pm weekdays and 10am until 4pm at a weekend with an additional out of hours cover.
- Due to the staff shortages in both the medical and radiographer workforce, we saw little interaction between the staffing groups during the inspection. We were told that radiologists were however readily available for queries and concerns for both the radiographer workforce as well as for other medical teams in the hospital.

Outpatients and diagnostic imaging

Diagnostic Imaging staffing

- During our inspection, we found that staffing levels and skill mix were planned and reviewed so that patients received safe care and treatment. For example, in April 2016, the radiographers covering computer tomography (CT) started a new way of working ensuring that there was a CT radiographer working on site during the night. Previously this shift was covered by an on-call arrangement; however, a workforce change was required due to the growing number of CT scans needed to be carried out overnight for both the emergency department and inpatient wards.
- Much like the rest of the NHS acute sector, recruiting radiographers and sonographers (specialist ultrasound staff) to the department was an on-going challenge and despite numerous attempts to advertise and interview radiographers, the hospital continued to struggle in recruiting and filling vacancies in both the radiographer and radiologist workforce.
- Radiographer vacancies in the diagnostic imaging department remained a large risk to the hospital. The inability to recruit experienced radiographers appeared three times on the risk register with catheter laboratory specialist radiographers being a risk since January 2015, CT and MRI radiographers since April 2015 and general radiographers since May 2015.
- CT and MRI currently had six vacancies with 14.8 WTE in post. The department had one assistant practitioner working in MRI performing basic scans such as heads and knees.
- We saw that ultrasound had two sonographer vacancies with 6.6 sonographers in post at the time of inspection. The department used two locums to cover obstetric scanning when needed. A third party provider supplied one sonographer per day in general ultrasound. This was introduced as part of the action plan to minimise the reporting delays freeing up radiologists to undertake more reporting sessions.
- The plain film rotation, which covered x-ray and fluoroscopy (both in theatre and in the department), had two vacancies at junior level, with a full establishment at senior level.
- The service had outsourced some of the image reporting and had also been engaged in training reporting radiographers to improve the backlog. The hospital had undertaken actions to improve radiology staffing, the service provision offered and the reporting backlog.
- The department had avoided junior radiographer vacancies through offering students jobs early on in their third year of training (on the condition of qualification) for when they had completed their degree. These radiographers were initially been employed as assistant practitioners while their professional registration was processed and once registration had been achieved they would be appointed as radiographers. Radiology management told us that this process had worked well.
- In order to tackle the high locum expenditure in the imaging department, where possible the department tried to use one locum radiographer for every two vacancies senior staff said.
- During our inspection we found that there was no job planning or set times for reporting radiographers to undertake their reporting activities; reporting activities were only undertaken when staff were released from clinical duties. This meant that reporting was sporadic and the radiographers were often pulled out of reporting sessions to undertake clinical duties, such as taking x-rays, due to staffing numbers and out of hours' arrangements.

Major incident awareness and training

- The hospital had a service contingency plan in place for staff to use in the event of interruption to essential services such as electricity and water supply.
- There was regular testing of generators occurred in case there was a failure of the electricity supply to the hospital.
- Staff were aware of the procedures for managing major incidents, winter pressures and fire safety incidents. Fire safety awareness training was a mandatory training and staff attended the training annually.
- In the event of a radiation or radioactive incident, there were effective arrangements in place. For example, training had been provided to staff and most staff who spoke with us about this were aware of the procedures to follow in the event of a radioactive incident.

Outpatients and diagnostic imaging

- There was an effective understanding amongst nursing and medical staff about their roles and responsibilities during a major incident. Staff were up to date on fire safety training.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

We inspected, but we do not rate the service for effectiveness. We found that:

- Some policies and guidelines were available through the hospital's intranet and staff told us they had opportunities to access computers to view these.
- The clinical lead for chronic pain conducted annual reviews of the treatments they provided and information was given to patients based on evidence and guidance.
- Clinical staff were involved in a national audit for Chronic Obstructive Lung Disease (COPD).
- The clinical lead for chronic pain conducted annual reviews of the treatments they provided and information was given to patients based on evidence and guidance.
- Most specialities within outpatient and diagnostic services delivered care and treatment in line with the National Institute for Health and Care Excellence (NICE) and national guidelines where appropriate.
- There was evidence of role development for radiographers.

However, we also found that:

- Diagnostic reference levels (DRLs) were not displayed in the imaging areas and not all staff we spoke with knew how DRLs were to be used. There is no national guidance on this.
- Outpatient clinics were held on weekdays with some exceptional clinics being planned to run on Saturdays.
- Following the upgrade of the RIS and PACS on 5 June 2016, there was evidence of a developing backlog of reporting of images due to IT downtimes and unreliability of the systems. While this issue was improving at the time of the inspection, there was a period of time when patients experienced long delays in receiving reports on their images (in some cases a number of months). These report delays affected the whole hospital and as a consequence patients waiting significant lengths of time either received a delayed diagnosis or treatment.

Evidence-based care and treatment

- Diagnostic reference levels (DRLs) were not displayed in the imaging areas and three members of staff in the plain film service we spoke with did not know how DRLs were to be used. DRLs are typical doses for examinations commonly performed in Radiology departments. They are set at a level so that roughly 75% of examinations will be lower than the relevant DRL. They are not designed to be directly compared to individual doses. However, they can be used as a signpost to indicate to staff when equipment is not operating correctly or when the technique is poor. There is no national guidance on this.
- Local CT protocols were seen to be out of date and due for review in 2014. This meant that best practice relating to a more recent evidence base was not being adopted and they may no longer reflect practise within the hospital.
- DRLs were audited by medical physics in line with patient dose audits to ensure that equipment and patient doses were kept as low as reasonably achievable. However, this showed little dissemination of this information and learning to the imaging department's clinical staff.
- We saw 'Pause and Check' posters displayed in all imaging areas visited. The Society and College of Radiographers produced this resource to reduce the number of radiation incidents occurring within radiology departments. This was introduced following the reportable IR(ME)R radiation incident to the CQC in January 2016.
- Policies were in place to ensure patients were not discriminated against. Staff were aware of these policies and gave us examples of how they followed this guidance when delivering care and treatment for patients. Staff were aware of how to access policies and procedures. Staff could also locate further guidance on the hospital's computer system, which was demonstrated to us.

- All staff we spoke with said they had access to policies, procedures, national and specialist guidance through the hospital's intranet. Overall, staff were positive about the hospital's intranet and reported that their managers communicated effectively with them via e-mail.
- The clinical lead for chronic pain conducted annual reviews of the treatments they provided and information was given to patients based on evidence from the reviews.
- The department, in partnership with a neighbouring hospital, had produced thorough, evidence based referral guidance for GPs across the county for ultrasound requests. However, on discussion with the hospital, it appeared this had not been well received, and the department had received poor feedback from the GP community due to its complexity. At the time of inspection, the department did not have the resources to review this due to the other issues relating to reporting and staffing.

Nutrition and hydration

- People's nutrition and hydration needs were risk assessed using the malnutrition universal screening tool (MUST) and met when required. For example, we observed on Lilford ward that caffeine free drinks and vegetarian food was offered to patients with specific nutritional needs.
- We observed staff offering food and drinks to people who had been waiting for long periods of time.

Pain relief

- Pain of individual patients was assessed using a pain management tool and managed accordingly. For example, on Lilford ward, patients were pain scored and analgesia was prescribed and given via a syringe driver.
- There was a dedicated chronic pain clinic, which took referrals from GPs, consultants and other departments within the hospital. This service was well used, with a range of medical and physiotherapy input.
- Specialities within outpatient and diagnostic services delivered care and treatment in line with the National Institute for Health and Care Excellence (NICE) and national guidelines where appropriate. For example, we looked at three notes in the cardiac unit and saw that patients were consented for procedures. We also found in the chronic pain department that patients were given a diary to record their individual pain scores and this was further used to carry out an effective patient centred pain assessment to ensure that evidenced based care and treatment was delivered.
- The chronic pain service involved nurses, physiotherapists, occupational therapists, clinical psychologists, and pharmacy input to provide a holistic approach to pain management. They used self-rated pain assessments and visual analogue questionnaires to monitor pain. Treatment was deemed successful if the patient reported a 40% reduction in pain after the intervention.
- The pain of individuals was assessed and managed. For example, patients in the chronic pain management department were given a pain diary and a 12-week telephone follow-up appointment. During the telephone appointment, the effectiveness of patient's injection treatment and diary results were discussed. This meant that patients were clearly able to articulate if their pain had reduced, if they slept better, if their mobility had improved and if their quality of life had improved.
- Nursing staff administered simple pain relief medication and they maintained records to show medication given to each patient.
- Patients we spoke with had not required pain relief during their attendance at the outpatient departments.
- Diagnostic imaging and breast screening staff carried out pre-assessment checks on patients prior to carrying out interventional procedures. Staff assessed pain relief for patients undergoing procedures such as biopsies through pain assessment criteria.

Patient outcomes

- Clinical staff had been involved in a national audit for chronic obstructive pulmonary disease (COPD) patients.
- The department was not participating in the Imaging Services Accreditation Scheme (ISAS). This was due to the department having other priorities, such as improving staff establishments and image report turnaround times.
- Following the upgrade of the RIS and PACS on 5 June 2016, there was evidence of a developing backlog of reporting of images due to IT downtimes and unreliability of the systems. While this issue was improving at the time of the inspection, there was a period of time when patients experienced long delays in receiving reports on their images (in some cases a

number of months). These report delays affected the whole hospital and as a consequence patients waiting significant lengths of time either received a delayed diagnosis or treatment.

Competent staff

- The hospital's appraisal policy stated that all staff were required to have an annual appraisal using the job description and person specification for their post. There was a process for identifying any training and development needs. Minutes of the monthly leadership team meeting showed that due to staffing constraints, some appraisals had been delayed.
- Appraisal rates in the imaging department were generally good. Between April 2015 and March 2016, 100% of additional clinical services, and administrative and clerical staff, and 95% Allied Health Professionals (such as radiographers) had received an appraisal. 67%, or two out of the three nursing staff in the imaging department had received an appraisal which was below the hospital target of 85%.100% of medical staff in the imaging department had completed their appraisals.
- We saw evidence of some development opportunities for radiographers. The department had three reporting radiographers (two WTE) for plain film appendicular acute injuries (limb injury x-rays from A&E) and radiographers in MRI were trained in reporting MRI pre-orbital x-rays.
- No nursing staff at Nene Park had paediatric competencies, despite clinics for children being run there on a weekly basis.
- During the unannounced visit at Kettering general hospital, phlebotomy staff did not possess paediatric competencies for carrying out all procedures on children and younger adults. For example, we found a child having venepuncture (bloods taken) and a baby (having a heel prick test) and when we asked about paediatric competencies, staff said they had not had any formal training. Staff said, "we just do it based on experience". We raised this concern with the hospital who put in place an assessment of competency that was to be observed and assessed by the clinical skills trainers starting immediately. A teaching session on paediatric venepuncture (venepuncture is the procedure of inserting a needle into a vein for withdrawing blood) had been arranged in order to provide staff with further paediatric blood taking competencies.
- The deployment of nursing staff in ophthalmology and fracture clinic did not ensure that the skill mix deployed was safe in all areas of the department. For example, we found in ophthalmology and fracture clinic departments that there were no paediatric-trained nurses available to look after children attending outpatient clinics.
- All staff in ENT had competencies in assisting with clinical procedures, chaperone duties and providing quality care for patients.
- Senior staff said that members of the team were encouraged to attend courses. For example, senior staff told us that they were going to do the nurse prescribing course next year.
- During the inspection, we saw no evidence of internal Continuous Professional Development (CPD) sessions for radiographers, however, senior staff said that the hospital funded and encouraged CPD activities outside of the hospital. Radiographers needed to be proactive in seeking courses and were likely to be funded where benefits were seen for the department. For example, one member of staff had been funded to undertake a master's degree in MRI and CT.
- At the time of the inspection, the department had two specialist registrars training with the radiologists. Consultant radiologists told us that due to the issues relating to the imaging backlog, they were concerned they were unable to support the specialist registrars learning and teaching fully due to the constraints on the consultant radiologists' time.

Multidisciplinary working

- Staff worked together to assess and plan ongoing care and treatment in timely manner. For example, MDT meetings were held in the dermatology clinic every Monday and were usually attended by skin cancer consultants, plastic surgeons and specialist nurses.
- Managers and senior staff in all outpatient and diagnostic imaging departments held regular staff meetings. All members of the multidisciplinary team attended and staff reported that they were a good method to communicate important information to the whole team.
- Regular meetings were held with consultants from nearby acute hospitals to discuss complex cases.
- Chronic pain clinicians were part of the Midlands Pain Group that was comprised of staff from neighbouring hospitals. They met quarterly to discuss service designs and improvements. Staff told us that this meant they

knew where to send patients who could benefit from a treatment not offered at their hospital. This was confirmed by speaking to patients who had been informed about treatment options at other hospitals.
- There were multidisciplinary one-stop clinics, such as in urology and the breast clinic, where patients could access consultations, diagnostics, results and clinical nurse specialists in one appointment.
- We saw a business case that the chronic pain service was developing to recruit a psychologist so that they could set up one-stop clinics for multi-disciplinary care. At the time of inspection, patients for this service were seen by psychologists in separate appointments.
- Radiologists supported the majority of multi-disciplinary team meetings (MDTs). Due to the large amount of preparation work and the reporting backlog that the department was experiencing, it was not always possible for the radiologists to attend.

Seven-day services

- Most clinics in the main outpatient department and Nene Park outpatients' clinic did not routinely provide a seven day a week service. In order to deal with appointment backlogs some outpatient services were planning to run clinics on Saturdays.
- The radiographers offered a 24-hour, seven-day week service for plain film, theatre fluoroscopy and CT x-rays for both inpatients and A&E patients. Plain film x-rays for GP patients and outpatient clinics were available from 9am until 5pm during the week, on a walk in basis at Kettering general hospital. Other x-ray departments were available at other locations and offered an appointment service for GP patients
- Radiologists provided onsite cover from 8am to 8pm weekdays and 10am to 4pm during the weekend. Outside of these hours, the department had a service level agreement with a tele-radiology company who provided reporting services for CT and MRI scans performed overnight.

Access to information

- Staff were generally able to access patient information such as diagnostic imaging records and reports, medical records and referral letters appropriately through electronic records. Systems and processes were in place if patient records were not available at the time of appointment.
- Some staff reported that missing notes were an on-going issue for some clinics although most said that the situation had improved recently. In these cases, temporary files were created if referral letters and clinic correspondence could be obtained electronically. In other cases, notes were not available at the start of clinic but could be located during the clinic running times.
- Clinic information was shared with patients GPs in letter format. These were produced by the clinician following the appointment and copies sent to GPs and patients.
- The hospital joined a radiology consortium with six other NHS Hospitals in the East Midlands on the 5 June 2016. This consortium, which has vanguard status and national funding, was to replace existing PACS (Picture Archiving and Communications System) and RIS (Radiology Information System) to enable images and reports to be shared across the consortium hospitals. This will eventually allow outsourcing of reporting amongst the hospitals that will support the capacity and cost reduction required to sustain timely radiology reporting. They will also have access to more specialised reporting across the region. At the time of the inspection, the consortium was still in its infancy and currently unable obtain these benefits.
- During the installation and the four months following the change over to the new PACS (Picture Archiving and Communications System) and RIS (Radiology Information System), the service had been experiencing severe issues with the stability of the PACS, RIS and reporting systems. This had meant the IT systems at times were unavailable to various members of staff across the hospital to review or report upon images in a timely manner. At the time of the inspection, this had appeared to be mostly resolved due to a software upgrade carried out by the supplier and the upgrade of the hospitals network connection.
- Staff said that there had been a lack of training on the new RIS system, and many of the features, especially data retrieval was still not being fully utilised. This meant that the administration and management teams were still manually recording data and performing their own data analysis.
- Radiology managers told us that the hospital was in the process of introducing an electronic referral system (due

early next year). This meant that the imaging department and the referrers had to rely on paper based imaging requests and all information was stored electronically.
- There were systems in place to escalate urgent unexpected findings to GPs and medical staff. This was in accordance with the Royal College of Radiologist guidelines.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- There was a hospital policy to ensure that staff were meeting their responsibilities under the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS).
- Consent for care and treatment was usually managed by individual specialist departments rather than the service.
- Staff said that they had had some training in MCA and DoLS as part of their safeguarding training.
- Nursing, diagnostic imaging, therapy and medical staff understood their roles and responsibilities regarding consent and were aware of how to obtain consent from patients.
- Patients told us that staff were very good at explaining what was happening to them prior to asking for consent to carry out procedures or examinations.
- People using the chronic pain service were given written information on every treatment option that was suitable for their needs and advised to go home and decide in their own time. Appointments were only booked once the patient had made their own decision. Staff would then discuss their decision with them in their appointment and ensure that they fully understood what they were consenting to. Patients we spoke with described this process and said they felt supported to make their own decisions.

Are outpatient and diagnostic imaging services caring?

Good

We rated the service as good for caring because:

- Staff treated patients with compassion, kindness, dignity and respect.
- Feedback from patients and their families was continually positive about the way staff treated them.
- Care and treatment was explained in ways patients and relatives could understand and patients were encouraged to make their own decisions.
- Staff were aware of the need for emotional support for patients and we observed caring interactions throughout the department.

Compassionate care

- Throughout our inspection, we saw patients were treated with compassion, kindness, dignity and respect. Staff respected patients' social, cultural and religious needs.
- We observed positive interactions between staff, patients and relatives. Staff introduced themselves and took time to interact in a considerate and sensitive manner. We saw that frequent patients had built relationships with staff and told us they felt at ease in their care.
- We spoke with 36 patients and relatives from outpatient clinics including fracture, dermatology, ENT, ophthalmology, medical oncology, x-ray, ultrasound and chronic pain clinics. They all spoke highly of the care they had received and described staff as 'brilliant' and 'supportive'.
- The outpatients' department regularly scored above the England average in the NHS Friends and Family Test. The NHS Friends and Family Test asked people if they would recommend hospital services. Positive recommendation results had been at 95% or above since October 2015. In August 2016, 97% of respondents said they would recommend the outpatient services at this hospital. There were 1,452 responses of an eligible 15,645 patients, equating to a 9% response rate. This was above the proportion of responses received across England, which was 6%. Patient comments from the NHS Friends and Family Test praised the friendly atmosphere, thanked staff for their help and noted their 'polite manner' and 'lovely attitude'.
- The hospital was part of the National Cancer Patient Experience Survey 2015. Results for the outpatient department were in line with or better than the England average. Questions covered aspects such as receiving understandable information, staff explaining test results

and being able to contact a clinical nurse specialist for support. For example, 94% of respondents said they knew who to contact if they were worried about their condition or treatment after they left hospital.
- Patients were directed to separate waiting areas and discreet changing facilities for appointments that required hospital gowns, to protect their dignity.
- Patients were given the opportunity to be accompanied by a friend or relative and there were chaperones available when personal care was provided. For example, female nurses or healthcare assistants were available to act as chaperones in all appointments in the breast clinic.
- We saw staff respecting patients' privacy and dignity, for example by knocking on doors to consultation rooms.

Understanding and involvement of patients and those close to them

- Patients we spoke with felt wellinformed about their care and treatment.
- After their appointments, patients were aware of when they would receive test results or future appointment dates. Patients understood when they might need to attend the hospital for repeat investigations.
- Staff communicated with patients and families in ways they could understand and patients felt they had been encouraged to make their own decisions.
- Patients were able to be escorted by their relatives or friends if they wished.
- Staff could give examples of when they had used face-to-face and telephone interpreters to ensure patients fully understood their treatment.
- We saw evidence of letters sent to patients informing them when there had been a change to their planned consultant. Patients we spoke with whose planned consultant had changed confirmed that they had received such letters before their appointment.
- We saw examples of carers and relatives being actively involved in patient care. For example, the chronic pain service offered appointments solely to provide advice and education to patients' relatives. Staff, patients and their families spoke highly of this and felt that it had improved their treatment outcomes.

Emotional support

- Staff throughout the department understood the need for emotional support. We spoke with patients and relatives who all felt that their emotional wellbeing was cared for. We observed staff providing additional support to patients who seemed anxious, for example nurses in the breast clinic sat and talked with patients when waiting for a mammography to ease their nerves.
- Staff had a good awareness of patients with complex needs and those patients who may require additional support should they display challenging behaviour during their visit to outpatients.
- Patients we spoke with said that they had been encouraged by staff to contact external agencies for further support outside of the hospital. For example, Macmillan support groups and the 'Heart to Heart Cardiac Support Group'. Staff in the chronic pain service were in contact with a local independent chronic pain support group and encouraged patients to contact them.
- Consultants were responsible for breaking bad news to patients and described examples of arranging additional support for these patients. Patients with cancer had access to a clinical nurse specialist for additional support. In the National Cancer Patient Survey 2015, 82% of respondents said that it had been 'quite easy' or 'very easy' to contact their clinical nurse specialist.
- Patients in the ophthalmology department told us that their condition had been explained to them and they had sufficient information to understand their condition.

Are outpatient and diagnostic imaging services responsive?

Inadequate

We rated this service as inadequate for responsive because:

- Patients were unable to access the majority of services in a timely way for initial assessments, diagnoses or treatment. At the time of inspection in October 2016, the service had 18,816 patients on the waiting list for new appointments in outpatient services. Trust data showed that 413 patients had been waiting over 52 weeks; however, this data had not been validated so we could not be assured of how many patients waited for long

periods of time. The services' own figures from October 2016 showed that 69% of patients were seen within 18 weeks (for incomplete pathways) against the national standard of 92%.

- The services' own figures from October 2016 showed that 69% of patients were seen within 18 weeks (for incomplete pathways) against the national standard of 92%.
- The hospital was not nationally reporting referral to treatment time (RTT) performance for incomplete pathways at the time of inspection due to historical problems with the validity of data.
- Data provided by the hospital showed that the majority of medical specialities were performing below the national standard of patients seen within 18 weeks of a referral for outpatient services. Performance at the time of inspection (for incomplete pathways) was:
  - Medical oncology: 47%
  - Ophthalmology: 59%
  - ENT: 72%
  - Cardiology: 69%
  - General medicine: 84%
  - Clinical haematology: 76%
  - Dermatology: 82%
  - Rheumatology: 75%
  - Gynaecology: 76%
- At the time of inspection, there were 11,733 images awaiting a radiology report. These were classified as non- urgent images and scans. The service was meeting performance standards for urgent images and scans.
- From April 2015 to March 2016, the "did not attend" (DNA) rate for the hospital was 8%, which was higher than the England average of 7%. The DNA rate remained above the England average and at the time of inspection was 10%.
- The hospital reported a total of 143 cancelled clinics were cancelled within six weeks of the clinic date in October 2016. This was 3% of clinics were cancelled that month.
- Services were not always provided in an environment that met people's needs. Some outpatient consultations for haematology clinics were carried out in consultation rooms with very thin walls which meant that patient confidentiality was not always maintained.
- It was not always possible to run additional clinics to meet demand due to staffing and availability of facilities. This was raised as a concern in the previous CQC inspection in September 2014.
- Patients told us that it was difficult to contact the department to book, rearrange or cancel appointments.
- The service had not met the trust's timescales for responding to complaints in the period August 2015 to July 2016, but following the introduction of a revised complaints' policy in July 2016, with longer timescales for a response, improvements had been made in responding to complaints with an average response timescale of 26 days (in the period April to September 2016).

However, we also found that:

- The hospital had an action plan for reducing the waiting list for outpatient services and was working ahead of its trajectory. Data quality issues were being addressed and the hospital was on track to start reporting RTT performance from December 2016.
- Some specialities had introduced one-stop clinics, which reduced the number of appointments patients had to attend and facilitated timely access to care.
- The hospital had taken action to minimise the delays in urgent diagnostics and imaging reporting by outsourcing their radiology reporting.

Service planning and delivery to meet the needs of local people

- We saw some evidence that some services were planned to meet the needs of the local population. For example, to accommodate patients across North Northamptonshire and South Leicestershire, outpatient services were provided from Kettering general hospital and peripheral sites: Corby Diagnostic Centre, Isebrook Hospital in Wellingborough and Nene Park outpatients' clinic at Irthlingborough.
- The NHS e-Referral service was a secure and free NHS appointment booking service. The hospital used NHS e-Referral to allow patients to choose the location, date and time of their first outpatient appointment. However, at the time of inspection, this service was unavailable.
- The facilities and premises were not always appropriate for the services that were delivered. For example, the environment in the outpatient department at Kettering general hospital did not always allow patient confidentiality to be maintained; clinic rooms in the haematology department were not all soundproofed

and patients could be overheard when in consultations. In addition, patient consultations took place in in open cubicles without doors in the ophthalmology department.

- We saw occasions where the environment and lack of space had a negative impact on patients' privacy and dignity. For example, inpatients waiting for x-rays in their hospital beds were in view of the outpatients' waiting area. Also, patients in the ophthalmology clinic were given eye drops in the corridor where other people were waiting because there were no other rooms available.
- The haematology clinic area did not provide appropriate facilities to prevent confidential patient information being overheard by people in adjacent clinic rooms. We found that the walls in haematology outpatients' consultation rooms were thin so that patients in the next consultation room could overhear sensitive conversations. During our unannounced visit to Haematology outpatient clinic, we observed a patient's consultation with a consultant (patient consent had been obtained), whilst a CQC colleague sat in the next room and could clearly hear the patients' name, date of birth and diagnosis. Senior managers told us that there was an informal local process of not using adjacent rooms to provide privacy for patients, but this system was not being followed during our inspection. We raised this as a concern with the service.
- The design and layout of the breast clinic was appropriate for the services delivered and maintained patients' privacy and dignity. For example, consultation rooms led to x-ray rooms via a private corridor so that patients did not have to walk through public areas in gowns. The design and layout of Nene Park outpatients' clinic was also appropriate for the services delivered and clinics were planned based on the facilities available; for example, uroflow clinics were allocated a private waiting area with toilets (uroflow measures the flow and force of your urine stream). The x-ray department also had private changing rooms that led straight into x-ray rooms.
- The environment was not always appropriate for children being seen in adult clinics at Kettering general hospital. For example, children waiting to be seen in the fracture clinic were waiting with adults from the emergency department due to lack of space. Staff told us that, because the area was shared, it was often overcrowded and they were not always aware of whom their patients were.
- There was a small waiting area for children with some distraction items such as toys; however, we observed adults waiting in this area due to lack of seating elsewhere. The waiting area had been risk assessed and was on the departmental risk register. Staff had raised the issue to the executive team and, as a result, children's clinics were moved to the paediatric department. However, children still attended clinics alongside adults in the main outpatients department. For example, the pathology department also treated children in adult clinics but there were no toys or books in the waiting area.
- There were areas of the department that did accommodate children, such as the ENT clinic at Kettering general hospital that had a separate room with toys.
- Car parking facilities were available at each site; however, the number of parking bays did not meet demand. There were a limited number of disabled bays at Kettering general hospital, which were located at a distance from the outpatients department. All patients we spoke with told us that car parking was an issue and added to the anxiety around their appointment. Relatives and patients who had mobility issues told us that they found it difficult to get disabled parking and had experienced problems getting to the department. Parking was raised as an issue in the CQC inspection in September 2014. The hospital had plans to develop another storey of car parking spaces but this had not commenced at the time of inspection. The service had included information in appointment letters to say that car parking may cause delays after it was identified as a theme in complaints.
- The main outpatient reception had been renovated since the last inspection and signs to the department had improved. However, not all patients we spoke with found the department well signposted and two patients described occasions when they had been late for appointments due to not being able to find the clinic.
- There was a café and shop at the main outpatient reception and waiting areas had water dispensers and vending machines.

Access and flow

- Patients were unable to access the majority of services in a timely way for initial assessments, diagnoses or treatment. There were long waiting lists with patients waiting up to 52 weeks for outpatient services. At the

time of inspection in October 2016, the service had 18,816 patients on the waiting list for new appointments in outpatient services. Trust data showed 413 patients had been waiting over 52 weeks; however their data was not validated so we could not be assured of how many patients were waiting for long periods of time.

- The NHS Constitution states that patients should wait no longer than 18 weeks from GP referral to treatment. All NHS acute hospitals are required to submit performance data to NHS England which then publically report how hospitals perform against this standard. The maximum waiting time for non-urgent consultant-led treatments is 18 weeks from the day a patient's appointment is booked through the NHS e-Referral Service,or when the hospital or service receives the referral letter.
- The hospital was not reporting RTT performance for incomplete pathways at the time of inspection due to historical problems with their data that occurred after an IT system upgrade in August 2015. The issues had compromised the validity of recorded waiting times on their patient tracking list which monitored how long patients waited for their first outpatient appointment. This meant the trust could not be assured that they were monitoring the patient waiting times accurately or that patients were being seen within the 18 week national standard. They had not reported RTT performance nationally since November 2015 but planned to begin again by December 2016
- When the issues were identified in November 2015, there were eight patients identified as having waited over 52 weeks for an outpatient appointment. However, after validating the data, it was found that 25,000 patients were waiting over 52 weeks. The hospital was in the process of validating over 150,000 data entries on the patient-tracking list to ensure they were accurately recording and managing waiting times. At the time of inspection, they had 413 patients waiting over 52 weeks for their first outpatient appointment. This data had not been validated so we could not be assured of how many patients waited over 52 weeks.
- The service was monitoring its own RTT performance for incomplete pathways as part of their improvement plan. Figures from October 2016 showed that 69% of patients were seen within 18 weeks. This remained below the national standard of 92%, although performance had improved since March 2016 when only 30% of patients were seen within 18 weeks. The hospital was on track to achieve their target of 77% by the end of November 2016, which had been agreed with local clinical commissioning groups.
- Data provided by the hospital showed that the majority of medical specialities were performing below the national standard of patients seen within 18 weeks of a referral for outpatient services. Performance at the time of inspection was:
  - Medical oncology: 47%
  - Ophthalmology: 59%
  - ENT: 72%
  - Cardiology: 69%
  - General medicine: 84%
  - Clinical haematology: 76%
  - Dermatology: 82%
  - Rheumatology: 75%
  - Gynaecology: 76%
- The RTT performance for medical oncology had remained between 40% and 50% since April 2016. The hospital had an action plan to address this which included a data validation exercise that was completed in November 2016; performance had increased to 63% as a result. However, this was still below the national standard of 92% of patients seen within 18 weeks. The hospital planned to meet the national standard by December 2016 by funding patients to receive treatment at external providers, such as local NHS and independent hospitals, from November 2016.
- Specialities that were performing in line with or better than the 92% national standard of patients seen within 18 weeks were gastroenterology and endocrinology, which were performing at 95% and 97% respectively.
- At the time of inspection in October 2016, the service had 18,816 patients on the waiting list for new appointment in outpatient services. This had remained relatively unchanged since July 2016. The hospital stated that this was due to their focus on validating their data during that period. Minutes from board meetings confirmed that their data validation programme occurred at this time and was completed at the end of September 2016. Ophthalmology and urology had the most patients waiting, with 1298 and 637 patients waiting for new appointments respectively.
- At the time of inspection, 9% of patients on the waiting list had been waiting over 31 weeks, 4% had been waiting over 40 weeks, and 2% had been waiting over 52 weeks for treatment. Data on their patient tracking list

showed that there were 413 patients waiting over 52 weeks; this number had reduced from 25,000 and was better than the hospital's planned reduction trajectory that had been agreed with commissioners. The remaining 413 patients were being prioritised and risk assessed for clinical harm. The data was being validated to ensure accurate waiting times were captured.

- Referrals were prioritised by clinical urgency; suspected cancer referrals first, then urgent referrals and then routine referrals on a 'next in turn' basis. Suspected cancer and urgent referrals did not experience delays in accessing appointments.
- The maximum waiting time for suspected cancer referrals is two weeks from the day a patient's appointment is booked through the NHS e-Referral Service,or when the hospital or service receives the referral letter. The hospital had met the national standards for cancer waiting times since October 2015, apart from in August 2016, when the percentage of patients receiving treatment within 62 days of referral was at 79%. The national standards were:
  - 93% of patients should be seen by a specialist within two weeks of referral.
  - 96% of patients should receive their first treatment within 31 days of diagnosis.
  - 85% of patients should receive their first treatment within 62 days of referral.
- Patients did not experience delays in receiving appointments for radiology and diagnostic tests. Since October 2015, the radiology department regularly achieved 100% of patients receiving an appointment for imaging within six weeks of the request.
- Results from the National Cancer Patient Experience Survey 2015 were in line with the England average for 'the length of time for waiting for diagnostic tests was about right'. However, the department scored below average for 'the length of time for attending clinics and appointments was right'.
- The hospital's action plan for reducing their waiting lists included running additional clinics to meet the demand for outpatient services; however, we found that this was not always possible in practice. During our inspection in September 2014, it was identified that the outpatients' department did not always have the capacity to run additional clinics to meet the demands on the service. The issue had not improved on this inspection. For example, there were 1,269 patients waiting up to 52 weeks for ophthalmology services but the hospital were unable to provide additional clinics, such as injection clinics, due to lack of space. There were examples of additional weekend clinics cancelled due to lack of appropriate staffing. The trust recognised that this was an issue across the service and were conducting a capacity and demand analysis to identify how they could improve; however, the review had not been completed at the time of inspection. Between May and October 2016, they had run 189 additional clinics but they were still not meeting the national standard for waiting times.
- The ENT department had run 46 additional clinics between May and October 2016 to minimise their waiting times, however, there were over 300 patients waiting up to 52 weeks for ENT appointments at the time of inspection. Staff described examples of patients choosing to pay for treatment at private hospitals, rather than waiting for appointments at the hospital.
- The hospital reported a total of 143 cancelled clinics were cancelled within six weeks of the clinic date in October 2016. This was 3% of clinics were cancelled that month. The main reasons for cancellations as reported by the hospital were annual/study leave, clinicians required at meetings, sickness, staff shortages, changes to clinic rules and industrial action. They were developing a policy in November 2016 that included the process for contacting and rescheduling patients.
- Our observation of practice, review of audits and discussion with staff confirmed that clinics often ran late and patients could be kept waiting for long periods of time. During the inspection, we observed three clinics running up to 90 minutes late. Staff told us that patients were often waiting two to three hours in the fracture clinic but this was if they required an x ray or a plaster after being seen by a doctor. There were occasions when patients were kept waiting up to six hours but this was after their journey had been completed within the OPD and they needed to be transferred to an inpatient bed within another department of the hospital. Information that the service collected on the timeliness of clinics showed that 27% of clinics started late and 79% of clinics finished late at Isebrook Hospital and Nene Park Outpatient's clinic from February to April 2016. For the same time period, 12% of clinics started late and 53% of clinics finished late at Kettering general hospital. This was not on the service risk register.
- Not all patients we spoke with had been informed about how long they would be kept waiting in the department.

Areas, such as the fracture clinic, had whiteboards showing the expected delay but we observed other areas that did not display this information. For example, we spoke with patients in the haematology clinic who had been waiting 40 minutes for their appointment but had been given no information and nothing was displayed.

- Patients found it difficult to contact outpatient services to book, cancel or reschedule appointments via the telephone. There were no answer phone or call-waiting facilities so all calls were directed to staff in the appointment centre. The appointment centre did not have enough staff to manage the amount of calls they received and receptions did not have enough staff to cover vacancies or sickness.
- We observed patients visiting Kettering general hospital main outpatient reception in person as their calls had not been answered for the previous week. The occasion we observed was not recorded as an incident or complaint, though the hospital had identified contacting the service as a theme in their complaints. Reception and administration staff did not have the time to answer the phone due to other work pressures, such as organising medical notes. They told us that patients and relatives often got angry and could get verbally abusive when they could not get through to the department. Staff reported these occasions as incidents. The service was developing their telephone system to address the issues, but this was not in place at the time of inspection.
- From April 2015 to March 2016, the "did not attend" (DNA) rate for the hospital was 8%, which was higher than the England average of 7%. The DNA rate remained above the England average and at the time of inspection was 10%. The booking department operated a call back system for DNAs, which was followed up by the relevant consultant or nursing team. The level of follow-up was at the discretion of the consultant and varied depending on clinical need and circumstance. For children seen in adult clinics, staff contacted the safeguarding team if a child missed more than one appointment. Staff described how they managed DNAs in their departments and their descriptions were in line with hospital policy.
- The hospital had implemented a free text message service in September 2016 to remind patients seven days before their appointment, however, this was a new system and patients we spoke with had not received a text message reminder.
- Image reporting delays has remained on the clinical business unit's risk register since November 2012, due to the risk of care being compromised due to potential pathologies not being identified in a timely manner. In order to mitigate this risk, some images have been outsourced to external companies, and additional work has been offered to hospital staff. The department monitors the backlog and we have seen evidence of increasing outsourcing been carried out when the backlog of reports have grown.
- In October 2015, the radiology service manager advised the hospital board of approximately 22,000 unreported examinations. Between February and April 2016, the imaging department undertook an exercise to reduce this backlog by outsourcing the reporting of images for CT, MRI and GP patients that were waiting for over 10 days. This was seen to bring down the backlog significantly by April. As of 23 February 2016 in CT, 145 patients and in MRI 184 patients were waiting up to three weeks for a report. This figure had dropped to zero patients waiting over 10 days by the 14 April 2016.
- In June 2016, the hospital joined a radiology consortium with six other NHS hospitals in the East Midlands to replace the existing picture archiving and communications system (PACS) and radiology information system (RIS). This was to enable images and reports to be shared across the hospitals for timely radiology reporting. However, there were issues with the reliability of the IT systems, which had a negative effect on productivity and turnaround. This meant patients were experiencing delays in receiving their scan results. The hospital had a backlog of approximately 4,700 patients when they commenced the PACS and RIS upgrade. This increased to 15,612 in September 2016 and affected the majority of specialities.
- All urgent referrals for imaging, including cancer imaging, were prioritised within two weeks. However, patients waiting for non-urgent imaging results were waiting up to ten weeks for CT scan results and up to 12 weeks for MRI scan results. Plain film images also

experienced a delay, but posed the least risk due to the images being initially reviewed by the referring team. Patients waiting times for plain film image results were up to:
  - A&E limbs: 10 weeks
  - A&E chests: 14 weeks
  - Paediatric: 10 weeks
  - General outpatient plain film imaging: 16 weeks
- The backlog peaked on 22 September 2016 at 15,612 images awaiting a radiology report. At the time of the inspection in October 2016, the backlog had reduced to 11,733 images following measures taken by the hospital to reduce the backlog
- The trust had taken action to minimise this backlog by outsourcing their radiology reporting. At the time of inspection, there were 11,733 images awaiting a radiology report. There was a backlog of 337 images outstanding for plain film appendicular skeletal A&E films. The most outstanding image was ten days old. This had reduced in the month prior to inspection when there were 2,995 patients waiting up to a maximum of ten weeks.
- Since October 2015, the radiology department regularly achieved 100% of patients receiving an appointment for imaging within six weeks of the request. This was with the exception of November 2015, which was still significantly better than the England average.
- To maximise use of their interventional suite, the radiology department had recently started to undertake 'low risk' angioplasties one morning every three to four weeks. A vascular surgeon or radiologist from a neighbouring hospital undertook these procedures on outpatients who had been reviewed and deemed as low risk. The department was looking to extend these services in the future.
- The radiology department used a dedicated imaging porter team at weekends and until 10pm on weekdays. This meant that inpatients were able to be imaged in a timely manner and spent less time on wards waiting for scans. Outside of these hours, general porters were responsible for transporting inpatients to the department.
- Specialities such as urology and the breast clinic had set up one-stop clinics to reduce the number of appointments patients had to attend and facilitate timely access to care. One-stop clinics combined consultations, diagnostics and results.

Meeting people's individual needs

- Services were planned to take into account the needs of different people, for example on the grounds of age, disability or religion. However, there were occasions where people's needs were not identified or met.
- There was a system to notify staff if people required additional support, such as people living with a learning disability, dementia or mental health problems. This information was added to patients' notes so that the department could make necessary adjustments prior to their appointment, for example fast-tracking patients to avoid unnecessary distress. However, staff told us that patients were not always identified or flagged up prior to their appointment. This issue was raised in the previous CQC inspection in September 2014 and was not in line with the hospital's access policy that states patients who are in vulnerable circumstances should have their needs identified at the point of referral. The hospital had recognised that they were not meeting standards for recognising dementia care needs and their mitigating actions included training staff in identifying and assessing people who may be living with dementia.
- When patients with learning disability or dementia arrived for appointments with no prior information or staff suspected patients may have an undiagnosed condition, staff said they contacted the hospital's specialist learning disability nurse for advice.
- Staff were aware of how to support people living with dementia and had accessed the hospital training programme in order to understand the condition and how to be able to help patients experiencing dementia. Butterfly stickers were put on the notes of patients who were known to be living with dementia so that staff were aware of their needs.
- Not all patients we spoke with had received written information before their appointment and two patients said they had missed appointments due to miscommunication. Both patients' appointments had been rescheduled.
- The outpatient departments had systems in place to provide sandwiches for patients waiting in the department either post procedure or waiting for transport home.

Outpatients and diagnostic imaging

- Patients who attended ENT clinic had water refreshment accessible to them in the ENT waiting area. This meant that patients were able to keep themselves hydrated while waiting to be seen by a clinician.
- Staff members and patients told us that contact details on letters from the outpatient services were not always correct. This had caused difficulties for patients who needed to contact the department for advice or additional support. The department had identified a complaint theme and the contact details were updated as a result, however, patients and staff we spoke with said that the problem still occurred.
- Wheelchairs were available at the main reception and the environment was accessible in most areas, such as the dermatology department that had a low access reception. However, consultation rooms in the ophthalmology department were not appropriate for wheelchair users and staff had to move equipment out to allow access. Also, due to insufficient space and seating, we observed overcrowded waiting areas in ophthalmology and the fracture clinic causing difficulties for people with mobility problems.
- Follow-up appointments were offered via telephone in departments such as haematology and chronic pain, to allow patients to access services from their own home.
- There was written information in treatment rooms and waiting areas on a variety of conditions and treatments. Examples included 'Helping you decide for breast screening' and 'Information on full pulmonary function tests'.
- Results from the National Cancer Patient Experience Survey 2015 were in line with the England average on questions about the amount of information patients received prior to their appointments.
- Within the inpatient haematology ward, there was one side room facility dedicated for people aged between 18and 24 years old who were receiving chemotherapy or intrathecal chemotherapy .
- Bariatric equipment could be accessed if required. We saw bariatric seating, examination couches and wide-bore MRI scanners that were compatible with heavy weights. Wide-bore MRI scanners were also used for claustrophobic patients.
- Translation services were available including written information in other languages, telephone interpreters and face-to-face interpreters to attend appointments.
- Hearing loops were in place at reception desks across the department.
- There was a multi-faith prayer room and a chapel of peace that patients and relatives could access and services were held for all faiths.

Learning from complaints and concerns

- The service had not met the trust's timescales for responding to complaints in the period August 2015 to July 2016, but following the introduction of a revised complaints' policy in July 2016, with longer timescales for a response, improvements had been made in responding to complaints with an average response timescale of 26 days (in the period April to September 2016). The most common themes of complaints were delays to treatment, communication and cancellations. This was not on the service risk register.
- Staff were aware of the local complaints procedure, and were confident in dealing with complaints if they arose. However, not all managers and senior staff we spoke with could describe recent complaints from their department or any themes or actions taken as a result.
- There were examples of changes made in response to complaints or concerns. For example, appointment letters had been changed in order to provide clearer directions for appointments.
- Feedback forms were available and accessible across the outpatient service. Information on the patient advice and liaison service (PALS) was included. Patients we spoke with knew how to complain.
- Information was accessible on the hospital website and also throughout the hospital which provided details of how patients could raise complaints about the care they had received.
- Following complaints from patients regarding difficulty contacting the department, the administration manager in the department was leading a project to improve the telephone system.

Are outpatient and diagnostic imaging services well-led?

Inadequate

We rated the service as inadequate for being well-led because:

- The delivery of high quality care was not assured by the leadership or governance in place.

Outpatients and diagnostic imaging

- There was a failure to make improvements following the last inspection. Risks identified at the last inspection had not been addressed.
- The service strategy for achieving priorities and delivering good quality of care was not fully embedded and understood by all staff. Staff could not clearly articulate the strategy to improve performance.
- Not all staff were aware of the strategy to improve RTT performance. Most of the staff in the service had no clear oversight on actual clinic backlogs in the diagnostic and imaging department.
- Some, but not all, leaders understood the challenges to good quality care and identified actions needed to address them but they lacked capacity to drive improvements in a timely way.
- There was a lack of an effective governance framework to support the delivery of quality patient care. The information used to monitor performance or make decisions was not always reliable.
- Significant issues that threatened the delivery of safe and effective care had not been identified. There was not a holistic understanding and management of risks in the service.
- The risks in the service identified were not always managed appropriately. Some risks found on inspection in some outpatients clinics and the imaging department had not all been recognised by the service or assessed, and included on the risk register. Effective mitigations were not always in place.
- Staff at Nene Park outpatients' clinic told us that they felt separated from the hospital and that they were isolated from the main hospital.
- There was limited evidence of engagement with patients beyond feedback being sought from the Friends and Family Test.
- The was limited evidence of innovation or improvement.

However, we also found that:

- Staff were treated fairly and had equal opportunities for training, development and career progression.
- There was very good working relationships between staff, their managers and senior staff and their managers and staff morale was generally good.
- Nursing and radiology staff found their managers to be approachable and supportive.
- The service had set up a five year outpatient transformation programme in September 2016. This work included focusing on DNA rates, clinic template changes and cancellation of clinics.

Leadership of service

- The service was led by operational leads and clinical leads who had worked in the hospital for many years. They managed the service across all four sites. Some, but not all, leaders understood the challenges to good quality care and identified actions needed to address them but lacked capacity to drive improvements in a timely way.
- Staff acknowledged the issues with RTTs and backlog reporting in diagnostic images but not all staff demonstrated an effective awareness of the plans to address these concerns. .
- Staff at Nene Park outpatients' clinic told us that they felt separated from the hospital and that they were left to manage issues alone. They told us that the executive team were not visible on site and they would not know how to approach them if they wanted to raise concerns.
- Senior nurses at Nene Park outpatients' clinic told us that they were not able to attend meetings, such as leadership meetings and clinical update meetings, due to lack of available cover. They also did not have enough time to hold local staff meetings due to staffing pressures.
- The general manager of the clinical support business unit was accountable for all services within the business unit such as therapy, and endoscopy but also acted as the service manager for imaging and the radiation protection for plain film. Since May 2016, they felt much of their time was consumed by managing large risks within radiology such as the reporting backlog and staffing issues. The other services in the business unit had service managers who reported into the general manager. An assistant general manager had been appointed and was due to start imminently to relieve the pressure on the general manager's workload.
- The clinical director of radiology started in post in June 2016 after the previous director left. The radiologist had previously been in the hospital for several years as a consultant radiologist.
- The general manager and superintendents of each modality in the diagnostic and imaging service were seen to be present and easily accessible to staff during the inspection. They were all approachable and had

several years' of experience working in the hospital and in radiography. Nursing and radiology staff spoke positively about the leadership and management styles of their line managers. Local leaders were visible and approachable.

- The appointment centre did not have enough staff to manage the volume of calls they received. Minutes from departmental governance meetings showed that managers were aware of the staffing issues in the administration department and had planned an external staffing review to be completed by November 2016. The risk was also on the outpatients' department risk register. However, the administration department was not supported with additional staff in the interim and did not have enough staff to cover vacancies or sickness.

Vision and strategy for this service

- The hospital had recently introduced new CARE values which were:
  - Compassionate – to take the time to be empathetic and open: treating each other and our patients as individuals that matter.
  - Accountable – to take responsibility and ownership both individually and collectively for our decisions and actions
  - Respectful – to value the experience and contribution of others: respecting others' thoughts, feelings, beliefs and behaviours.
  - Engaging - to ask for and listening to the opinions of others and facilitating an open environment for dialogue.
- Staff generally understood the hospital wide strategy and their role in achieving it.
- We spoke with four senior staff nurses and seven staff nurses and they were able to articulate the 'CARE' values of the hospital, which were 'to be compassionate, accountable, respectful and engaging'.
- The service strategy for achieving priorities and delivering good quality of care was not fully understood by all staff. Staff could not clearly articulate the strategy to improve performance.
- Staff told us that they were aware of the "I will" campaign and they could describe examples of the campaign in practice. The hospital's "I will" campaign was to improve patient's experience and safety and staff pledged through this campaign to keep patients safe, comfortable, treat patients with compassion, keep the environment tidy and abide by the core values and behaviours of the organisation.
- The service had set up a five year outpatient transformation programme in September 2016. This work included focusing on DNA rates, clinic template changes and cancellation of clinics. The scope included choice for patients, better attendance rates and fewer cancelled clinics. The programme was designed to identify potential areas for improvement, oversee the design and implementation of solutions and monitor progress to achieve an outpatient service that was benchmarked as performing in the top quartile. The programme key deliverables included:
  - E-Referral implementation for GP
  - New Access Policy
  - Patient Reminder Service (2 Way-Text service implementation)
  - Clinic template optimisation achieved through the introduction of new tools'

Governance, risk management and quality measurement

- There was an inconsistent governance framework to support the delivery of quality patient care. Staff were unclear about their roles and could not demonstrate what they were accountable for. The general managers did not have a clear oversight of the day to day working of the service. For example, the service had failed to identify risks associated with space issues in some outpatient areas, medication storage issues, lack of BLS training in radiologists and lack of paediatric competencies in phlebotomy staff.
- Not all staff had an effective oversight of the risks affecting their service. Effective strategies to manage risk were not always in place and understood by all staff.
- Working arrangements with partners and third party providers were arranged through a service level agreement (SLA). During the inspection, we found that the diabetic centre was under a SLA with another NHS hospital. There were no clear governance procedures for managing and monitoring the SLA in place. For example, when we visited the diabetic centre, we found equipment that had expired and a fridge used by the external NHS hospital staff with no thermometer to check the temperatures. When we spoke to staff who used these equipment, we found that there was no

procedure for monitoring equipment in the diabetic centre. We raised these with clinical leads and found that this had been rectified during the unannounced visit.

- Managers ensured that there was a plan in place to develop local safety standards for invasive procedures using the national safety standards for invasive procedures and assessed the need for these against all invasive procedures carried out within their departments.
- Monthly governance meetings were held with action plans discussed. The radiation protection committee annual meeting in August 2016 discussed a variety of topics, including the latest radiation protection advisors audit, which was carried out in July 2014.
- The radiation protection committee (RPC) reported into the health and safety steering group which subsequently reported into the integrated governance committee. This allowed opportunity for any issues relating to radiation protection discussed at the RPC was escalated to the chief operating officer and the board.
- A new risk manager had recently been appointed at the hospital. One of their early roles was to review the reporting backlog delay and monitor the department's response and improvement plans and performance. The clinical director of radiology told us there were known problems with the lack of reporting capacity monitoring due to the old IT systems not having the capability of recording that information. It was recognised that this was an area to action once the service had recovered from its reporting backlog issue. Senior staff told us there had been difficulties in recruitment that had affected image reporting capacity.
- Diagnostic imaging risks fed into the clinical business unit's risk register. This was regularly reviewed at the business unit's governance meetings. Risks identified included the Inability to recruit qualified staff in the imaging department. Various staffing groups had been identified as a particular risk such as cardiac catheter lab and CT and MRI specialist radiographers.
- Image reporting delays was also included on the risk register since November 2012. The department had attempted to mitigate this risk by outsourcing imaging to external companies and offering overtime to staff in the department. In 2012, we saw evidence that the department had risk assessed an agreement to not make formal reports on some examinations which would be viewed and reported by other clinicians in the hospital. Even with these actions in place, we saw evidence of two further peaks in imaging backlog (in October 2015 and summer 2016). The second peak in 2016 was largely beyond the trust's control due to problems in the transition to the new RIS and PACS systems. The trust took actions to further mitigate risks and to reduce the backlog.
- The risk register did not reflect all risks found on inspection. For example there was no specific mention or actions in place relating to the inpatient waiting area for x-ray that was not fit for purpose, poor compliance with mandatory training for radiologists. This meant that we were not assured that appropriate monitoring or interim measures were in place to reduce these risks. Risk found on inspection in outpatients clinics had not been recognised by the service or assessed, and included on the risk register. Effective mitigations were not in place.
- Some other risk identified on the register appeared to have no obvious actions relating to them such as the aging imaging equipment. At the time of the inspection we saw evidence of actions relating to this, but this was not reflected on the risk register.
- Some policies and guidelines such as the IR(ME)R employers' procedures and radiation safety policy were available through the hospital's intranet and staff told us they had opportunities to access computers to view these. However, many of the departmental standard operating procedures were still in paper form within the department and were therefore not subject to version control. Staff were not always aware of the most up to date versions of procedures and policies and we were not assured that there was consistency across of practice across the clinical workforce. We were also not assured that there was an effective system of review for procedures and radiology protocols.

Culture within the service

- During the inspection, staff said there was a strong emphasis promoting the safety and wellbeing of staff.
- Staff told us they felt respected, valued and were treated fairly, with equal opportunities for training and development, career progression.

Outpatients and diagnostic imaging

- The culture in outpatients and radiology was centred on the needs and experience of patients. For example, all staff we spoke with were proud to work at the hospital; they were passionate about the care they provided for their patients.
- Staff and teams worked collaboratively, resolved conflicts quickly and constructively and shared responsibility to deliver good quality of care. For example, senior sisters told us that they were proud of their teams and were always looking at the patients' journey. However, they also told us that they struggled with increased capacity and this had been escalated.
- Senior nurses in Nene Park outpatients' clinic and the fracture clinic told us that staff morale was affected by the pressure and demand on services. In the other outpatient areas we visited, staff morale was good and staff told us they were well supported, despite the demands and challenges. Managers were said to be available to support staff and to provide advice where needed.
- Staff attended the hospital's daily safety huddle and took part in daily discussions. Regular staff meetings were held.
- We saw minutes from monthly staff meetings for the radiographers and assistant staff. Topics included feedback from reporting radiographers relating to image quality was discussed for shared learning in plain film, feedback relating to waiting times was given so staff could keep patients informed.
- Several staff members told us that the problems the department had experienced with the PACS had had a negative impact on morale due to the number of patient complaints that the department had received.

Public and staff engagement

- There was limited evidence of engagement with patients beyond feedback being sought from the Friends and Family Test.
- Feedback was sought from patients, those close to them and their representatives by the NHS Friends and Family Test questionnaires were available for patients in clinic waiting areas and we saw posters displayed, which encouraged patients to leave comments about the service.
- We saw in the maxillofacial clinic that the Friends and Family Test outcomes, patient feedback and comments were displayed in a glass covered quality board.
- Regular staff meetings took place with monthly newspapers and leadership briefings.
- We spoke to one patient who had been featured in the hospital's newsletter to share the positive outcomes of their treatment.
- There was a forum for suggestions on the staff intranet, called 'KNet'. Staff described using this to contact the executive team with their ideas for improving services and received feedback.
- A monthly newsletter called "Medical Records and Outpatients newsletter" was circulated to staff working in medical records, outpatient admin, main outpatients, the fracture clinic and peripheral clinic staff. This was produced by the lead nurse for each area.

Innovation, improvement and sustainability

- The was limited evidence of innovation or improvement. During the inspection in 2014, we found that the environment within the outpatients department was not fit for purpose, clinical areas were small and clinical rooms were not soundproof. During this inspection, we found that this had not improved and the areas were still not appropriate for the services delivered.
- A healthcare assistant from the chronic pain service had been nominated for a 'KGH Smile Award' as recognition for their work on developing a patient outcome form that the service had implemented.
- Training of voluntary staff to support patients, relatives and friends ensured they were able to support people. Volunteers added a great deal of value to the patient experience and as a talent pool for the future workforce. The hospital had 149 active volunteers ranging from a variety of administration functions, chaplaincy, meet and greet, ward based and patient contact roles.
- The department had avoided junior radiographer anticipated vacancies through offering student jobs early on in their third year of training (on the condition of qualification) for when they had completed their degree. These radiographers were initially been employed as assistant practitioners while their professional registration was processed and once registration had been achieved they were appointed as radiographers. Radiology management told us that this process had worked well.

Outstanding practice and areas for improvement

Outstanding practice

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

Areas for improvement

Action the hospital MUST take to improve

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

Outstanding practice and areas for improvement

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

Outstanding practice and areas for improvement

Action the hospital SHOULD take to improve

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

Outstanding practice and areas for improvement

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

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

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

This section is primarily information for the provider

Requirement notices

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment How the regulation was not being met: • There were insufficient numbers of medical and nursing staff within the service who had safeguarding children level 3 training, a requirement for all staff caring for 0-18 year olds in line with the Royal College of Paediatrics and Child Health Intercollegiate document 2014. • Systems and processes to prevent abuse of service users were not established and operating effectively to minimise the risk. • Not all staff in children and young people's service were trained to the required level of safeguarding.

This section is primarily information for the provider

Requirement notices

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Transport services, triage and medical advice provided remotely	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: • The risk management systems did not provide sufficient oversight to mitigate the risks related to the carrying out of the regulated activities. • There was no effective process in place to manage and record the ambulance handover times and a lack of systems to monitor, collate and review this information to improve performance and patient experience. • There was no effective cyclical audit process in place to monitor compliance, identify best practice and areas for improvement. • There was a lack of effective policies and governance system to support service delivery. • Confidential patient information was not always stored in accordance with the Data Protection Act 1998. • National Early Warning Score (NEWS) charts were not all filled in clearly, accurately and legibly in medical care.

This section is primarily information for the provider

Requirement notices

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

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: • There were insufficient numbers of registered nurses (children's branch) to ensure that the children's ED had one such nurse on at all times.

This section is primarily information for the provider

Requirement notices

- Adult nurses working in the area had not received sufficient training to ensure that they were competent to care for children.
- The hospital were not following the British Cardiovascular Society guidance on nurse staffing numbers in the Coronary Care Unit.
- There was insufficient number of medical registrars and junior doctors to cover out of hours and weekend shifts at all times.
- There were inadequate medical and nurse staff numbers in accordance with its own minimum staffing levels in the children and young people's service.
- Staffing levels for both medical and nursing staff did not meet levels as recommended in national guidance in the children and young people's service.
- Only 57% of staff in the radiology department were up-to-date on the mandatory basic life support training.
- There was a lack of paediatric competencies for staff who had direct contact with children in outpatients.

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

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

This section is primarily information for the provider

Enforcement actions (s.29A Warning notice)

Action we have told the provider to take

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

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